A Yes.

Q Who?

A The attending physician, that's in section B-1 on this statement --

Q Yes.

A -- is referring to above it in B, one or more qualified physicians who are approved and have the privileges granted by the governing body to do that function.

Q Well, were you -- were you approved to do procedures at the endoscopy center?

A Not anesthesia.

Q No. I'm asking you if you were approved to do procedures at the endoscopy center?

A Endoscopy procedures, yes.

Q And you had to apply for those procedures, correct?

A For privileges, yes.

Q For privileges. And part of that application was to be approved. In other words, you had to fill out an application and that had to be approved by somebody. Who was that?

A By the so-called governing body.

Q And who's that?

A Dr. Desai was on the governing body and I may have been on it but I never participated in that. I don't

know who was on the governing body.

Q But nevertheless, you were approved to have those privileges to perform those procedures, correct?

A Endoscopy, yes.

Q So if another doctor came in here and testified that those provisions applied to him as an attending physician in that procedure room would he have been mistaken?

A He's mistaken.

Q And if that other doctor came in here and testified that he was quote the captain of the ship and responsible for everything that happened in that procedure room, would he be wrong?

A He'd be wrong regarding anesthesia.

Q So you didn't feel that you had any supervisory role in that procedure room whatsoever; is that your testimony?

A Supervisory role for whom, the anesthetist?

Q The nurse, the GI tech, the CRNA that were in there?

A Not for the CRNA. I was available to answer any questions that a tech or a nurse might have about the case. But did I have official supervisory responsibilities? Not that I'm aware of.

Q You testified that if you saw something that was not medically correct being performed, and I'm adding this

part to it, by either a GI tech, a nurse or a CRNA, would it not be your responsibility to either stop the procedure or speak to that person?

A If I saw something that was not right or I didn't like, yes, it would be my responsibility.

Q And did you ever have occasion to do that?

A Yes.

Q When?

A I don't remember the date, but it was regarding the bite blocks.

Q Okay. And you testified to that, correct?

A Yes.

Q Okay. Other than that at that time, did you know who the tech was --

A I don't remember --

Q -- in that case?

A -- I don't remember.

Q But the CRNAs are not responsible -- or let me ask you, are they responsible for bite blocks?

A No.

Q So other than that one time in your ten, twelve-year practice with the endoscopy center, you had one occasion to call somebody on a procedure in that procedure room, correct?

A Well, I did testify that I did note and report

that one of the CRNAs had been pulling some of the propofol in February of 2008.

Q We're going to talk about that. But that was after the CDC had arrived, correct?

A Right.

Q So prior to the CDC coming onto the facility, this one time was the only time you ever had occasion to call somebody on an improper procedure?

A To the best I recall. Certainly if you have something I would be happy to answer it.

Q I just want your honest testimony.

A I don't remember ever having an issue before.

Q Now, as lawyers, we belong to the Bar Association and as lawyers we have an affirmative duty to report another lawyer that we see is engaging in misconduct. Does -- do doctors have that same thing?

A I believe so, but not that I'm personally aware of the details.

Q So do you feel that as a doctor you have a responsibility to report another doctor to the medical board if you see something that they're doing wrong or improper?

A Not necessarily. You can take a different way to correct it.

Q And have you ever done that in the past?

A Done what?

Q Reported another doctor to the medical board or taken some alternative action to correct the situation?

A Not that I'm aware of. I've never reported a physician to the medical board.

Q Have you ever had to sort of take a doctor aside and say, hey, you're doing this wrong or, you know, we need to stop this?

A Not that I recall.

Q So it's -- would it be fair to draw the conclusion that in the 10 to 12 years that you practiced at the endoscopy center you didn't observe any of the CRNAs doing anything improper?

A That's correct.

Q I want to talk to you about this lawsuit you were involved in. I believe the plaintiff's last name was Rexford?

A Yes, sir.

Q And when did that -- when was that suit filed?

A 2006 -- excuse me, 2007.

Q Now you mentioned Mr. Lakeman's name in relation to that lawsuit and I want to clarify this. Mr. Lakeman was never a defendant in that lawsuit, was he?

A No, he was not.

Q And I believe your testimony was that as a result of that lawsuit you became aware of this billing time

situation of 31 minutes; is that correct?

A Correct.

Q And when did you become aware of the billing time problem, potential problems?

A In -- best that I recall February of 2008.

Q Do you ever remember talking to a CRNA named Ann Lobiondo and having her tell you about how they bill?

A I -- I just recall seeing Ann after all this occurred at a health food store and I remember talking to her briefly about it but I don't remember anything else about the times.

Q So you don't remember that prior to the CDC's arrival?

A I don't recall that.

Q But it could have been but you just don't know?

A It's possible, I just don't remember.

Q What was the result of that Rexford -- or what were you sued for in that Rexford lawsuit?

A I was sued for the alleged -- it was alleged that I missed a colon cancer on -- during a colonoscopy in the right side of the colon and that even though I discovered it a year later because I had missed it, the patient suffered metastatic colon cancer.

Q And I believe you testified that you settled that case; is that correct?

A That case was settled, yes.

Q Now, I want to talk to you about this incident with Vincent Mione.

A Yes.

Q Okay. Who is Vincent Mione?

A Vincent Mione is one of the CRNAs that was employed with our practice.

Q And I believe you testified that you had occasion to look at his chart on the bottom right-hand corner and you noticed the times were filled in, correct?

A Correct.

Q And I believe your testimony was that the start time was not incorrect. Matter of fact, the start time was correct; isn't that your testimony?

A That is my testimony.

Q But the end time was incorrect?

A You are correct.

Q And in fact had been put in prior to even starting the procedure?

A The best I recall, yes.

Q And as a result of doing that, tell me what you did as a result of that -- of observing that?

A I went to Dr. Desai to tell him about that and to tell him that the end time had to be the end time.

Q Now, I want to know more about how you

discovered this with Mr. Mione because you were in a procedure room when this happened, I'm assuming?

A Yes.

Q And a procedure room is very dark; isn't that correct?

A Not before the procedure starts.

Q Okay. So the lights are on?

A Yes.

Q And the CRNAs are usually at the head of the bed?

A In this case he was to the left of the patient and on -- if you imagine the gurney, he was to the left of the gurney but not yet at the head of the bed.

Q And what were you doing?

A Getting ready to do the procedure. I walked over to the left side of the bed where he was. I don't remember what I was looking for, what I was doing, but that's when I looked and saw what was happening with it.

Q And in your 12 years of experience, that was the first time that you actually walked over and looked at a CRNA's notes; is that your testimony?

A Yes.

Q Now you -- you testified before the grand jury; is that correct?

A Yes.

Q And there was some questions asked about CRNAs and their procedure, and propofol, correct?

A Best of my recollection, yes.

Q And one of the questions asked of you was did the CRNAs ever leave a procedure room in the middle of the procedure. And do you remember what you answered?

A I don't remember that question. I thought it was if a -- did a doctor ever leave --

Q Okay --

A -- can you show it to me?

Q -- it might have been and I might be mistaken. Let me just check the transcript real quick. Well, let's answer that question. Did a doctor ever leave?

A No, not to my recollection. I -- no.

Q And in your experience, did you ever see a CRNA leave the procedure room in the middle of a procedure?

A No.

Q I don't need to look then. Thank you. You testified that colonoscopy times varied; is that true?

A Yes.

Q And in fact they vary from physician to physician; isn't that also correct?

A I think that's reasonable, yes.

Q And isn't it true that Dr. Faris and Dr. Carrera took longer then perhaps you and Dr. Desai?

A I think that's true on average.

Q In fact, their procedures could last from 30 to 45 minutes. Do you have any knowledge about that?

A Yes.

Q Is that --

A Occasionally a procedure that they would have would last that long.

Q So when you said that a procedure lasted for 10 to 15 minutes, that was for you?

A For me on average.

Q Okay. Your testimony seemed to indicate that you were intimidated by Dr. Desai; is that fair to say?

A That's fair to say.

Q And in fact that intimidation inhibited you from going to him and requesting changes, for example, in -- in patient scheduling?

A No.

Q Okay.

A I'm not sure I understand that.

Q All right. Well, you testified that there was a time when you became in charge and you reduced the patient load.

A Yes.

Q And then you testified that Dr. Desai came back and the patient load increased.

A Correct.

Q And I believe you testified that he called you in or you had a discussion with him where he said something to the effect that I don't want you to ever do that again or something like that --

A Something like that.

Q -- is that fair to say?

A Fair to say.

Q And I believe that reading in your testimony in the grand jury transcripts, and correct me if I'm wrong, you felt intimidated by confronting him and standing up for what you believed in at that time. And those are my words, not yours.

A That's true.

Q And you had this feeling as a partner physician, correct?

A Correct.

Q Second on the hierarchy of the organizational management chart; isn't that correct?

A Again, there's no management. I had no management position, I was a partner.

Q Right. I'm talking about the organizational levels. You were second under Desai; isn't that correct?

A Yes.

Q And the CRNAs were far down the list, aren't

they?

A Well, what -- I'm not sure I understand what does it mean, far down the list. They were professionals, they were very well respected professionals.

Q Well, I'm talking about in the hierarchy of the management organization of the clinic. They didn't have any management role in the clinic, did they?

A No.

Q They didn't have any say so as to what supplies were purchased and what weren't purchased, did they?

A Well, I want everyone to know that I don't know the answer to that because sometimes -- I'll give you an example. There came a time when the CRNAs wanted to have a wedge, a wedge about two or three feet long that would go behind the patient's back when he or she was on the left side to prevent the patient from falling back during a procedure. They -- one of the CRNA's asked -- told me about that.

Q Who was that?

A I don't remember. And --

Q And what happened?

A -- and -- and as I said, one of the CRNA's who I don't remember said we would really like to have this, can we please just purchase it? Now, yes, I'm not a manager but I said sure, just order it if you think it's important.

Q And who would they order that from?

A I don't know.

Q Okay.

A I don't who they -- how they order it.

Q If you needed something who would you order it from?

A I have no idea.

Q How would you get the things you needed?

A We would ask -- ask Dr. Desai, ask maybe one of the nurse managers how to get something.

Q And who would they be?

A Katie Maley and Jeff Krueger.

Q None of the CRNAs had any role in ordering supplies as far as you know?

A That's correct.

Q And none of the CRNAs had any decision making with regard to how many patients got scheduled on a given day; isn't that correct?

A That's correct.

Q I want to talk about one CRNA that was Linda Hubbard.

A Yes.

Q And you mentioned an incident that occurred after the CDC had arrived, right?

A Yes, sir.

Q And do you know when the CDC was there?

A CDC was there from early January to mid-January.

Q Of 2008?

A Yes, sir.

Q And I'll represent to you that Mr. Lakeman left the employment in October of 2007. Okay? So I'm presuming that Mr. Lakeman -- you didn't see Mr. Lakeman there when the CDC was there, did you?

A No.

Q Now tell me about the incident with Linda Hubbard again.

A Sure. Okay. When I was doing a procedure on February 7th, 2008, again, we had -- I had written in response to what Brian Labus, the epidemiologist said about you should have a policy about --

Q Can I interrupt you there and tell me about that while we're -- while we're talking about it. What did you write?

A I wrote a -- I actually wrote a one-paragraph policy and in that policy I wrote generally -- I can outline it for you.

Q Please.

A I wrote that from now on, without exception and without excuse, the way the propofol would be administered would be as such. New bottle of propofol, new syringe, new needle. The propofol is administered to the patient. That

syringe and that needle are discarded completely. If the patient requires another dose of propofol you can enter the same bottle with a new needle and a new syringe. That needle and syringe needs to be discarded. If the patient requires more propofol, then you may get a new bottle and use another new syringe. If the patient no longer needs propofol, any remaining propofol in that bottle that was just used is to be discarded. That's the outline of what I wrote.

Q Okay. And that was a new procedure?

A That was a new policy. We never had any sort of policy like that before.

Q Okay. It was a new policy.

A Yes.

Q A policy that had come into effect after February, 2008 or thereabouts?

A Correct.

Q And you testified earlier that you had no experience in administering propofol; isn't that correct?

A Correct.

Q So what anesthesiologist did you consult with in writing these -- this new policy?

A I did not consult an anesthesiologist. I used what Brian Labus the epidemiologist told me that he had seen and what -- that we should have a policy against this.

Q So you, who had no experience with the drug --

A Correct.

Q -- and didn't consult an anesthesiologist formulated a policy by which all CRNAs were to use after February, 2008 at the endoscopy center; is that correct?

A That's correct.

Q Would you say that writing that policy and directive was some sort of management responsibility?

A No, I didn't think it was a management responsibility. I took it upon myself to do that because I was there and I was talking to Brian Labus and the CDC and I thought that I could -- I could produce and write it clearly for everyone to understand it.

Q Did you contact or consult with the other 10 or 11 physicians that were employed by the endoscopy center before you disseminated that information?

A No.

Q Now let's go back to the incident with Linda Hubbard.

A Yes.

Q You had written these policies and then you observed something. What do you observe?

A I observe that a portion of a bottle of propofol with propofol remaining in it was not being discarded and thrown away but was being kept on a small brown table at the foot of the bed and was being utilized to draw up propofol for

the next patient, even though what was being drawn up was only a few ccs and then a new bottle was being used to finish the draw into the 10 cc syringe. Now, I wasn't sure because I'm doing procedures, I didn't want to accuse her of anything that I wasn't sure of. So I asked Jeff Krueger to -- I pulled him out of a room and I said this is what I think I just saw, can you observe the next case with me and tell me if that is correct. He did and he said yes, that's what's happening. That's when I shut down the room and called Dr. Desai.

Q So she had done it twice?

A Yes.

Q Once with you there, once with you and Krueger there; is that correct?

A Yes.

Q So your concern was she wasn't abiding by the new policy that you had drafted?

A Correct.

Q And which she signed, initialed rather --

A Yes.

Q -- correct. And she was basically reusing propofol bottles on multiple patients, correct?

A Yes.

Q And basically that was the old procedure?

A What was the old procedure I don't really know because I wasn't observant of that or understood it but it was

certainly not what had just been written down in the new policy.

Q And obviously she -- it was something she had done in the past because she was doing it two times in front of you and Krueger?

A Well, I say to you I never observed her directly do that until I watched this time.

Q Okay. And as a result of that, you asked Dr. Desai to fire her, he didn't do it and instead sent her for some training or something?

A Sent her for some training and reassigned her to our other center.

Q Did you ever work with her again?

A You know, I don't remember. I may have, I just don't remember.

Q Can you tell me some of the other CRNAs that you worked with?

A Sure. Vincent Mione, Vinnie Sagendorf, Ron Lakeman, Keith Mathahs, Mr. McDowell, Ann Lobiondo and there were some others who spent some time with us but I just don't remember their names.

Q Okay. And of all those individual CRNAs that you worked with at the clinic, there wasn't one time where you had occasion to correct the procedures that they were using; isn't that accurate?

A That's accurate.

Q I have nothing further. Thank you.

A Thank you.

THE COURT: All right. May I see counsel at the bench?

(Off-record bench conference.)

THE COURT: All right. Mr. Wright, why don't you get started on your cross-examination.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q Good afternoon, Dr. Carrol. As you know, I'm Richard Wright.

A Hi, Richard. Nice to see you.

Q I represent Dr. Desai. I'd like to go back to where the prosecutor started with your background and education and experience and then your joining of the practice, which -- and then as the growth of the practice. Okay?

THE COURT: Mr. Wright, keep your voice up.

MR. WRIGHT: Okay. Everybody get that?

BY MR. WRIGHT:

Q I -- I want to -- I'm going to take you where the prosecutor started, your background, your education, your experience and then coming out to Las Vegas, joining the practice and then the evolution and growth of the practice and

your participation in it. Okay?

A Okay.

Q And you're from New York?

A Yes, sir.

Q Okay. You were -- went to school in where?

A I went to college at Adelphi on Long Island.

Q Okay.

A Medical school in Buffalo, New York.

Q Okay. Did you grow up in Long Island?

A Yes, I did grow up on Long Island.

Q Okay. High school there?

A Yes.

Q Okay. Then college --

A On Long Island.

Q Okay. So that's a four-year college?

A Yes.

Q Okay. Then now we're not always familiar with residency and medical school and all the education. So after your four years of college you then go to what we call medical school?

A Yes, at State University New York at Buffalo.

Q Okay.

A For four years.

Q So that's eight years of college education?

A Yes, sir.

Q Okay. And at that point are you a specialist or just a doctor?

A I am just a M.D., that's it.

Q Okay. Not -- not that it's just, but I mean it's a -- you then went ahead and specialized?

A I then -- I went ahead and did all the requisite training to do what I had to do to become a gastroenterologist.

Q Okay.

A That meant going to an internship in medicine at Mount Sinai.

Q Where's that?

A In Miami, Florida.

Q Okay. And how long does that internship --

A Well, the internship is one year. The -- you can stay for two more, a total of three but I moved to New York because I met my wife and I moved back to New York to finish medicine at Beth Israel in New York City for my second year.

Q Okay.

A After my second year I -- I applied for radiology residency and I was accepted for radiology residency in New York City, which I did for one year but did not like it. So I decided to go back to Beth Israel, finish my medicine, then become Chief Resident of Medicine at Beth

Israel from 1991 to 1992, which meant I was in charge of all the residents. Then from 1992 to 1995 I did my three-year gastroenterology and liver fellowship at Stony Brook on Long Island.

Q Okay. As I tracked through that you had the eight years of college and then three more years of internship?

A Yes.

Q Leaving out the -- the year that you lost because you didn't like it?

A Yes.

Q That's 11 and then three more years of fellowship?

A Yes.

Q Okay. So that's 14 years of education to get to where you're going to go to work?

A Yes.

Q Okay. And then you're married. You achieved all of that success and your first job --

A My first job that I took was back in Buffalo where I went to medical school and joined a single gastroenterologist there in 1995.

Q Okay. So in 1995 you and another gastroenterologist?

A Someone who was experienced, had been there for

years, I joined him.

Q Okay. And what -- the -- your -- how long did you practice in Buffalo before you moved to Las Vegas?

A About a year and a half.

Q Okay. And during that period of time you're -- you are now a practicing gastroenterologist?

A Yes.

Q And doing endoscopies, colonoscopies, uppers, everything you ultimately did in Las Vegas?

A That's correct.

Q Okay. And at that time is propofol being used?

A No.

Q Okay. And the anesthesia at that time -- were -- were you practicing in what we'd call an outpatient clinic or were you in a hospital?

A No, I was exclusively in a hospital.

Q Okay. And so you would take -- you would get patients who were going to have a colonoscopy and it would be done in the hospital?

A That's right.

Q Okay. And how -- on -- did you do it a couple days a week -- the procedure that is?

A I don't remember, about three days a week --

Q Okay.

A -- I had procedures.

Q And the -- how many -- how many were you doing like a day -- procedures?

A When I had my day at the hospital I would probably be doing 12 and 16.

Q Okay. Twelve to 16 procedures and were you self-medicating?

A I was instructing the nurses to provide what we call conscious sedation.

Q Okay. And conscious sedation -- at that time there was no CRNA, no anesthetist -- what are they --

A Anesthetist, anesthesiologist --

Q Right.

A -- no, there was not.

Q Okay. And so if someone was having a -- a colonoscopy, you would instruct the nurse to give what?

A I would instruct the nurses to give either Versed, which is a Valium derivative and I would instruct on the dosage. And then I would instruct the nurses to give either Demerol or Fentanyl, which are both narcotic pain medications, which amplify the effect of the Valium Versed compound but I would direct the dosages.

There was one time where I wasn't directing the dosages and that was during a very difficult ERCPs and I -- I had to complain because the nurses were giving the medicine without my instruction and giving too much of a dose while I

was in the room. But for the most part I gave the instructions and I told the dosages and I estimated how the patient was doing.

Q Okay. And -- and at that time you were responsible for giving the anesthesia?

A Well, it's not anesthesia, it's sedation.

Q Okay. Sedation, I -- I use them interchangeably. What's anesthesia and what's --

A Well, for me I never use them interchangeably because I've been traumatized by that.

Q Okay.

A So sedation is the administration of a medicine that sedates the patient to a state of reduced consciousness but not intubated and still has control of breathing, heart rate, and all muscles. That's conscious sedation.

Q Okay.

A That's where -- that's how -- what we achieve with Versed and Demerol.

Q Okay.

A Anesthesia is the administration of medication to render a patient unresponsive and paralyzed, therefore the need to control the airway and breathe for the patient while an invasive procedure requiring that is done.

Q Okay. With -- unconscious and paralyzed?

A Yes.

Q Okay. But not paralyzed like the way I think of paralyzed?

A When I say paralyzed, I mean unable to initiate a breath and that's why a machine is used.

Q Okay. Now, the -- after practice -- you're practicing in Buffalo and you all -- you make the decision to move west?

A Yes.

Q Okay. And you see an advertisement?

A In the New England Journal of Medicine.

Q Okay. And you respond to it?

A Yes.

Q Okay. And you come out for an interview?

A Yes.

Q Okay. And who interviewed you?

A Dr. Desai interviewed me, Doctors Carrera and Sharma interviewed me.

Q Okay. And on direct you indicated there were at the time the practice you were applying for a job --

A Yes.

Q -- that practice had five physicians?

A At the time that I was applying there was Dr. Desai, Dr. Carrera, Dr. Sharma, and Dr. Faris, that was four.

Q Okay.

A Dr. Sood had just arrived -- again, in the same

year, but just a month before me, so I was number six.

Q Okay. So he just got in a month earlier?

A Yes.

Q Okay. And you were the sixth?

A Yes, sir.

Q And you were interviewed and they offered you a job?

A That's right.

Q Okay. And what -- you accepted?

A Yes, sir.

Q Because?

A Well, because my wife truly wanted to be in a place that was warm and sunny. She couldn't take the winters anymore, that was the predominant reason we moved. Kids were young and if we were going to do this we were going to do it then and not later.

Q Okay. And had you applied elsewhere?

A I had looked at other jobs in North Carolina, South Carolina, Florida, Georgia --

Q Okay. And did --

A -- New Jersey.

Q And this looked like the best fit for you geographically and you liked the practice that you saw?

A Yes, I had a good interview experience. I thought I could make it work here.

Q Okay.

A And I thought my wife would be very happy here.

Q So you move out to Las Vegas and start when?

A May of 1997.

Q Okay. And at that time you testified on direct that you're the -- what we've called the Shadow Lane office or clinic was an -- a one procedure office -- smaller on Shadow Lane, correct?

A All right. So at that time there was an office for seeing patients and there was an endoscopy center, it's own facility, but it only had one room. You could walk to it. You literally could walk across the hall to it from the office.

Q Okay. And the -- the job offer that was extended to you, which you accepted, was that you were going to be hired as a employee physician?

A Correct.

Q And in about three and a half years you and they would see if it is a good fit --

A For partnership, yes.

Q Correct. And you were to expect if everything went well and they liked you and you liked them, that you could become a partner at three and a half years?

A Correct.

Q Okay. And during that time you were paid

monthly just like any other employee?

A Yeah, I was paid biweekly.

Q Okay. And when -- and as we know because you're here testifying, and were a partner, at about three and a half years --

A Yes.

Q -- they said, welcome?

A Yes.

Q Okay. And when they -- and they -- are you dealing with Dr. Desai?

A Well, Dr. Desai is the person I'm dealing with. He's making the decisions about partnership.

Q Okay. And so the -- you -- you then became -- and I might not be using the correct terminology, but you became a partner in the gastro side, meaning the medical practice?

A That's correct.

Q Okay. And to do that you -- you were not required to buy in to the practice?

A That's correct.

Q Okay. So it was after three and a half years of work, if you're good at what you do and we like you, we will make you a partner without any cost to you and you then essentially own a portion of the medical side of the business?

A That's accurate.

Q Okay. And the -- do you know what percent -- at that point what -- I know we -- we talk percents, you talk shares.

A Yes.

Q Okay. And I'm just talking about the Gastro Center --

A Yes.

Q -- not the -- we'll get to the Endoscopic Center of Southern Nevada where all the procedures are but on the gastro side you're like what when they welcomed you in?

A One-sixth.

Q One-sixth?

A Because at the same time Dr. Sood who had preceded me by one month was also offered partnership.

Q Okay.

A So that brought me to six, so I would have one-sixth or maybe -- or one-seventh or perhaps Desai had two-sevenths. I'm not sure I remember.

Q Okay.

A Because Dr. Desai always had two shares to our one.

Q Okay.

A So it may have been two-sevenths, one-seventh.

Q Okay. And -- and -- in any event, if you had one share and every other partner except Dr. Desai had one

share of the medical side of the business --

A Yes.

Q -- and Dr. Desai, the founder, had two shares, correct? So if -- if -- if there were -- if it went to 10 partners -- physicians --

A Yes.

Q -- if there were 10 persons we'd have 11 shares, Dr. Desai would be two and the other nine would each have one?

A Correct.

Q Okay. And on -- on that -- that side of the business, money's generated and you're no longer just salaried but if the medical practice -- the medical side is profitable, that is divided up according to those shares?

A Yes, sir.

Q Okay. And if it was like with the exception, two-sevenths goes to Dr. Desai, one-seventh goes to Dr. Carrol?

A That's correct.

Q Okay. And then aside from that the -- I'm saying they but it's Dr. Desai you were dealing with, correct?

A Yes.

Q Okay. Dr. Desai offered you the opportunity to buy into the endo practice?

A Yes, he did after I asked if I could.

Q Okay. And did -- and Dr. Desai said yes?

A Yes.

Q Okay. And do you recall what it cost?

A Yes. It cost $90,000 to buy six shares --

Q Okay.

A -- $15,000 each.

Q So it was $15,000 per share --

A Yes.

Q -- and that was to be a -- a sixth share owner of the endo practice?

A Correct.

Q And did you -- how -- how was payment arranged?

A At the time the payment took me about six -- maybe nine to 12 months. Dr. Desai helped me arrange a way to get paid my salary but take some money away from that and pay for those shares. He didn't ask me to take a loan or pay for it up front. He helped me make an arrangement over time to pay for those.

Q Okay. So ultimately over time by withholding portions of your earnings or something --

A Yes.

Q -- you were all square?

A Correct.

Q And so you were a part owner in each practice?

A Right. I had to buy three shares from Dr. Carrera and three shares from Dr. Sharma.

Q Okay. And the -- when you did this you entered into written agreements with -- these agreements we've seen here in court, like Operating Agreement or something?

A Right, yes.

Q And that shows -- spells out your shares?

A Yes.

Q Okay. You were familiar with all the terms in there?

A Well, maybe not, you'd have to show -- there's very confusing phraseology and terms in there.

Q Okay. Well, were you -- were you aware of the -- what do you call that covenant in medical practices --

A Restrictive --

Q -- if you leave the practice you can't take the patients with you --

A -- that's called a restrictive covenant.

Q Okay, restrictive covenant. Is it -- is that unusual?

A It's not unusual, it happens.

Q Okay.

A And sometimes you have to be -- you know, when you come out of medical school and residency, you have to be wary of these things when you're looking at joining practices, these so-called restrictive covenants.

Q Okay. And you had understood the -- how long --

did you know how long Dr. Desai had been here building his practice?

A Yes, I did.

Q How long?

A Since 1981 if memory serves.

Q Okay. And he -- he had built it up and he -- he was being protective of the business --

A Yes.

Q -- by preventing people from coming in, taking some patients and opening up next door?

A Yes.

Q I mean, that's what the whole restrictive covenant's about, correct?

A That's correct.

Q Okay. And you -- you were questioned about it by Mr. Staudaher but you never attempted to leave and couldn't or something?

A No, I never did that.

Q Okay. And you were very content and proud of the business and your ownership in it all the way up until it was closed down, correct?

A Well, that's a lot of adjectives in there.

Q Okay, break them down. Which one bothers you, content?

A Content's a little problematic.

Q Okay.

A Now, I didn't want to complain because it's ingrained in us and as doctors, as soon as you walk into that internship year that you are going to work harder than you ever thought possible for 80 to 90 or 100 hours a week. So it's ingrained and you go to residency and you work hard, then you go to fellowship and you work hard, and then when you go to private practice.

It's not like you walk into a nine to five job unless you seek out one like that, like a VA job, for example. You know you're going to work very hard and Dr. Desai told me that, you're going to work hard here. I said, okay. But to say that I was content, there were many, many days and nights where I just didn't think I could do this anymore --

Q Okay.

A -- being on call for 12 hospitals every other weekend, working so hard during the day. And that's why in 2007 I -- I said to Dr. Desai, I can't do this anymore, I have to go part-time. I can't be expected to scope every day and see and then have a beeper available to 12 emergency rooms at night and then come back the next day and then work weekends. So we worked -- we tried to work something out where it -- I could do it.

Q Okay.

A And he was very helpful.

Q Okay. And he -- he -- and this -- you knew walking in -- I mean at your interviews at the beginning, you were told this is a long hard practice. If you think it was tough getting to your position in medical school, now you're really going to work?

A Well, that -- that exact phrase wasn't used but the phrase was you're going to work hard.

Q Okay. And you understood that, correct?

A I understood what working hard was, I didn't understand what all the details were.

Q Okay.

A How could you?

Q I understand. The -- all of the other doctors -- I mean, by the time we end up 2008 there are like 14 physicians?

A Yes.

Q Okay. Were -- are we talking physician partners?

A By the time 2008 rolled around we had I think 11 or so physician partners and three -- again, I think, three employee physicians about to become partners in January of 2008.

Q Okay.

A And you know something, I was proud of that. I was very proud of these three guys sort of making it through

all that hard work and becoming partners. Yes, I was proud of it.

Q Okay. And -- and it's not like the other partners were dumping on Dr. Carrol, you had to work like that, we're talking about a hard working practice, correct?

A Correct. Now, yes, it's a hard working practice and if there was an unequal distribution perhaps of work, it was addressed. You know, maybe we should do something about how much some -- some people doing while others don't seem to be doing as much.

Q Okay. And were there times where some individuals opted to do less and to take less?

A Yes.

Q Okay. Like whom?

A Dr. Carrera and Dr. Mason opted to go part-time, which meant a reduction in their percentage from one share to a 60 or 65 --.65 I believe share in exchange for not doing night call or weekends and that's what I was asking to do myself because I -- I had trouble working this hard.

Q Okay. Now, when you first come and go to work in Las Vegas --

A Yes.

Q -- and you're a physician employee, where are you assigned?

A I was assigned initially to University Medical

Center as my hospital and at that time Lake Mead Hospital and the office.

Q And at that time when you started, what -- what type of sedation or anesthesia was being used in the practice?

A That would be -- when I started it was conscious sedation. Again, the Versed and the Demerol.

Q Okay. And the -- it's -- at some point it started to change over?

A Yes.

Q Okay. And why did you start at UMC, do you know?

A Not for any particular reason but that's where traditionally when new folks came to our practice they went through there, almost as a right of passage because it's such a arduous, difficult place to work. But again, I just started and when Dr. Desai said do X, I did X.

Q Okay. And then ultimately, if I follow it correctly, you mainly worked out of the Shadow Lane Clinic?

A That's right.

Q Okay. And you were there before the 2004 addition to two procedure rooms?

A Yes.

Q Okay. And you testified that you -- you and or the practice started utilizing anesthesiologists more?

A Yes.

Q Okay. And was there one particular anesthesiologist you used more than others?

A Well, at that time I met a Dr. Maduga [phonetic] and I got to be friendly with him. He's a very nice man and he's an anesthesiologist and he started to help me with my difficult cases that required a patient really to be still for a prolonged period of time. And then he started to come in to the practice to sedate patients. And then I think he and Desai worked out something where he would do that more often.

Q Okay. And first, you were using him like in hospital settings initially?

A Yes.

Q And so when -- when we say Dr. Desai worked it out for him to come in to the practice, we're talking about coming to the clinic and being utilized at the clinic on Shadow Lane?

A Right, at the surgical center.

Q Surgical center?

A Yes.

Q Okay. And do you recall how the utilization of CRNAs evolved?

A I can generally recall that for you.

Q Okay.

A Again, about 2000, in that time frame, the idea of hiring Certified Nurse Anesthetists occurred. I don't know

how it was generated. And Dr. Desai investigated it and researched it and began the process of taking these folks in to our practice and hiring them, and then hiring another and another over time.

Q Okay. And were -- were CRNAs being utilized at any of the like 12 hospitals?

A Yes, at Lake Mead Hospital and at St. Rose San Martin Hospital.

Q Okay. And so if -- if you went to one of those and instead of an anesthesiologist for a colonoscopy --

A Yes.

Q -- what I call a less complicated procedure, a CRNA would be used?

A Right.

Q Okay. And do you recall the first CRNA who was hired and went to work?

A I think it was Ann Lobiondo or Keith Mathahs, I'm not sure.

Q Okay. And do you recall that -- when it was being -- you said Dr. Desai investigated it and looked into it --

A Yes.

Q -- do you recall who he was talking with about that?

A I believe he was talking to Dr. Yee about that.

Q Okay. And did you have an understanding that Dr. Yee was going to somehow be available or involved in the budding, the starting, utilization of the CRNA practice?

A I had an understanding, and it's vague because it's 13 years ago, that Dr. Yee was going to have some involvement with this -- with us.

Q Okay.

A How and what way, I don't know.

Q And the -- did you see Dr. Yee at -- at the clinic on Shadow Lane?

A No.

Q Okay. Did you view Dr. Yee as your go-to guy on CRNA issues?

A Well, I viewed Dr. Yee as a go-to guy for anesthesia questions or problems, yes.

THE COURT: If you're having trouble finding that maybe we should take our recess because we were probably going to --

MR. WRIGHT: Good idea.

THE COURT: -- be taking it in a few minutes anyway. So ladies and gentlemen, let's just take a recess, we'll go until 2:50. During the recess, of course, you're reminded you're not to discuss the case or anything relating to the case with each other or anyone else. You're not to read, watch, listen to any reports of or commentaries on this

subject matter relating to the case. And please don't form or express an opinion on the trial. Notepads in your chairs please and follow the bailiff through the rear door.

(Court recessed at 2:40 p.m. until 2:50 p.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session and Mr. Wright you may resume cross-examination.

MR. WRIGHT: Thank you. May I approach the witness?

THE COURT: You may.

MR. WRIGHT: I found the form I was looking for.

THE COURT: All right.

BY MR. WRIGHT:

Q The question was, was Dr. Yee a person to go to for anesthesia services on supervising the CRNAs.

A Okay.

Q I'm showing page 50. Read this to yourself, ignore my commentaries in the underlining, so just read from here down.

A Sure. Yes, okay.

Q Page 52, start at the bottom of 51 so 52 makes sense.

MR. STAUDAHER: I'm sorry, is there a pending question that he's refreshing on here? I'm not exactly sure what the issue is. We just have him read transcripts now?

MR. WRIGHT: I'm going to ask him a new one. I don't

remember the one --

MR. STAUDAHER: Again, that's not the proper way to do it as it's been pointed out numerous times.

THE COURT: Counsel, I don't know what the question is. He can show him whatever he wants and then we'll see what the question is and then if it's objectionable, Mr. Staudaher, make your objection at that time.

MR. STAUDAHER: What are we looking at now as far as pages?

MR. WRIGHT: Page 50 -- 50, 51, and 52.

BY MR. WRIGHT:

Q Did you understand that Dr. Yee was the -- had an agreement to supervise the CRNAs?

A Okay. I understood that -- like I just said in whatever document that was --

Q That's your interview with the Metropolitan Police.

A -- okay. That there was some informal understood agreement that Dr. Yee would be -- be the person or the supervisor to -- in this use of CRNAs.

Q Okay. And you thought there was a verbal arrangement that Thomas Yee was the guy we would be using as the anesthesiologist of record for having CRNAs?

A Yes.

Q Okay. And that he would not have to be on the

premises, you understood that?

A I understood that, yes.

Q And that he would just be available for consultations, correct?

A Correct.

Q And you weren't aware of any written contract until a later time?

A I wasn't aware of any written contract and I still, to my knowledge, never saw a written contract other than that supervisory agreement.

Q Okay. And Dr. Yee was our go-to person for anesthesia, correct?

A Correct.

Q Now, did you -- did you need a supervising anesthesiologist on board in order to have CRNAs?

A Well, in the State of Nevada you don't.

Q Okay. And you researched that, correct?

A I researched it myself, yes.

Q Okay. And even though it was not needed legally there -- there -- you understood there was this arrangement or verbal agreement with Dr. Yee?

A Yes.

Q Okay. And when you researched it -- the -- you -- you researched whether or not a CRNA had to be supervised by an anesthesiologist, correct?

A Yes. I researched it twice.

Q Okay.

A Once before all this happened when we were trying to get Valley Hospital to agree to have one of our CRNAs provide the sedation for patients that we did there. So I was sort of assigned to under -- to research this to make a presentation to the subcommittee at Valley Hospital and I did.

Q Okay. Would that have been in 2005, do you recall?

A Something around there.

Q Okay. And at -- at -- at that time you were having to use anesthesiologists at Valley Hospital?

A That's correct.

Q And you -- the practice, your practice, Dr. Desai's practice --

A Yes.

Q -- wanted to be able to use your CRNAs at Valley Hospital?

A That's correct.

Q And you -- your practice was able to use CRNAs at other hospitals?

A Only one other, Lake Mead.

Q Lake Mead.

A When I said St. Rose San Martin before, yes, there were CRNAs there but they were not ours, they belonged

to that anesthesia group.

Q Okay. But using your own was only at Lake Mead?

A That's right.

Q Okay. So did Dr. Desai ask you to research this?

A Yes.

Q Okay. And you did thoroughly research it?

A To the best of my ability I did.

Q Okay. And you came to -- what conclusion about the need -- the legal reasons?

A Well, I came to the conclusion that it was reasonable and legal to have a CRNA provide services at a hospital. That in the State of Nevada, as according to the research I did, it was required to have a supervising physician, dentist or surgeon, but it was not required by Nevada statute to have an anesthesiologist be supervising. But the person who was to be the supervising physician had to agree, consent and understand what that responsibility was. So I presented that --

Q Okay.

A -- but it was unsuccessful.

Q Okay. And by presenting it, in order to get authorization like from Valley Hospital to use your own -- when I say your I'm talking about the practice and Dr. Desai --

A Yes.

Q -- CRNA there, you had to go before a committee --

A Yes.

Q -- correct? And you made a presentation to the committee?

A Yes.

Q Okay. And was that accepted?

A No, it was -- it was not -- it was rejected.

Q Okay.

A By the medical executive committee under pressure and concern from the anesthesiologists on staff.

Q Okay. And was that pressure and concern part of the ongoing turf war between anesthesiologists and CRNAs?

A Yes, you can say it was a turf war. Someone else might say it's a concern for adequacy of training. Some people's perspective might be different but, yes, it was a turf war.

Q I got the turf war words from you, right?

A Okay.

Q I mean do you recall that?

A Did I say turf war --

Q Yeah.

A -- then I said that.

Q What -- what is -- what is the turf war that was

ongoing?

A It's fundamentally this, that from the perspective of an anesthesiologist, having a nurse anesthetist, despite the training to provide sedation, without an anesthesiologist immediately available is not safe for patients.

Q Okay. And it harms them economically?

A Well, that wasn't mentioned in the argument but the safety was.

Q Okay. The -- and what do the CRNAs say?

A The CRNAs have the opposite position, that we are very well trained, we have master's degrees, we are -- we are -- have every skill necessary to adequately sedate a patient and anesthetize a patient. We don't need an anesthesiologist.

Q And they charge less, right?

A Yes, they do.

Q Okay. And in -- in your practice with the clinic at that time --

A Yes.

Q -- before going to your new one, you utilized CRNAs from 2002 or '03 up through 2008?

A That's right.

Q And they always performed safely in your judgment?

A In my judgment they did.

Q And the -- you used the term MAC --

A Yes.

Q -- and that is what?

A Monitored Anesthesia Care.

Q Okay. And so they -- they are -- you need the CRNA there to be ready to do what?

A Can you repeat that?

Q You need the CRNA there to be ready to do what? What is their expertise and specialty?

A Their expertise and specialty is to assess a patient's need for anesthesia, to properly sedate the patient with proper dosage of the medication based on a number of factors, to monitor that patient during the sedation so that the procedure can be performed safely and efficiently, and to be able, if necessary, to rescue a patient who is having some untoward event from that sedation like cardiac issues, arrhythmias, breathing issues. And it's that skill that I depend on from these -- from individuals who are professionals to -- when they're giving sedation. I assume that if -- and it's a rare event, if anything goes wrong that person will step in and resolve it quickly.

Q Okay. And you're a --you're a M.D. --

A Yes, sir.

Q -- plus your specialties?

A Yes.

Q And do you feel qualified to jump in and do that?

A I personally don't.

Q Okay. And so it's -- you take safety -- I mean it is comfort having a specialist there being able to do that, which you don't feel comfortable doing?

A Yes.

Q Okay. And on -- on occasion did something like that happen where one of the CRNAs there had to jump in?

A Yes.

Q Okay. And when was that?

A I remember an incident that a patient had a respiratory arrest during the procedure, meaning that the patient's oxygen levels fell quickly and it was clear that the routine of just adding more ventilation with a mask wasn't adequate and Linda Hubbard, the CRNA, was able, and quite effectively, and quite skillfully intervene and intubate the patient, protecting that patient's airway and saving that patient's life and then transferring the patient to the hospital and she did well. So when I say rescue, that's what I'm talking about. It only happened once to my recollection, but once is enough. So she was able to manage that.

We've had one patient have a very bad asthma attack. One of the only transfers I remember, treated with medications

and transferred to the hospital. So it's very rare but it's just like an airplane crash, it's rare but catastrophic. So if something goes bad, it's potentially catastrophic and could cause death. So I was very impressed with her ability to intervene and protect that airway.

Q Okay. And the -- every CRNA there that you worked with, to your knowledge, was -- you -- you never saw them doing something in your presence unsafe, wrong, jeopardizing the patient?

A That's correct.

Q And on -- have you ever used propofol?

A Do you mean did I -- did I ever physically inject it?

Q Right.

A No.

Q Okay. And because that's -- that brings with it all of the dangers you just talked about --

A Yes.

Q -- and monitored --

A Anesthesia care.

Q Yeah, MAC.

A MAC.

Q And so you -- you have never personally administered it?

A That's correct.

Q And before all of this came up, meaning the CDC came knocking on the door --

A Yes.

Q -- and there was the incidents in which patients contracted hepatitis C --

A Yes.

Q -- had you ever studied or read up on propofol?

A No.

Q Okay. Did you even know that propofol was single use or multi use, terms we're throwing around now?

A No.

Q Okay. And you're -- you're a practicing physician that have done tens of thousands of practices in which propofol was used, correct?

A Correct.

Q And until CDC came you never even heard of single use, multi use propofol and whether it was right or wrong; is that fair?

A It is fair.

Q Now the -- Linda Hubbard who jumped in and saved the patient's life, this is -- excuse me, this is the nurse anesthetist who also screwed up on following procedures --

A Yes.

Q -- in February, 2008, right?

A That's correct.

Q And at -- at that time after CDC and Southern Nevada Health District, you learned propofol single use for a patient then discard?

A Yes.

Q And tied with it one needle, one syringe, one time in, toss?

A Yes.

Q Okay. And the -- those were the instructions, advice, whatever you want to call it, from Brian Labus, Health District, CDC, as to how it should safely be done?

A Correct.

Q Okay. And so you participated in implementing that --

A Yes.

Q -- by writing it up as you described and then having every CRNA sign off on it?

A That's right.

Q And then on Linda's procedure, what you saw violated the multi use of propofol, correct?

A Correct.

Q Okay. Yet she was engaging in aseptic practice, correct?

A Correct.

Q Okay. So but she -- she was technically wrong but she was not doing anything to endanger a patient, correct?

A Now, I would say that that is correct because she, to my knowledge and my observation, she was not changing a needle or changing a syringe.

Q Okay. I mean what -- what you saw her do was she has propofol, patient there, and she would take new needle, new syringe, go in to propofol, dose the patient?

A Right.

Q And if patient needed more, she's following the throwaway needle and syringe protocol --

A Yes.

Q -- she's using brand new needle and syringe every time she enters?

A Correct.

Q And so that part she's got but what she's doing is not throwing away a partially used propofol vial, right?

A That's right.

Q And then using the partially used one on a next patient and using a brand new needle and brand new syringe to get the remainder of the propofol to put in a new patient?

A That's right.

Q Okay. And utilizing that procedure there was no way there could be cross-contamination, correct?

A So to my knowledge I think that that's correct. I don't see, as you described it and as it happened, I don't see how there could be a cross-contamination. It was just

A Yes.

Q Did that surprise you to hear him say that again?

A Well, he was again very forthright and very straightforward, very sure. Again, I -- I took him at his word that this was okay.

Q Was there any indication that we should look into this, find out what's going on, anything like that?

A I -- no, there was no conversation like that at all.

Q Then what do you do, walk away?

A Walked away.

Q So after you walk away, what happens next?

A Again, it's very hard to remember the exact time frames and dates, but not long after there came a time --

Q And are we talking about a day, a week, two weeks --

A Maybe a week.

Q Okay, just for clarity sake.

A Right. There came a time when I was about to do an upper endoscopy procedure on a patient. The patient is to my right and behind the patient is the CRNA. His name is Vincent Mione. And Vincent Mione is the anesthetist and, he's about to sedate the patient and I walk over for whatever reason, I think to check on some information or to check on

something, and I see -- I notice on his clipboard that he has with his anesthesia sheet, I notice for the first time that on the bottom right of that sheet is where he's putting the times down for his anesthesia procedure. And I noticed that there's two little blank lines, one says start and one says finish. And I notice that he's putting in the start time already, but that's okay, the patient's in the room. But he's already put down the end time of the procedure even though I haven't done it yet and it's -- it said 31 minutes of time.

Q So before you even do the procedure --

A Correct.

Q -- this is all filled out?

A Yes.

Q Did that cause you some concern?

A Yes.

Q What did you do as a result of that?

A I asked him why --

MR. WRIGHT: Objection. Hearsay.

BY MR. STAUDAHER:

Q I said -- hold it. You asked the -- the CRNA why?

A I asked -- I asked the CRNA.

Q Okay. Without getting in to what he said, what did you do after you heard what he said?

THE COURT: That's fine.

THE WITNESS: I went back to Dr. Desai. I walked out of the room -- after the procedure was done I walked out of the room, back to Dr. Desai's office --

BY MR. STAUDAHER:

Q Let's stop, I want to stop you there for a minute. Was that the first place you went after that?

A Yes.

Q Do you ever recall talking to Tonya Rushing during any of this?

A I would -- I did speak to Tonya but after I saw Dr. Desai.

THE COURT: Maybe we should take our break now.

MR. STAUDAHER: That's fine, Your Honor.

THE COURT: Ladies and gentlemen, we're just going to take a break until 11:00. During the break you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch or listen to any reports of or commentaries on the case or any person or subject matter relating to the case. Don't do any independent research and please don't form or express an opinion on the trial.

If you'd all place your notepads in your chairs. If anyone has any questions that they've already written out you can hand them to the bailiff if you want to on your way out the door.

And Doctor, please don't discuss your testimony with any other witnesses during our break.

(Court recessed at 10:47 a.m. until 10:59 a.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session and Mr. Staudaher, you may resume your direct examination.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q Now, when we left off you said that you were walking in to a procedure; Vince Mione was there. Before the procedure even starts you look down and you see an anesthesia record that in the lower right-hand corner had the start and stop time already listed on it.

A Correct.

Q And I'm showing you -- this is a -- obviously not that one, this is from -- I'm representing to you that this is from the 21st of September of 2007. It looks as though you were actually the doctor involved. Do you see this?

A Yes.

Q Is this the type of form that you're talking about that you saw?

A Yes.

Q And for the record what I'm showing him comes from State's Exhibit 4. The time period that we're talking

about, was it the area here in this lower right-hand corner of that page?

A Yes, that's the box.

Q The page is designated anesthesia record Bates number 2601 for counsel and record. When you see -- saw this, this document, was it all filled out or did you just notice the time or what was it?

A I just noticed the time.

Q Now, you say that after that -- after you saw that, I mean, did you continue on with the procedure?

A To the best of my knowledge I think I finished the procedure then I went to see Dr. Desai.

Q Tell us how that went.

A I walked into his office and he was there and I sat down with him and told him what had just happened, what I was -- just observed and I was very upset and very nervous and I said to him that the -- the end time has to be the end time on these procedures, just has to be.

Q And when you saw that record, did that cause you some concern? I mean, why is it a big deal?

A Well, it's a big deal because the end time of the procedure I was just about to do was already put down before I finished the procedure, and therefore the timing -- the time of the -- of the anesthesia's not correct. It's not truthful. That's what the concern was. That's the -- that

was what made me very upset.

Q False information in a medical record essentially?

A Correct.

Q So is that why you went and confronted Dr. Desai about this?

A Yes.

Q Now you go up to him, you say this to him. What was his reaction? I mean, how did he -- first of all, before the words, we talk about the words, what was his reaction when you came up and talked to him? Did he seemed shocked, surprised, indignant, what?

A No. I came into the room, he seemed normal and I sat down with him and told him what happened. And then after I said to him that the end time has to be the end time he -- he agreed, he said okay.

Q What did he tell you to do if anything?

A He told me that I -- I shouldn't be the one who tells the CRNAs about this change. I shouldn't do it personally, that I should ask Tonya Rushing our Chief Operating Officer to do that and to talk to each CRNA.

Q Okay. Did you do that?

A Yes, I did.

Q So tell us about that.

A I called Tonya, told her what had just

transpired, told her that Dr. Desai wants her to speak to every and each CRNA that we have employed anywhere and talk to them about this anesthesia time and make sure that the end time is the end time.

Q When you went up and talked to Tonya -- and I don't want to get in to what she said to you --

A Okay.

Q -- just when you go up and give her this information, you talked to her about that, what was her expression or response?

A To be clear, the conversation was by phone. I called her upstairs in the office; she's on the fourth floor.

Q Without telling us what she said, did she appear to be calm, reasonable, surprised? What was it?

A She appeared to be surprised and shocked.

Q Did things --

MR. WRIGHT: Objection. He just elicited hearsay.

MR. STAUDAHER: That's not --

THE COURT: Possibly. Don't -- don't base your statements on -- or opinion as to what she may have said. If you know, I mean, was she screaming, crying, her voice was calm and steady? That you can tell us, anything you observed about her demeanor, which would obviously be through her voice or noises she was making that you were able to hear on the other end of the phone. Was there anything?

THE WITNESS: She was -- her voice -- her level of her voice elevated. She -- she was incredulous --

MR. WRIGHT: Objection. That's hearsay.

THE COURT: Yeah, don't -- don't -- right. I -- Mr. Wright, I already --

MR. WRIGHT: Mr. Staudaher knows it, Your Honor. I object to --

THE COURT: I sustained it as to hearsay if his opinion is based on her -- her words, anything she said.

MR. WRIGHT: I move to strike.

THE COURT: All right. That is probably, you know, stricken. Again, you can comment on, you know, the tone of her voice, you know, sounds you heard through -- you know, like is she crying, is she pausing, you know, that -- that sort of thing.

BY MR. STAUDAHER:

Q Based on what -- the way she responded and I'm not talking about the words that she actually said but you mentioned the elevated voice, things like that. The way she responded --

MR. WRIGHT: Objection. Not things like that, Your Honor. That's hearsay.

THE COURT: Well --

MR. STAUDAHER: It's not hearsay. It's a perception of her actual voice.

THE COURT: All right. Okay. Ask your question, Mr. Staudaher.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q Based on the way she responded, not the words, did she appear to be calm or surprised or whatever you would describe her as?

A Surprised.

Q Now subsequent to that call, did you keep your sort of -- I mean eye out for this kind of thing again?

A Well, after that call Tonya called up the CRNAs --

MR. WRIGHT: Objection. Mr. Staudaher knows this is hearsay he's eliciting, Your Honor.

THE COURT: That's -- that's sustained unless you witnessed Tonya making a phone call or you witnessed the CRNAs picking up the phone and speaking with Tonya. Don't testify as to anything Tonya may have told you.

BY MR. STAUDAHER:

Q Did you at some point see anesthesia records later on?

A Yes.

Q When you saw the anesthesia records later on, did they appear to comport with the actual time?

A Yes.

Q And what were the actual times that would be -- that you were seeing on those anesthesia records?

MR. WRIGHT: Foundation.

THE COURT: I'm sorry?

MR. WRIGHT: Foundation. I'm just --

BY MR. STAUDAHER:

Q After the phone call --

THE COURT: Okay, how --

MR. WRIGHT: -- well, just like -- like to get a month now because I think we're --

THE COURT: All right. Mr. -- how soon after the phone call did you start, you know, looking at the anesthesia records and discerned that now they comported with the actual time, the phone call to Tonya Rushing?

THE WITNESS: Within the week.

BY MR. STAUDAHER:

Q Okay. This is something that you continued to do up until the time that the clinic closed?

A Well, you know, I didn't look at them every day but as -- when this occurred, the times were changed immediately, it was effective immediately.

Q So you saw the results of that?

A I did see results of that.

Q At some point down the road, and I'm talking about when -- after the CDC came in, did you take it upon

yourself to try and figure out what was going on?

A Yes.

Q Did you pull all the records for the days in question, the 21st specifically of September of 2007 and look at all of the charts, all of the anesthesia records for those days?

A Yes.

Q Now this was pre-dating the phone call with Tonya Rushing, pre-dating your seeing that record, pre-dating you actually having the conversation with Dr. Desai; is that fair?

A That's not -- that's inaccurate actually.

Q Okay.

A I was able to look at all the records from September 21st of every patient that had a procedure because all of those records had been acquired by the law firm that Dr. Desai had hired to help us through this called Lewis and Roca. So at some point I think after the announcement in late February I was able -- I -- I took it upon myself to go to that office into a conference room and look at every single one of those records. I do not remember the exact date, but I sat for more than one day looking to try to -- for myself to figure out if I could understand what happened on that day and how this -- how this happened to these patients.

Q So you looked at every single record for that

day for all the patients done?

A Yes.

Q Whether you were the doctor or not?

A Correct.

Q And were you looking at -- I mean you saw them all?

A Yes.

Q When you looked at those, did something jump out to you?

A Yes.

Q What -- what was it that you saw that jumped out to you?

A What jumped out to me was that for every one of those records the anesthesia times that were listed on the bottom right corner were all either measured up to 31 or 32 or 33 minutes.

MR. STAUDAHER: Your Honor, I'm going to display right now State's Exhibit 56.

THE COURT: Okay.

BY MR. STAUDAHER:

Q This I'll represent to you is a chart. Do you see the -- and the numbers here on the right-hand side, do you see those?

A Yes.

Q There's some names but the rest of them are

numbers. And I'll represent to you that the numbers have been transposed for the actual patient files of those patients who are not in fact in this particular case. Do you see that?

A Yes.

Q Okay. So, if we move over to the column that shows -- entitled Anesthesia Records Calculation, do you see that?

A Yes.

Q Do you see the start and stop time? This is coming from the charts, individual charts, the anesthesia records that you're talking about.

A Okay.

Q As we move up -- and the blue column is what I'm referring to here. Do you see those?

A Yes.

Q Is that what you're referring to, seeing them all in the 30 plus minute range?

A Yes.

Q When you saw that, how did that affect you?

A Well, it was very alarming to me. It confirmed that there was some issue with the timing of the anesthesia.

Q Did you understand the implication of that at the time when you're going through every single one of those records?

A Yes.

Q What was the implication?

A That the implication was that these times of 31 minutes or more were -- were false, that they didn't correspond to the actual time of the anesthesia during the procedure.

Q Did you know that this was used for billing purposes, the anesthesia record, the timing?

A At the time of my review of these records?

Q Yes.

A Yes.

Q So when you're looking at this and you know that --

MR. WRIGHT: Lay the foundation as to that time period.

BY MR. STAUDAHER:

Q You said by the time you were looking at these records, which was in February of what?

A It was in 2008, it could have been March. I just don't remember when I was at that office looking at this but it was after the announcement.

Q So that's when you went to look at these --

THE COURT: I'm sorry?

MR. WRIGHT: Which announcement? Your Honor, I just --

THE WITNESS: The public announcement on February

24th.

THE COURT: All right. So sometime --

MR. WRIGHT: Okay.

THE COURT: -- after February or March.

MR. WRIGHT: I didn't hear.

THE WITNESS: The public announcement, the public news announcement.

MR. WRIGHT: The press release and --

THE WITNESS: The press conference.

MR. WRIGHT: -- the CDC. Okay.

BY MR. STAUDAHER:

Q That's when you got to sit down and look at them all, you see them and you realize what this means; is that fair?

A That's fair.

Q Were you concerned that it could open you up to some liability if you were part of this?

A There's always that background concern because my name is on these charts, but I knew in my heart that I didn't generate these times so I didn't have fear that this was a direct personal liability to me but I was very concerned about these times of course.

Q You didn't question, you know that this is for reimbursement purposes, right?

A Now I understand -- at this point I understand

that.

Q Well, you actually participated in getting some of the reimbursement for this type of billing; is that right?

A What do you mean by that?

Q I mean, did you partake in the money that came in for this type of billing, anesthesia billing?

A Yes. I was paid for -- as a partner I got paid, yes.

Q In fact, were you aware that there were different funds in the group, one of which was a CRNA anesthesia fund?

A I was aware that there was a CRNA account, yes.

Q And did you actually get bonus checks from that account?

A I do remember getting at least one bonus check from that account.

Q Who controlled that account?

A Dr. Desai did.

Q Did you have even the ability to go back and look at the -- pull the business records and look at that account, see how the disbursements came in -- or from that account, money went into it, anything like that?

A No.

Q So you just got a check cut to you from Dr. Desai for -- but related to this billing?

A As a bonus check, yes.

Q Now, during the time that you are sitting there looking at all these charts, after you do that, you realize what's going on, do you -- what do you do?

A By this time it's really -- I can't do much. It's after the public announcement, there's the press conference in late February. I think by this time the practice is either shut down or being shut down. This was really -- I was doing this for me to figure -- to help try to figure out what happened.

Q Did you ever confront Desai about this? Ask him why this was going on?

A No. At this point, no.

Q Did you ever confront him about that?

A No, other than the meeting I told you about.

Q Well, let's talk about the meeting. What meeting are you discussing?

A The one where I went to his office and -- and said what I had just -- just observed. I did have -- I did talk to him one more time at a personal meeting in 2008 in June.

Q Let's talk about that. Where did that meeting take place?

A It was in June of 2008. I had already started back in practice with my small group, I was at Southern Hills

Hospital. It's very hard to describe how despondent and depressed I was about everything that had happened. And I reached out to Dr. Desai as a mentor and a friend and asked if I could meet with him and talk to him and he agreed and he met me at Starbucks on Charleston.

Q Were you alone?

A Just he and I, yes.

Q Okay.

A And I was very happy that he was gracious enough to meet with me because I was so sad and I reached -- and he was -- he was a person I admired and looked up to and he met with me and I remember putting my hands in his hands and crying and saying I -- I remember saying I think I'm dying. I don't think I'm going to survive this. And he was very comforting and very helpful and we -- and we talked about things, about what happened, why is there a criminal investigation because I was so sad and so confused.

And then I did ask him -- I asked him why did the nurse anesthetist put that extra -- that 31 minutes down on those billing sheets and he said -- he told me that -- if I remembered when we had one room, when we had a single room before 2004 and when cases would take that long. They just got into a habit of putting down that much time and they carried it over to the 2004 expansion.

Q That was his explanation to you?

A That's what he told me.

Q Did you go any further with him with that? Ask him --

A No.

Q So let's step back. That's after -- after --

A This is long after --

Q -- okay. Let's go back to the -- the day that you actually have all this stuff happen. After you go confront Dr. Desai about this, do you call anybody else? Do you tell anybody else about this?

A Yes, I did. I called Dr. Mason.

Q And I'm not going to get into what Mason said to you, I'm just wanting to know what you told Mason.

A I called Dr. Mason immediately because Dr. Mason was the person who was doing most of the procedures at the other facility on Burnham and I told him what had just transpired and I asked him to please check the records of the cases that were being done there to see if this was happening over there. And I told him what I was talking about and he said he would look into it and we hung up.

Q Now, beside that, I want to go back to this record for a moment. When you're going through these, was there anything about this record as far -- and you know how this is set up right now? If we move over a little bit -- actually you'll see the column marked CRNA. Do you see that?

A Yes.

Q And you'll see the -- the columns look like, for the most part, it's one CRNA in one room and one CRNA in the other room with the exception of -- of Keith Mathahs in this position and Keith Mathahs right here. Do you see that?

A Yes.

Q So he's in two -- he's on the record here what appears to be around, 11 to noon, somewhere right in there?

A Yes.

Q And also back up here at 10:13. Do you see that?

A I see that.

Q And if we go back up here to the ones involving Keith Mathahs predominately, you'll see that Ronald Lakeman appears around the noon hours as well somewhere.

A Yes, I see that.

Q Now, in going through the records of all of these patients, was there anything that you noticed that gave you a different -- or -- that you noticed that was different between records, for example?

A Yes.

Q What was that?

A Interestingly, when I went through all those records sitting in a conference room all by myself just going through one at a time and reconstructing this, it was -- there

was a problem with the timing of the procedure at the -- at the signature line for the doctors to sign. The problem was that on half the charts the date was wrong. It wasn't September 21st on half of the charts, on half of the charts it was August 21st. So clearly there was a glitch in the computer because all these cases were from September 21st.

So when I noticed that -- I noticed it once and then I noticed it again and then I looked for it and I saw it on half the cases this was happening at one of the computers, it was mislabeling the day of the procedure. That allowed me to more clearly separate the cases out. Now I could tell what room was happening in what room -- what room the procedures were happening in and where the patients were, that helped me personally try to figure this out.

Q So on this -- if I understand you correctly, even though we're looking at this one where it says Ron Lakeman and the whole line of Keith Mathahs here, you could tell that this was -- Ron Lakeman was in this room because of that date glitch?

A Right. So no matter what name appeared, I can tell by the date glitch that it had to be a -- one -- a single room, say room A or room 1, we didn't have labels on them. But I could tell from -- that all the cases with that date glitch occurred in one room and all the cases with the right date occurred in the other room.

Q With the exception of this -- of the thing where it's -- it looks like around the noon hour, there's a name change that also correlate with a single CRNA being in that room the entire day?

A Yes.

Q Okay. Now did the CRNAs move from room to room at any time?

A Yes. In my experience they tended to move when lunch hour came in. They, you know, each employee has to have lunch. They had their -- their lunchtime. And when lunchtime rolled around, around 11:30, one CRNA would leave and the other CRNA would then go back and forth, room to room, as the cases proceeded. Once that CRNA who had taken lunch came back, the other CRNA went to lunch and that CRNA took over until they both finished their lunches and they were both working again.

Q Was there ever any situation where -- bathroom emergency, anything like that, where you -- where are CRNA from one room might go for a temporary period relieve somebody else in another room?

A Well, you know, it's hard for me to say that I can remember specific examples, but people need bathroom breaks, people need to take breaks. Some -- I think that happened.

Q So it wasn't -- wouldn't necessarily be unusual?

A No.

Q And again, just with your sorting and everything that we see on this particular record, if we go down, see where Keith Mathahs is around the noon hour or 11 --

A Yes.

Q -- period, which I think based on what you've said, corresponds to a lunch break?

A Okay.

Q We go back up here we see Keith Mathahs at a separate time over there for it looks like just one patient or thereabouts, right --

A I see that.

Q -- is that correct?

A Yes.

Q So at least according to the record, it looks like there was at least twice that Mr. Mathahs must have gone over to that room according to the date glitch and your analysis of the records.

A That's what it seems to -- to suggest.

Q CDC comes in -- oh, before I go to that, I want -- I want to ask you one last question about the timings that you -- you noticed that were down in the range of what you thought was appropriate or accurate. After the 30 -- you saw the 30 minutes, then you look at the records and they're down to whatever they were supposed to be?

A Correct.

Q What were -- what was the range that they were down in to what they should be?

A I saw records that reflected eight minutes, 12 minutes, 13 minutes, in that range.

Q And is that more along the lines of what you experienced yourself when you're doing these procedures?

A That was more consistent, yes.

Q After the CDC comes in, were there some issues regarding, you know, policy changes, things like that that took place within the practice?

A Yes.

Q What were some of the things you instituted after the CDC came in based on things that you had learned from the CDC?

A Right. It's important to understand that when this -- when this happened and the CDC and the health department came in and announced that there had been a possible transmission of hepatitis C at our facility, I want you to know that we opened our doors immediately to them. They wanted to do an investigation, we didn't say no, they came right in. We absolutely participated in all of it. They wanted to do blood tests, we did blood tests. Anything they wanted we did because this was a shock to me. A complete, total shock.

Now, when they came in and they evaluated everything, we had a meeting with the representatives from the health district and the CDC in Tonya's office to -- for them to tell us what they had been observing and what they were seeing. And one of -- Brian Labus said to me with Tonya in -- in Tonya's office that he -- he had observed one of the CRNAs taking a needle off the syringe and putting a new needle on and then going back into the propofol to give sedation and that those propofol bottles were not -- were being used for the next patient if they weren't exhausted.

That was the first I ever heard of that, so I asked him if he was sure. Is -- are you sure that's what you saw? He said yes and that's a possible way that this could have happened through backwash by changing the needle and have the -- the virus was backwashing into the syringe and then passing it on to the next patient.

So then Brian Labus said do you -- don't you have a policy about how to give sedation? So I asked the nurse managers, do we have such a policy; Jeff and Katie. No, there's no such policy on how to give medication. These folks are professionally trained, there's no policy. Well, Brian Labus said well, you should have one, you should have a written policy on how the medicines are provided. Well, I just -- I volunteered to write that policy and I did write it and I wrote a policy that became part of our policy handbook

on exactly how to give the propofol and how to do it. And we instituted that immediately as per our recommendation from Brian Labus and we had all the CRNAs sign off on that.

Q After that, after you institute that policy, did anything happen that gave you concern down the road?

A Yes.

Q Did you observe this directly?

A Yes.

Q Tell us about that.

A On February 7th, 2008 after this policy had been written and signed off on, unfortunately I observed something that concerned me greatly and that is during a case -- and remember, the public announcement hadn't yet occurred yet so we're practicing, we were seeing patients. I thought I noticed that one of the CRNAs was not doing what she had signed off to do. She was not discarding the unused propofol in the bottle, she was saving it for the next patient but I wasn't sure because I'm watching the procedure, I'm doing my scope.

So I ask Jeff Krueger, the nurse manager, who was in the room with me to -- to please observe this with me because I think this is what I saw. And he saw -- so I did the next procedure with -- with her and he said, yes, she is pulling the propofol, she is not discarding it, she's taking the unused portion, putting it into a syringe, a new syringe, but

-- and then finishing with a new bottle of propofol for the next patient. But -- so -- so therefore part of that propofol being given to the next patient came from the case before.

So as soon as he verified that with me I immediately shut down the room and I called Dr. Desai to tell him this is what I saw and that she has to be fired right now.

Q What was the response?

A He said, do it. He said, yes, do that.

Q Did you go ahead and do it?

A So I go -- I shut down the room, I tell Linda to meet me on the fourth floor of the -- of the building where Tonya Rushing's office was, I closed the door and I say to the CRNA, I saw this is what you did, you signed off on this new policy, I cannot take it anymore, you have to be terminated. She denied it, she said no, I didn't --

Q Without getting into what she said --

A Okay.

Q -- you did that?

A I did that.

Q So you think she's gone?

A I think she's been terminated.

Q You find out later on that that's not the case?

A Correct.

Q She's actually still working?

A Yes. I thought she would be terminated but I

was overridden on that.

Q Who overrode you?

A Dr. Desai overrode me and -- and decided not to have her fired but rather transfer her to our other facility and have her take an OSHA, O-S-H-A, course on how to give anesthesia.

Q You related something of direct patient -- or patient safety concern to Dr. Desai and he countermanded that order and reinstated her?

A Correct.

Q Now I want to move to another area. Was there ever any issue of using saline flushes -- and I'm not talking about when the IV's put in and they flush the IV when -- you know, the heplock thing at the very beginning before a procedure, I'm talking about once a procedure is in process, the use of saline with the propofol or following the propofol, anything like that. Did that ever come up?

A Yes.

Q Can you describe how that came up and what the context was, when roughly, that kind of thing?

A Now again, it's hard for me to tell you a date but there was a meeting with Dr. Desai and the other doctors, one of our general meetings. And the issue came up that Dr. Desai was -- thought that an idea that one of the other doctors had was a good idea and that is that when propofol is

injected into the heplock or the line in the vein, which is not connected to a drip, it's just a heplock, that some of that propofol, which has sedative effects on people is -- is trapped in the mechanics of that -- of that line and that in order to get the rest of that propofol into the patient's body it's a good idea to follow the injection of the propofol with some sterile saline. Sort of to push the little bit of remaining propofol that might be in there into the patient's vein and that this is a good idea that one of the other doctors had come up with and that that's going to be instituted.

Q He just said we're going to do it?

A Yes.

Q Now, you've seen those little heplocks and the little needles and all that.

A Yes.

Q I mean, are we talking about very much propofol?

A No.

Q Tiny, tiny bit, right?

A Tiny bit, yes.

Q But that was a policy got instituted?

A Correct.

Q How long did that last?

A I honestly don't remember. I know it stopped. I just don't remember how long it lasted.

Q Did he ever come back to you at any point and talk to you about how he thought it was going with regard to that?

A No.

Q Are you sure? You sure he didn't get back to you about that --

A Did Dr. Desai --

Q -- Dr. Desai --

A -- come back and tell me how it's going, that policy? I don't recall that. If you have something, show it to me. I don't recall that.

MR. STAUDAHER: May I approach --

THE COURT: You may.

MR. STAUDAHER: -- with a copy of the transcript? Page 79 for counsel.

BY MR. STAUDAHER:

Q Again, same thing, read as much before and after --

A What page?

Q Page 79.

A Okay. I remember this.

Q Okay. Does that refresh your memory?

A Yes.

Q Tell us about that.

A I think it was a very brief -- I remember a very

brief, very positive, small little comment that the policy's working, we're using less propofol.

Q So he was monitoring it at least?

A In some way.

Q When he gives this sort of policy, I mean, did anybody stand up and say this is totally ridiculous, we're not doing this? Anything like that? Confront him in any way about it?

A No.

Q Did you think that it was a reasonable thing to do?

A I didn't think it was dangerous for anybody. I thought it was kind of silly a little bit more than it was necessary to -- to -- to save money for this. But I didn't think it was dangerous, I thought it was silly.

Q Was Desai fairly adamant about this?

A He was adamant, yes.

Q With regard to his -- and we're going to go kind of back to the management side of things for a minute. What would you say his management style was in the practice?

A Well, Dr. Desai's managing -- management style comes from a -- a place of great experience and tremendous intellect and knowledge and so he -- he oversaw every aspect of the practice. You know, he built it up from 19 -- early 1980's, 1981 to a very successful practice. And he was very

concerned with every layer of its operation at all times.

Q Was he concerned about costs?

A Yes.

Q Supply wastage, things like that?

A Yes. He was concerned about cost and supply usage and wastage.

Q Did he ever talk to you about reusing, not using, anything to do with supplies?

A Yes.

Q Can you describe for us some of the things had he discussed with you?

A Sometimes he would make an off-the-cuff remark about me wearing this white gown during procedures. So when we do procedures we wear a gown. It could be blue. It could be white. We had white gowns with little snaps in the front. And sometimes those gowns would -- would have material, pieces of liquids or even pieces of liquid stool on the gown that has to be thrown away or if we did an upper endoscopy there'd be nothing on the gown because nothing happens during an upper endoscopy. If I -- sometimes he would admonish me that every time I change one of those gowns it cost $5 and you shouldn't do that.

Q So you wanted to change -- was it your practice to change between patients, you take it off and throw it away?

A Well, it was my practice to change when it was

necessary. I didn't change after an upper scope but generally after each colonoscopy I would change. Or if it was particularly clean, an easy colonoscopy, I might not because nothing happened to my gown.

THE COURT: Are the gowns discarded?

THE WITNESS: The gowns are thrown away and discarded.

THE COURT: Okay.

THE WITNESS: They're disposable. But when it came time to throw it away, I threw -- I would throw it away.

BY MR. STAUDAHER:

Q And he gave you a hard time about that?

A Yeah, he admonished me for that.

Q And when you say admonished, what -- what does that word mean?

A He said every time you throw one of those away you're costing me $5.

Q What about other items? Anything else that you're aware of that was something that he didn't -- he was getting on people about whether it be -- and, you know, I'm talking about all the supplies related to a colonoscopy; KY Jelly, bite blocks, all those kinds of things?

A Well, there came a time when -- when I was doing a colonoscopy and on my little 4x4 gauze pad where I get the KY Jelly, the technician only gave me just a drop where I

usually I have a pretty good dollop to use. So I said why are you giving me so little --

Q Let's not get in to what he said, but did you ever see or hear Desai talk to anybody about that issue or did you ask him about it or anything?

A I asked about it. I asked why I was getting so little.

Q And what did he say?

THE COURT: Asked Desai about it?

THE WITNESS: No, I asked the technician.

THE COURT: Okay.

BY MR. STAUDAHER:

Q That's what we're talking about. Is anything -- did you ever talk to Desai about this, like this is crazy, anything like that?

A No, I didn't talk to Desai about it.

Q But it was related to you just getting a tiny bit on your --

A Yes, and it was -- yes, and I asked the technician why that was happening.

Q Do you know what a thing called an endospot is?

A Yes.

Q What is that?

A An endospot is a substance. It's black liquid. It's made out of carbon and it's very, very important for us

because it allows us to inject this black liquid, which is a -- causes no harm and in around a potentially dangerous lesion that we find. So that in anticipation of surgery for that lesion, the surgeon, when the belly is opened, can see that black spot like a road map to get to the lesion so there could be no mistake. Why is this important?

Earlier on in my experience as a gastroenterologist in Buffalo we had a case where a surgeon took out a piece of colon that didn't have the lesion in it. So this marking material is critically important so that there can be no surgical mistakes, that's a road map. It's permanent. It never goes away, and it doesn't hurt a patient. So once this became a product and I learned about it at UMC Hospital, University Medical Center, I asked that we get it at our facility to mark lesions as well.

Q Asked who?

A Dr. Desai.

Q Okay. What was his response?

A His response was it's too expensive, we shouldn't get that, costs too much money.

Q And you thought this was a critically important thing for patient safety care, follow-up, all that stuff?

A I thought it was a very good tool -- important tool to have to do these endoscopies and do the standard of care, which is mark the lesions.

Q And cost was the issue that he gave you as the --

A Yes.

Q -- reason why he wouldn't do it? What was the response of the other doctors and yourself related to that?

A Well, the other doctors also wanted to have this available in the center. One of the doctors said he'd pay for it himself to have the box of endospot in there. After awhile, and I don't know what happened, we had it. So it was purchased and we had endospot.

Q Are you telling me that at least one of the doctors, I mean, was willing to come out of his own pocket to pay for this because he thought it was --

MR. WRIGHT: Objection to the repeating of it, Your Honor.

THE COURT: Sustained. Do you -- I have a question. How long was it from the time you told Dr. Desai about this new product that you thought would be beneficial for the patients until it actually had been purchased and you could use it?

THE WITNESS: I just don't remember. Because at the time it was not much of an issue. But it would -- I don't remember how long it took for us to -- for me to see it on the shelf.

THE COURT: Okay. Go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q Let's move to CRNAs. You've had a situation, I assume, where you haven't worked with CRNAs and you have and you even did procedures by yourself without any anesthesia, correct?

A Correct.

Q When did you first start interacting with anesthesia or CRNAs in the practice? When did they first start coming in?

A I think to the best of my recollection, around 2000.

Q Around 2000?

A 1999, 2000.

Q And this was when it -- when you were at the center with just one room --

A Correct.

Q -- is that right?

A Yes.

Q And then later on, did you still have CRNAs when it expanded to two rooms?

A Yes.

Q Were there CRN -- CRNAs in the practice up to the point where it closed?

A Yes.

Q During that window of time, after the CRNAs came

in, did you ever use or see anesthesiologists, meaning medical doctors trained in anesthesia, in the practice working?

A No. Maybe once when an insurance issue came up that the insurance would want a certain anesthesiologist to perform the case, not our CRNAs. Once in a while that would happen.

Q Was that a very rare occurrence?

A That was a rare occurrence.

Q So predominant anesthesia person to give anesthesia was a CRNA after they came in?

A Yes.

Q Now, lets -- let's talk about that. Were you aware of any policies or procedures in place in the clinic for dealing with -- with CRNAs?

A At what time frame, any time?

Q At any time. Let's just talk about that in general. At any time, were there policies and procedures in place for how you were to interact with the CRNA? Meaning supervising them, co-supervising them, anything like that?

A Not that I'm aware of.

Q Did this ever come up in a doctor's meeting at any time when Dr. Desai was there, about how you were to handle the supervision of -- of CRNAs, who would be responsible?

A Not at any meeting that I recall.

Q What was your belief on how this was -- or what the situation was?

MR. WRIGHT: Foundation.

THE COURT: Well -- yeah.

BY MR. STAUDAHER:

Q In general when you were working with the CRNA, what did you feel your role as a supervisor was?

A I never considered myself as a supervisor in any capacity for the CRNAs.

Q Did at any time Dr. Desai not in necessarily in a doctor's meeting, but tell you, look, you're responsible for that person when -- when you're in the room with them?

A No.

Q Did you ever see any written procedures or policies about any of that at the time you were in -- in the office?

A No.

Q Now, do you know what a -- what an attending physician is?

A Yes.

Q What is your sort of definition of an attending physician?

A An attending physician is a physician who's responsible for the patient in question. Now for me, an attending physician, as I'm going through training, is the

person who does the rounds on a -- at the hospital with the residents and the interns. When we refer to an attending physician, we're referring to that person who's responsible to whom we answer, to whom we give reports, to whom we ask questions about the -- of the patient. That's my understanding of an attending physician.

Q Did you feel comfortable being a super -- being -- if you were asked to do it, being a supervisor for the CRNAs themselves?

A No.

Q Supervising any kind of their anesthesia practice or anything?

A No.

Q Would you feel comfortable -- or would you ever just reach around the table and inject the propofol yourself if you didn't think they were doing it fast enough?

A I would never ever do that.

Q Why not?

A Because I am not an anesthetist and I'm not anesthesiologist so for me to push propofol and not be a trained anesthetist or anesthesiologist is dangerous because I could cause the patient great harm and not be able to rescue the patient from that. So the answer is I would never push a medication that -- in any fashion, like propofol, because I'm not trained to manage a potential complication from that.

Q Would you ever feel comfortable maybe starting procedures before the anesthesia was on board?

A No.

Q Do you think that would be appropriate?

A No.

Q Talk about the other end of the procedure, literally. I mean, you're about -- you're doing the procedure --

A Yes.

Q -- maybe you're three-quarters of the way through, maybe you're somewhere in between, I don't know, a patient starts to move around, clearly not still on the table. Anesthesia person wants to give more propofol. Would you ever feel like you could intervene and say don't do that?

A No. I don't think I would want to intervene and say don't do that because the patient requires it. Now, sometimes, for example, during a colonoscopy, a colonoscopy is a -- is a procedure where we put the camera through the colon, it's about four or five feet long. We know when we're at the end, there are certain landmarks where I know the procedure's completed and it's time to withdraw the instrument. The pain and discomfort of a colonoscopy is actually when the camera's going in. The pain and discomfort is the pushing against the colon, the stretching. That's where a patient feels uncomfortable.

If -- if you would undergo this without sedation, it would be a terrible ordeal because it's worse than any cramp that you can imagine because we're really stretching those receptors in there. But when the scope is finished and we're at the cecum and it's time to withdraw it, the patient's calmed down because I'm not pushing anymore, it's just pulling it out. The patients no longer have the reason to have pain.

So during a procedure, if I'm at the end of the colon, I would often tell a CRNA I'm at the end, I'm pulling out now so that he doesn't overeaten. It's important for him to know where I'm at in the procedure. But if I'm still struggling to get the scope through the tight turns and twists and the patient needs more medication, I would never say don't do it.

Q But you wouldn't -- if they wanted to give more because of their -- their assessment of the patient, you wouldn't intervene and say don't do it?

A I wouldn't intervene, no.

Q With regard to that, did you ever see any supervising anesthesiologists in the practice at Shadow Lane at any time?

A No.

Q Did you ever see -- do you know who -- a person by the name of Dr. Thomas? Yes?

A I know him, yes.

Q Do you know a person by the name of Satish Sharma?

A Yes.

Q Did you ever see them in the clinic during the time you were there supervising any of the CRNAs and intervening, giving classes, anything at all?

A No.

Q Were you aware that they were considered, at least on paper, the co-supervising physicians of the CRNAs?

A I became aware of this after this event occurred --

Q Back -- back then?

A -- back then, no.

Q I want to ask you a couple questions --

MR. STAUDAHER: Your Honor, may I approach?

THE COURT: You may.

BY MR. STAUDAHER:

Q Showing you what's been admitted as State's 151. Have you just look through that? There's some tab sections, which actually pertain to your name, but I want you to tell me if you're familiar in any way with that document.

A Okay, I'm generally aware of this.

Q Okay. What is this document?

A That's an Operations Agreement for the endoscopy center.

Q So in this, and I'm going to just go to it, it's -- and again, it's Bates numbers 146 for counsel through 179. I'm going to ask you about were -- were you a partner when this agreement -- was this -- was this part of the agreement that made you a partner?

A I -- I believe so. I became a partner in early -- I think in 2000 I was able to purchase shares in 2000.

Q Now, the shares that you purchased -- and this -- this was for which facility or facilities?

A This is for the endoscopy center we call Endo 1 on Shadow Lane.

Q So where you worked?

A Yes.

Q So you had some ownership in -- in the practice; is that right?

A Yes.

Q Your shares that you purchased, were they something you could dispose of, say sell them to me, give them to your wife, do something else with?

A No.

Q What kind of shares were they?

A They were shares, single shares that were priced at $15,000 per share and I was given the opportunity to purchase six of those shares in I think 2000.

Q So the shares themselves, if you can't sell them

what good are they?

A Well, they represent a partial ownership that was six percent at the time of ownership. So that I would be -- it would be possible for me to have financial gain from that to be paid a distribution if the center did well at the end of costs and expenses to distribute money to the shareholders.

Q In proportion to the shares that you had?

A Always in proportion.

Q Now, were there different -- did it -- I assume Dr. Desai had shares as well?

A Yes.

Q Did other doctors that were partners have shares?

A Yes.

Q Was there a difference between your shares and Dr. Desai's shares?

A Well, each share was the same but there was a difference in the number of shares that we each had.

Q Well, did people -- you mentioned when you first started practicing that there were about six people, meaning doctors, that were in a group at that time?

A Yes.

Q At the time that you ended in practice in 2008, how many doctors were in the practice?

A There were 14.

Q Were there more persons party to this endo center during that time?

A Yes.

Q So they added over time?

A Correct.

Q What would happen to the share's value over time as -- as at least the percentage that you might get from all of that sort of net, taking away the expenses and the like, how would that -- how would that affect the shares that you had, Desai had, the other doctor's had?

A Well, when there were new physicians that might be ready to have purchase -- ready to purchase some shares in the endoscopy -- some responsibility and accountability and become part of that financial possibility, they would be able to buy shares, but those shares would come from the pool that I had or Sharma had or the other doctors. They didn't come from Desai's pool, he maintained his own pool.

Q So would -- in a sense would your shares be diluted in value to some degree by other people coming in?

A Well, the shares -- per share they wouldn't be diluted but I might lose a share or may give up a share at some place to be able -- for someone else to buy one.

Q So your share number would go down?

A Number would go down so therefore I'd have less

shares or fewer shares.

Q Would Dr. Desai always maintain his -- his level though?

A To the best of my knowledge, yes.

Q What percentage of the practice did Dr. Desai own -- control?

A On the endoscopy side or the medical side?

Q Well, let's talk about both.

A On the medical side Dr. Desai always had two shares of the practice, the medical side, whereas the partner like me had one share. So Dr. Desai always maintained two shares. So as more doctors came on and became partners for example -- let's say at one time there were nine new partners, Dr. Desai's share of the practice would be 2/9 where the rest of us would be 1/9.

What does that mean? That means that if there was any money to be distributed to partners, if I got a dollar, Dr. Desai would take -- would get two dollars. And you know that's because -- you know, he had that -- he set it up that way, it was his practice, he started it many years ago, he built it to this level. So he shared -- he had two shares.

Q What about the endo side?

A On the endo side, Dr. Desai had around 60 percent of endoscopy 1.

Q So even if you had all gotten together and

decided to stage a coup or something and make a decision as partners, could you have done it if he decided it didn't need to be done that way?

A No.

Q Were your shares even voting shares?

A On the endoscopy side I wasn't aware that these shares were voting shares at all. On the gastro -- gastroenterology, the medical side, they were voting shares but we very rarely had votes on anything.

Q Now, under -- what about cash distributions? How did -- how did the money get distributed?

A From the medical side or the endoscopy side?

Q Let's talk about endoscopy.

A So on the endoscopy side, at Dr. Desai's discretion, you usually have four to eight weeks, somewhere in there, he would analyze the finances of the endoscopy center and distribute money based on our percentage shares to us, whoever had a partnership interest. So, for example, if there was $100 ready to be distributed I would get six dollars because I had a six percent share. And that would happen when -- when the money was available and at Dr. Desai's discretion.

Q So he controlled that?

A Yes.

Q What about if you would have said hey, I want to see what the books are, I want to see all the, you know,

assets, the losses, all of that stuff, could you do that?

A You know, I never did. Could I? Would I have met resistance? I don't know, but I never did.

Q To your knowledge in these meetings, did anybody stand up and say, hey, look we want to get an accounting of all of this? Ever?

A Not that I recall in any meeting.

Q Were you restricted in any way if you chose to leave the practice on what you could do in Las Vegas?

A Yes. If -- as an employee physician there's something called a non-compete clause, which means this. If I'm an employee physician and I don't want to be there anymore and I want to go on my own, there's something -- and I sign the agreement and it makes it so that I -- I'm restricted where I can go and what I can do, where I can practice. And these things are usually in terms of distance, certain number of miles away, for a certain number of time.

So there was a -- a restrictive covenant or non-compete clause in our contract but there wasn't -- there wasn't anything like that for partners. So once you became a partner you could -- if you had to leave for any reason you could open up a door next door, but that did change. At some point even the partners were restricted if he or she wanted to leave in terms of where we could practice and for how long we -- we have to be outside some radius.

Q And according to the -- and you know where the endo center is, correct? It was on 700 Shadow Lane?

A Correct.

Q And according to -- and this is Bates number 150, we're looking at 6.1 of the contract or the agreement rather, the time period is three years?

A Correct.

Q And 25-mile radius of the endoscopic center?

A Correct.

Q Now, effectively what was your feeling on what -- if you could practice or not when the time came if you wanted to leave?

A Well, this particular one you're showing me is a non-compete clause for the endoscopy center. There was a different one I believe for the medical side, two of them. This one you're showing me --

Q So there's one of each; is that correct?

A Right. This one you're showing me is for the endoscopy so this -- this precluded us from having an ownership in any other endoscopy center. So therefore, I couldn't build my own. Let's just say if I could build a better mousetrap, I couldn't do that for three years and for 25-mile radius -- 25-mile radius. So that means 50-mile diameter. So practically that means I would have to leave the Valley.

Q Do you think if you ever left the practice that you would be able to remain in Las Vegas based on this -- these kinds of agreements? Do you recall?

A Only if I waited the three years but I would -- I always thought I would leave if I was -- if I stopped working at the clinics.

Q And just so we know, you actually -- that's actually your signature on the document?

A Yes.

Q And it shows -- looks like it says number of shares six; is that correct?

A Correct.

Q And some of the others are just other places where you're listed signing certain subscriptions.

A Right.

Q So this is related to you?

A Correct.

Q The CRNA account again, did you have any -- could you do an accounting of that account at all?

A No.

Q You just got the bonuses from it?

A I got bonuses from Desai at his discretion if he thought I deserved it or not and he would decide where that money came from, but I had no control or influence over any of the accounts.

Q Now I want to talk to you about after all of this took place and I'm talking -- when I say this, I'm talking about the, you know, it comes out in the press and the endoscopy center closes and all that kind of stuff, did you and Dr. Sharma and Dr. Desai ever meet together?

A Yes.

Q What -- where was that? When was it? What was it about?

A Dr. Sharma and I went to Desai -- Dr. Desai's house in Red Rock Canyon and I cannot give you the exact date but it was after the public announcement in late February when the media was all over this and we were under enormous pressure and stress about what had happened. We went to Dr. Desai's house and he was in his library study sitting in a chair with a t-shirt on and I think some sweatpants and he looked very bad. He looked very upset. He looked very frightened, and we were too and we went to see him and talk to him about what had happened. Principally, the purpose of the -- of me going to see him, Dr. Sharma said to him -- am I allowed to say what Dr. Sharma --

THE COURT: Well, I mean --

MR. WRIGHT: No objection.

THE COURT: -- did it lead to something that then Dr. Desai responded to?

THE WITNESS: Right. Dr. Sharma said, you know, D --

he called him D, no one's going to refer us patients if we -- if you don't make a statement about what happened. And he said no one -- no one will send us patients anymore unless you make a statement that you were -- you were in charge and the manager. And Dr. Desai agreed that he would make such a statement, a public statement, that the younger guys had no decision making power and that I made all the decisions.

BY MR. STAUDAHER:

Q You, Carrol --

A No, no, meaning he, Desai made all the decisions. I remember crying because I was so upset, hugging him and -- and Dr. Sharma and I left but that never occurred.

Q Never came forward and said he was in charge?

A Right.

Q Let me go back to 156 for just a second. I'm going to ask you -- do you see that name Kenneth Rubino there?

A Yes.

Q That was a patient of yours you dealt with, correct?

A Yes.

Q Known hepatitis C patient?

A Yes.

Q Now he is in the scheme of things the whole day and this is one -- one day for the room, he's -- he's up there near the morning time, correct?

A Correct.

Q He's clearly not at the end of the schedule that day?

A Correct.

Q Is there any issue about patients that were know hepatitis C carriers, infectious disease, I mean HIV, hepatitis B, whatever it is, for when they should be scheduled in the day? Try to schedule them at the end, try to schedule them at the beginning, anything like that?

A No, we did not do that. We did not discriminate like that.

Q Was there a reason? Do you know if any policy was ever in place to where you tried to do people like that near the end of the schedule in case for some reason there was a breach of the universal precautions and somebody might have had an exposure?

A Not that I'm aware of. And my feeling is that there was no such policy or strategy because we -- we -- in medical field we approach every patient with universal precautions and we know who has infectious diseases because we take a history before we do the test.

Q Did you ever become aware that Dr. Desai was trying to sell his practice?

A I did become aware of that, yes.

Q And -- and was this through him or was it

through somebody else?

MR. WRIGHT: Objection if it's hearsay.

THE COURT: Well, he's saying how did he become aware of this.

MR. WRIGHT: Well, the question -- the question -- he questions knowing it is hearsay when he proposes the question --

THE COURT: All right, okay. Now --

MR. WRIGHT: -- it's not proper for --

THE COURT: Mr. Wright, you didn't object at the time he asked the question --

MR. WRIGHT: -- I object, hearsay and move to strike the question.

THE COURT: All right. Well, we'll see how he knows.

MR. STAUDAHER: Well, maybe I'll withdraw it and I'll go another direction.

MR. WRIGHT: Right.

THE COURT: Right, go another way.

MR. STAUDAHER: We'll get there.

BY MR. STAUDAHER:

Q Did Desai ever talk to you at any point about how much money he lost as a result of this?

A Yes.

Q What did Dr. Desai tell you about how much money he lost as a result of --

THE COURT: Wait. When did -- how did this --

MR. STAUDAHER: Okay, that's fine.

THE COURT: Before Mr. Wright objects, when did you have this conversation, and where did you have this conversation, as closely as you can recollect, with Dr. Desai?

THE WITNESS: Well, the conversation occurred at that meeting at Starbucks in June of 2008 sitting at a table together.

BY MR. STAUDAHER:

Q You and he?

A You and he -- he and I, no one else.

Q Okay. So what does he tell you?

A He -- he told me that this -- this episode cost him one hundred million dollars.

Q Hundred million bucks.

A But that he had no ego and it was okay for him. And he said that he lost a hundred million dollars because of this and then he broke it down for me why he lost a hundred million dollars.

Q Well, what did he say?

A He said that he lost 30 million dollars in bad land investments and bank investments and he also said that he lost 45 million dollars because of the amount of money that he would have received in a potential -- in a -- in a sale that

was pending of the endoscopy center.

Q So you heard that actually from him?

A From him after I learned it from someone else.

Q I'm not talking about that, I'm talking about what --

A Heard it from him, yeah.

Q So acknowledges that he -- I mean at the time he's telling you about a pending sale for 45 million dollars you said?

A That would have been his proportion of it.

Q Okay. So that he would have derived from the sale of -- of -- well, did he say what entity it was?

A He didn't mention it to me, no.

Q Okay. But you know the endoscopy center closed down, correct?

A Right.

Q Okay. So pending sale. Did you know at any time that he was planning to sell the practice?

A I did learn that after -- before this meeting but after the practice closed down.

Q Okay. Let me step back because I -- I know that you've learned it and I know you've even learned it from him later on --

MR. WRIGHT: I'm objecting again to the --

THE COURT: All right.

MR. WRIGHT: -- question when counsel knows. He's trying to elicit hearsay.

THE COURT: Okay, that's sustained, just -- I said it was sustained, you don't need to -- Mr. Staudaher, try not to preface the questions with your own knowledge or your own --

MR. STAUDAHER: Certainly.

BY MR. STAUDAHER:

Q I'm just trying to get the time frame that we're talking about. We're talking about now before all of this broke with the press and the centers close down.

A Okay.

Q Not talking about any knowledge you got from any source including Dr. Desai thereafter.

A Understood.

Q Prior to that time, did you have any knowledge at all that there was a pending sale of the practice?

A No.

Q Now, you're a shareholder.

A Yes.

Q You went to meetings?

A Yes.

Q Did even tangentially this get raised by Dr. Desai in any meeting, thinking about selling the practice, anything like that?

A Not that I recall. At one meeting long before

any of this happened, Dr. Faris once mentioned the possibility of Dr. Desai when he retires that we would buy him out. We -- all of us would get together and buy his shares out but Dr. Desai said you could never afford that.

THE COURT: Maybe this would be a good time to take our lunch break.

MR. STAUDAHER: Sure. Actually, I've just got a few. If I can have five more minutes I'll be done.

THE COURT: Five. Go ahead.

MR. STAUDAHER: Okay. Sorry.

BY MR. STAUDAHER:

Q But afterward, that's when you learned it and you heard it from him directly?

A Correct.

Q Now, as far as who was in charge, we talked about that for a minute but there was -- something came up with one of the -- one of the persons who was infected on this day, a Stacy Hutchinson. Do you see that person right there?

A Yes.

Q Do you ever remember meeting with her in the office at any point?

A Yes, I do.

Q Are you Desai's boss?

A No.

Q Did Desai come out and talk to you about going

in and talking with Stacy Hutchinson?

A Yes.

Q What was that all about?

A Well, Stacy had come back to the office for a management of acute hepatitis C. She was there to see Dr. Desai, I was in the office. So Dr. Desai came out of the room after briefly speaking with her and asked if I would go in and talk to her and manage this problem and I said, okay, I'll do that. So I went in, I spoke to Stacy about what had happened and how we should go about managing this.

Q So he just passed her off to you and asked you to do -- go in and deal with her?

A Yes.

Q Have you ever heard Dr. Desai refer to you as his boss in any -- any situation?

A No.

MR. STAUDAHER: I have nothing further, Your Honor.

THE COURT: All right. Ladies and gentlemen, we're going to go ahead and take our lunch break. You'll be in recess for your lunch break until 1:20. Before I excuse you I must remind you that you're not to discuss the case or anything relating to the case with each other or anyone else. You're not to read, watch or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Do not do any independent research by

way of the Internet or any other medium and please do not form or express an opinion on the trial. If you all would please place your notepads in your chairs and follow the bailiff through the rear door.

And Dr. Carrol, just to remind you that during the lunch break you are not to discuss your testimony with anyone else.

THE WITNESS: Okay. What time is -- reconvene?

THE COURT: 1:20.

(Jury recessed at 12:05 p.m.)

THE COURT: Lawyers at the bench, please. Who's going to do cross first?

MR. WRIGHT: I'm going to need more than a lunch hour.

THE COURT: So I guess Mr. Santacroce.

MR. WRIGHT: Now, I'm going to need to be here for his cross too.

THE COURT: I understand what you mean, you need more than the lunch hour. I mean, you're saying you need more than the lunch hour to confer with your client.

MR. WRIGHT: Correct.

THE COURT: So Mr. Santacroce can go first. How much time do you need?

MR. SANTACROCE: I would guess maybe an hour.

THE COURT: That's it?

MR. SANTACROCE: That's it.

THE COURT: I thought this guy was going to take two days. Okay. So how much longer do you need because I took an hour and 15 minutes roughly for lunch?

MR. WRIGHT: [indiscernible] total.

THE COURT: Total of two hours. So why don't we do this? We'll come back when I told the jury to come back, we'll do Mr. Santacroce's cross-examination then approach the bench, tell me how much longer you need and then we'll take maybe a 20-minute break or something like that. Okay? That's the plan.

(Court recessed at 12:07 p.m. until 1:19 p.m.)

(In the presence of the jury.)

THE COURT: Counsel approach.

(Off-record bench conference.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the Deputy District Attorneys, the presence of the defendants and their counsel, the officers of the court and the ladies and gentlemen of the jury. Did we find it?

MR. SANTACROCE: We found one.

THE COURT: Okay. And Doctor, obviously, you're still under oath. We're having a little confusion locating an exhibit. Obviously there are a number of exhibits in this case and Ms. Husted's charged with, you know, collecting them

at the end of the day and making sure they're all back in the courtroom in the morning.

Obviously, before you folks deliberate, we'll make sure we have all the exhibits, which will go back into the jury deliberation room with you. In the meantime, we might be able to just use what Mr. Staudaher has on his computer so that Mr. Santacroce can go forward and ask the witness about the exhibit. Can we do that?

MR. STAUDAHER: I've got it on my Ipad, he can just put it up on --

THE COURT: Okay. We're going to use that for right now. Again, before you folks go back to deliberate we'll make sure we have that as well as all of the other exhibits and those will go back with you. All right.

Are you ready, Mr. Santacroce?

MR. SANTACROCE: I don't know if I'm ready, but I'll go.

THE COURT: You'll start anyway. All right.

MR. SANTACROCE: I'll start.

MR. STAUDAHER: And the -- just so we are clear, that document was one that we had proffered initially. It was a proposed exhibit but I don't believe it was ever completely determined whether that was coming in or not so that's why it's not part of those -- those records over there.

THE COURT: Okay. And that's which exhibit number?

MR. STAUDAHER: Financial Exhibit -- it's not marked yet because --

THE COURT: Oh, it hasn't been marked. Okay. Well, here we've been blaming this -- poor Ms. Husted.

MR. STAUDAHER: We can mark it -- we can mark it as defense -- next --

THE COURT: And it was Kenny we should have been blaming -- no.

MR. SANTACROCE: I'm going to mark Mr. Staudaher's Ipad.

THE COURT: All right, all right. Go ahead.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Doctor.

A Hi.

Q I represent Ron Lakeman. You know Mr. Lakeman, right?

A Yes.

Q In fact, you've done hundreds if not thousands of procedures with him; would that be fair to say?

A Fair to say.

Q I want to talk about your current position now. Can you tell me what you're doing -- doing right now?

A I'm a practicing gastroenterologist in a small group.

Q And how many doctors?

A A total of three.

Q Where's that located?

A On Rainbow near Spring Valley Hospital.

Q And is it sort of like the endo centers, are you doing procedures?

A Yes. I do procedures, yes.

Q Do you have your own sort of ambulatory surgical center?

A I don't own any ambulatory surgical center.

Q Where do you perform these procedures?

A I perform them at a place called Stone Creek Surgical Center, which is adjacent to our office but owned by someone else.

Q And the other doctors in your practice are Dr. Mason and who else?

A No, not Dr. Mason.

Q Oh, I'm sorry.

A Dr. Sharma and Dr. Carrera.

THE COURT: Is that Vishvinder Sharma?

A It's Vishvinder Sharma and Eladio Carrera.

BY MR. SANTACROCE:

Q Okay. And as I go through this testimony, if I misstate something that I thought you said, correct me like you just did. Okay?

A Sure.

Q And Dr. Vish Sharma was a doctor that was -- you worked with at the endo center, correct?

A Yes.

Q And who was the other one?

A Dr. Carrera.

Q Oh, Carrera was also -- you worked with at the endo center, correct?

A Yes.

Q Now as far as you're concerned, you didn't lose your medical license as a result of this [indiscernible], correct?

A Correct.

Q And you're not being prosecuted criminally, correct?

A Correct.

Q And, in fact, you entered into an agreement with the State whereby you would get immunity for your testimony; is that correct?

A I have -- I have immunity.

Q Okay. And what are the obligations of that immunity contract? Do you know?

A No, I don't.

Q Now, I want to talk to you about the organization of the center. I believe you said when you first

started you were an employee physician, correct?

A Yes, sir.

Q And then you became a partner physician; is that also correct?

A Yes.

Q I believe your testimony was that Dr. Desai was at the top, partner physicians were underneath him and employee physicians were next to you guys or under the partners?

A Well, they were under the partners but that doesn't mean we had any say as -- how they performed or how they acted. I had no role over them.

Q So everyone was pretty much an independent -- independent as to what they did?

A Yes.

Q Now you were shown Exhibit -- State's Exhibit 151. Let me move that down a little bit. And I believe you testified that this was an Operating Agreement that you had signed, correct?

A Yes.

Q And what was your understanding of this Operating Agreement?

A At that time I understood this to be an agreement on how the operation was to work, the endoscopy center.

Q And you signed this agreement, correct?
A Yes.
Q Did you read it?
A I don't remember reading it. No, I don't remember reading it.
Q It purports to be executed on the first day of June of 2002. Would that be accurate?
A Yes.
Q And I believe you testified that you received six percent by virtue of this agreement; is that correct?
A No, the -- the -- I -- I did get six percent interest. I don't -- I don't know if it was because of this particular agreement but it -- it may be in here but I did get six percent.
Q I want to draw your attention to section 3-1 of the agreement that you signed. It talked about article three management. Do you know what an operations manager is?
A Yes.
Q What is an operations manager?
A An operations manager is the person who is designated to oversee and manage the facility.
Q Did you ever become an operations manager?
A No.
Q Would you look at that -- let me show you the section, article three, management. Ask you to read section

3-1, please.

A Would you like me to read the whole thing?

Q Just read section 3-1.

A The company --

Q I don't want you to read it out loud, I want you to --

A Oh.

Q -- read it to yourself.

A Okay.

Q After reading that I'm going to ask you the same question, did you ever become an operations manager?

A No.

Q Was there a provision in this agreement whereby you would eventually become operations manager after five years?

A It says after seven years.

Q Okay, after seven?

A There's a provision, yes.

Q And it's your testimony that that never happened?

A Correct.

Q Was there ever a time when you recall that you were voted in as an operations manager?

A No, sir.

MR. SANTACROCE: Court's indulgence.

THE COURT: That's fine.

BY MR. SANTACROCE:

Q Was there ever a time when you acquired additional shares?

A In what, sir?

Q In the endoscopy center.

A Yes.

Q When was that?

A The best of my recollection I received a purchase additional shares in 2007.

Q And how much did you receive?

A There were two purchases. On the first one I was able to go from six percent to nine. And then finally in late 2007 when there was a shift of ownership throughout the two endoscopy centers, I was able to finally have 14 percent.

Q And then in 2007 how much did you hold? How many percentages did you hold?

A At that -- at the end of 2007 I believe I held 14 percent.

Q And can you estimate the income you derived from the endoscopy center in 2007?

A I don't know. I don't know off the top of my head but that would be available in records.

Q I'm going to show you Mr. Staudaher's laptop and this is a financial analysis. I'm referring to Bates stamp

000769 and I'll ask you to take a look at that and see if that refreshes your recollection?

A Okay, I'm looking at this.

Q Does that refresh your recollection?

A Yes, I -- I see this, yes.

Q Okay. How much did you make in 2007?

A You mean total from endo center?

Q Total.

A Total was 1.967 million dollars.

Q And that was for services that you provided in what way?

A All services that I provided, hospitals, night call, rounds, seeing patients in the office, endoscopy, endoscopy -- my shares from the endoscopy center.

Q And you would receive different checks periodically, correct?

A Yes.

Q Every couple of weeks?

A It varied, every four to five weeks.

Q And those checks would be written on several different accounts; is that correct?

A Which checks now?

Q The checks that you received.

A The checks that I received, yes, would be on different accounts.

Q And do you remember what those accounts were?

A One was Gastroenterology Center of Nevada, one was from the first endoscopy center and when I had shares of the second one, Desert Shadow -- there would be checks from the Desert Shadow.

Q And additionally, you received checks from the CRNA account?

A Occasionally I did receive money from the CRNA account.

Q Now, the income that you received was the net income from all those centers and all the services they provided, correct?

A Correct.

Q And that money was derived in part at least from reimbursements for the procedures from insurance companies, correct?

A Yes.

Q Now the employee physicians didn't receive that, did they? They received just a salary?

A That's correct.

Q So it'd be fair to say that your income was based upon the procedure -- the number of procedures you did as well as the other functions that you did, correct?

A Not -- that's inaccurate.

Q Okay, tell me where it's wrong.

A Because what you said was that my income was based on the number of procedures I did. There wasn't a direct relationship between the number of procedures that I did, consults that I saw, nights that I worked, and my income. It was -- it was -- this money was distributed from all the money brought in to the practice by all the activities to the physicians.

Q Well, tell me how -- how it would be -- let's say you had a consult with a patient, would you bill the insurance company for that consult?

A Yes.

Q And the insurance company would reimburse the clinic, correct?

A Reimburse the practice.

Q The practice.

A Yes.

Q And if you did a procedure you would bill for that, correct?

A Correct.

Q So if you did 100 procedures you would get more money than if you just did 50 procedures, isn't that in theory correct?

A No, it's incorrect, sir.

Q Okay, tell me where it's wrong.

A Because there was no direct relationship between

the number of procedures that I did or any of us did and the reimbursement we received. We all received our share. So, for example, on the medical side if I had one share, I got one share's worth of distribution. It didn't matter if I was more productive or less productive than somebody else.

THE COURT: I think what Mr. Santacroce is asking is if you did 100 procedures you would generate more income to the clinic than if you did 50 procedures, correct?

THE WITNESS: That is correct.

THE COURT: And then your percentage would remain the same but six percent of 100 times whatever the compensation is, is greater than six percent of 50 times the compensation.

THE WITNESS: That's reasonable, yes.

BY MR. SANTACROCE:

Q Thank you. And my point was that no one else that was employed at the clinic received that kind of reimbursement of payment; isn't that correct? Other than the other doctors, partner doctors?

A Correct. Now, partner doctors received that money, the employment -- employed physicians received a salary.

Q Correct. Now I want to talk about your responsibilities as a doctor in a procedure room. How many people were in the procedure room when a procedure was done?

A About six.

Q And can you tell me who they were?

A Sure. The physician performing the procedure, the anesthetist performing the sedation, the technician helping us with the procedure, a nurse, a charge nurse, a nurse overseeing the procedure and documenting the procedure. That's about five people.

Q And you defined what an attending physician was earlier, correct?

A Right.

Q Who would be the attending physician in that room?

A That -- that term as you put it is misleading.

Q How?

A Because the attending physician does not refer to the physician in that -- in the room. In those -- in what you were about to show me.

Q Okay. Well, let me show you what's been marked -- or been admitted as State's Exhibit 106. These are -- this is the Policies and Procedures of the Endoscopy Center of Southern Nevada and I'm directing your attention to section eight. Can you see that okay?

A Yes.

Q And I'm asking you to look at section B-1. Now, can you tell me who -- who is being referred to there as the attending physician?

A Yes, sir.

Q What happens?

A Well, propofol is a very fast-acting medication. It literally makes you sleepy in 10 to 20 seconds. Maybe if it was a cardiac problem and a bad heartbeat, 30 to 40 seconds. But the medicine is a profoundly powerful cardiopulmonary suppressing medication, which means that if the dose is too high you can stop, literally just stop breathing and your oxygen levels go down and you're in trouble. It can cause arrhythmias, a slow heartbeat to occur. But the principal problem with propofol is its respiratory depressing effect, making you stop breathing.

Q And everybody would agree breathing's important, correct?

A Correct.

Q So if you're in a situation where -- I don't know, would you ever feel comfortable directing the anesthesiologist or the CRNA in how to use that medication?

A Me? No, because I'm not directing anesthesiologists or the anesthetist on how much to give, that's his or her choice, how to give it, in what increments to give it because they are independent practitioners who are well trained to do that, better training than I have. It's not as if I can step in, nudge them aside and take over his role. I don't have that training. So the answer to that is

no, I would not feel comfortable telling a person who administers that anesthesia how to do his job.

Q Along those lines, I mean you've seen many, many anesthesia records now since this case came about, correct?

A Yes, sir.

Q As far as the propofol -- and you -- and you see I assume that propofol is the drug given for the anesthesia for those procedures?

A Almost entirely, yes.

Q Did you notice as you went through that there were multiple doses of propofol given on a typical patient?

A Yes.

Q Is what you just described the reason why, because you don't want to give a whole bunch at once and shut -- maybe make somebody not -- or stop breathing, that you give it a little bit of time or whatever and that has to be monitored?

A Correct. It's called monitored anesthesia care, MAC. So it has to be given in divided doses and it has to be monitored. That's why it's called MAC, Monitored Anesthesia Care.

Q Before we go to that other place I told you about, I want to ask you one last question. You said in I think one of your answers a while ago that you actually treat patients with hepatitis C; is that correct?

A Yes, sir.

Q Can you explain that to us?

A Well, interestingly and quite ironically after all this happened, I am an expert in the treatment of hepatitis C. I trained not only to do endoscopies and colonoscopies and upper endoscopies and liver diseases and pancreas diseases and gallbladder diseases. I also -- also spent a good deal of my time at Stony Brook learning about hepatitis C because I am also a hepatology person, a liver person. So as soon as I started private practice I treated patients with hepatitis C. I interviewed them. I took their histories about their risk factors of acquiring hepatitis C. I've guided them through therapy, which could take six months to a year. It was very difficult therapy.

I went to support groups here in Las Vegas and talked to the hepatitis C support group and patients. I went around when I first arrived to different doctors' offices and gave lunches and talked about hepatitis C and how it's treated and how important it is to get these patients in because we now start to actually cure these patients. Not everyone, but at that time we had better and better medicine. And I still to this day, despite what happened, treat hepatitis C, patients are referred to me for evaluation.

Q Were you the only one in the practice that did that or --

A No, we all -- we all have training to do that.

Q When you say we all, are we talking about doctors in general or gastroenterologists?

A Gastroenterologists.

Q So that's an area of special -- I mean your specialty area is gastroenterology and one of the areas that you treat is patients with hepatitis C?

A That is generally correct. Now, in any practice there may be a doctor who's more knowledgeable, who's better at that. I -- at my practice on 700 Shadow Lane, I tended to gather those patients, they tended to be referred to me. Even other doctors would ask that I see them for treatment of hepatitis C. Some people are just more comfortable with the complexities of that because the treatment is difficult, there are side effects that can be -- you know, seeing me month after month after month and trying to manage these complexities. But the answer is yes and part of my training and every training that I know, liver disease is part of it.

Q In fact, I mean you're familiar with the patients who were infected in this particular case, correct?

A Yes, sir.

Q And I'm going to give you three names of -- of those individuals and tell you if -- ask you if you had anything to do with their treatment related to what you just talked about, treating for hepatitis C, seeing them in the

office, that kind of thing with the knowledge that they had.

A Yes.

Q Kenneth Rubino?

A Yes.

Q Okay. So you treated him and -- and saw him as a patient for that condition?

A Yes, sir.

Q And what about Sharrieff Ziyad?

A I don't recall seeing him as a patient.

Q Okay. If the records show that you were involved with his care would that be consistent with at least the fact that you treat that kind of a -- of a disease?

A Yes.

Q What about Michael Washington?

A Michael Washington and I did have an office meeting after the fact, after July 25th, where I discussed with him that the way to get the hepatitis C treated.

Q And what was the typical treatment that -- a patient walks in, I walk in to you, I've got the disease, what -- what kind of treatment was available at that time?

A At that time we had a treatment called interferon and Ribavirin. And interferon is an injectable medication that used to be Monday, Wednesday and Friday when I was in training. But at that time it had been reformulated so that it was once a week injections. And the Ribavirin pills

were every day. And depending on which type of hepatitis C it was, the treatment could be six months or 48 weeks or close to a year. So at that time the treatment available was interferon and Ribavirin.

Q Now Ribavirin, what kind of a drug is that?

A Ribavirin is a tablet medication that inhibits the -- by the way, the mechanism is not clearly understood but it is involved in -- in inhibiting the replication of hepatitis C virus from one cell to the next.

Q So it kind of helps prevent that from occurring --

A Right.

Q -- is that right? What about the interferon, what kind of drug is that and how does it work?

A The interferon is an injectable medication, you put it under your skin, you literally inject the liquid in -- under the skin. It gets absorbed into the body and its principal mechanism is not to stop the replication of the virus in the cell, if this was the cell, but to stop it from going -- leaving the cell and getting into the next room, the next cell. That's how that drug works. That's why it takes time because there are so many viruses being replicated and put -- going out to more cells. The interferon takes time, that's why it's a year or six months, so that we can stop that next step. Neither one of those drugs directly kills the

virus.

Q It stops the spread; is that fair?

A It stops the spread from one cell to another. There's a question?

Q Oh, we can't --

A Okay.

Q As far as your treatment, when you treat patients like this, we've heard some stories of patients that actually have gone through that process.

A Yes.

Q It does not sound as though that's a very pleasant process to go through. Would you agree with that and if so, can you kind of explain to us why that is?

A So when you get treated with interferon and Ribavirin there are side effects that we go through with every patient. Not every patient gets these side effects. Some patients get the side effects so badly that they cannot continue the therapy. There's no way to predict this. But generally speaking, patients will have side effects; insomnia, headaches, irritability, mood swings, difficulty with important relationships, joint aches, muscle aches, fever, chills, rash, shortness of breath, changing blood counts, anemia, a long list of side effects. Some patients suffer with them so badly we have to stop just by trying to manage them.

Some patients would ask me, doc, are you giving me a placebo, I'm not feeling anything. There's no way to predict that. So that's why the patients followed up with us every -- every month because of managing these side effects.

Q What about something like suicidal thoughts, anything like that?

A Yes, mood swings, homicidal thoughts, suicidal thoughts can occur. That's why a patient who has an underlying problem with depression or anxiety is -- is a difficult patient to manage.

Q And if I understood you correctly, some patients just can't tolerate it?

A That's correct.

Q And not a volitional decision on their own, they just can't do it because of what -- the things you've described?

A No, it's not volitional at all. It's because of the side effects are so horrendous they can't simply put up with it.

Q Now, I want to go back to the area that I told you we were going to go back to, which is the -- the group dynamic between the doctors and Dr. Desai and the practice, who run -- ran that -- that kind of thing. Okay?

A Okay.

Q Did you ever see any kind of an organizational

chart which had the various parties in the group; clerical staff, CRNAs, doctors, Desai, that kind of thing listed in it?

A While I -- I did see that after the fact, not before.

Q Let's talk about before. That's primarily where I'm focused on at this point. So you didn't see that before?

A No.

Q And your -- did you know what the organizational chart sort of was without seeing the actual document on -- in front of you --

A Yes, I -- I had a sense of it very strongly from living it everyday, sure.

Q Okay. Can you describe for us what that was?

A Well, the organizational framework in the practice was that Dr. Desai was the managing partner of Gastroenterology Center of Nevada. Under him were other partners. It took me three-and-a-half years to become a partner. Under the partner doctors were employee physicians who were in -- on track to become partners. All of the other employees were under Dr. Desai. We had other levels of employees such as physician assistants and nurse practitioners who were also under Dr. Desai and were assigned to his -- to specific doctors according to Nevada law. We had office management that answered to Dr. Desai. We had a COO and another managerial positions in the practice that involved

over watching nurses, over watching other employees.

Q So during the time -- and I'm talking about from the time you started there in '97 all the way to the end in 2008, did that organizational structure change at all? And I know there was one time in 2007, in September or October of 2007, I'm not talking about that, I'm talking about in general, did that organizational structure change?

A No.

Q So as far as Dr. Desai kind of controlling everything, how far down did it go in the organization? What kinds of things would -- how far down would he control things?

A Dr. Desai is a -- is a -- is a highly intelligent managerial person who organized and managed everything from the top down. He would be involved not only in decisions about contracts and the -- the general direction of the practice and our relationships in the community, to managing everything from how many patients would be scheduled, who's not seeing enough patients, supplies, we're ordering too much, from that range.

Q Did he actually immerse himself into the -- the supply end of it very much as well?

A Yes. He was very concerned about supplies and cost of supplies.

Q I mentioned that area -- that time period in 2007. It would have been end of September, October, beginning

of October of 2007, was there any time when there was some sort of shake up in that whole sort of organizational structure for any period?

A Yes.

Q Can you describe for us what that issue was or what happened?

A In -- in September of 2007, unfortunately, Dr. Desai had suffered a -- a stroke traveling to India. We didn't know this. Actually, he was -- he was supposed to return to work and did not and as -- the physicians didn't know what happened but we later learned that Dr. Desai had suffered a stroke and needed emergency treatment in Asia. When he did return from that he was weakened, he -- he obviously -- his walking was weaker, he looked weaker, and he had a meeting with us, all the doctors, to discuss what happened and what the practice should do about it.

All the doctors were there at that meeting. And during that meeting he told us that he had -- what had happened, that he had suffered the stroke and that he doesn't -- he didn't think he could return to work for at least six months. And during that time the practice had to be managed, he couldn't do it, he couldn't make day-to-day decisions.

So he -- he assigned different parts of the practice in -- in the Las Vegas valley to different doctors to oversee in his stead. I was the one to take Shadow Lane, Dr. Mason

was the one to take the Burnham location, and Dr. Sharma was the one to take the Rainbow location. We were all told that these were our assignments. We had to control them ourselves but we should go through Tonya Rushing who would be overseeing it all as our Chief Operating Officer and that's how the meeting ended, and -- and -- and he hugged us all, kissed us all and told -- and said he'll do the best he can to come back.

Q Prior to that, did you have concerns about how the practice was run? I mean as far as the number of patients rolling through, things happening, staff, all that kind of thing?

A Yeah. Yes, I did have concerns.

Q What were those concerns at least at that time, before he goes off and has -- and has the stroke and then comes back and says he's going to take himself out for six months?

A Well, I had two concerns. One was I had concerns about the number of patients that were -- were being assigned on a daily basis to the endoscopy area. And I also had concerns about how the patients on the medical side were being treated and making sure that the paperwork was easy for them and not tedious, making the intake process easier because patients were waiting too long in the waiting room to -- to see the doctors.

Q You mentioned patients waiting too long. Was that in part due to how patients were scheduled, booked, so to speak?

A Well, on the office side it -- remember it's not just me seeing patients, it's me, maybe two other doctors, a nurse practitioner, a physician assistant. We may have had four or five providers in our office seeing patients and each one assigned 15 to 20 patients in the afternoon or morning session. So you can quickly see that that's 70 to 80 patients coming in to see the doctor or the nurse practitioner.

Q Did you think that that was too many?

A I thought that that was too many. I even tried to make sure that the nurse practitioners and the physician assistants had a certain limit of patients, that they could not see more than that.

Q Now, was this after you kind of take over though?

A It's even before.

Q Oh, so you tried to limit it beforehand?

A Yes.

Q Were you successful beforehand at limiting the -- the number of patients rolling through?

A Not entirely. I was not -- I would try to limit the number of patients a nurse practitioner could see. They're not doctors. They don't have the knowledge right at

their fingertips like we do. So I try to limit that to 14 or 15 per afternoon or morning session or even -- or even less. But I -- I was told that that's not -- that's not going to happen, that they should be able to see more patients than that.

Q Who said that?

A Dr. Desai told me that.

Q So he countermanded something that you were trying to institute before he went off to India?

A That's true.

Q Now you said that -- you've seen the records, you see that he's actually on the record for the September 21st date, correct?

A Correct.

Q Did this event occur after that 21st date?

A Which event?

Q Meaning him going off to India having a stroke?

A As I remember yes, it did, it occurred afterwards.

Q When did he actually -- what did you find out about it when he -- when he eventually came back?

A Well, we found out that there had been a stroke before he actually came back. Tonya told me, Tonya Rushing. But he came back as -- as best I can remember, in early October of 2007.

Q And did you learn about the fact from Tonya, was that in close proximity to when he actually physically came back into the facility?

A Yes. The best I can remember about a week.

Q Now, during the time that he's assigning these various parts of the practice to you and to Dr. Mason and Dr. Sharma, was it the same sort of plan for each one of them, they were the ones in charge of the practice while -- in his absence?

A Correct.

Q And you would be the one in charge of Shadow Lane in his absence?

A That's right.

Q Did you say okay? I assume that you agreed to that at some point?

A I -- I agreed to that.

Q What did you do after -- I mean, did he then leave and go home or --

A Right. It was an evening meeting, he left -- literally, like I told you, hugged us, kissed us, shook our hands and sort of said, you know, I'll be back but I'm not going to be around for six months. And by the next day I was there in Shadow Lane in charge of it.

Q Okay. Now, I just want to be clear before we go on any further. That -- that little -- that period of time

that you were taking over and that Mason was taking over and Sharma was taking over their respective areas, was there any other time during the entire period that you worked for Dr. Desai that anything like that happened where he relinquished power, control at all?

A No.

Q So that's the isolated event?

A Yes.

Q So let's walk through that. What do you do the next day, if anything?

A Well, the next day I told the nurse manager, Jeff Krueger, that I -- I never want to see more than 6-0, 60 patients scheduled at the endoscopy center. To give you some perspective, sometimes it'd be 75, sometimes even 80 patients scheduled. So I said starting on the day, that next day, there can only be 60 knowing that there's usually 10 to 12 either no shows or cancellations that on average, that would mean around 48 patients per day from seven a.m. out to three, four or 5:00. I also said that I wanted them not scheduled in such a way where they -- 13 or so were there at 7:00 in the morning. I wanted them spread out in a rational way so that the patients would not wait so long.

I also mandated and changed the preparation time so for patients who were having colonoscopies at 12:00 in the afternoon or later, they wouldn't take their preparations the

day before and be hungry and waiting, they would take their preparations in the morning, sleep the night before, so that those patients had better preparations and were more comfortable.

I also made the intake process on the medical side easier. I made the forms easier to fill out, I made it so that the real information we needed and not all the extraneous information that were on those forms were included so that the process of getting to see the doctor was just easier.

Q So when you institute these things, I mean you say that it's the very next day you're instituting this?

A Yes.

Q Why didn't you just kind of let the patients filter out like they would normally, meaning just go to your scheduling people and say we don't want you to schedule anymore like that down the road? What was the reason why you did it so quickly?

A Well, for me, I didn't want that to happen because that would mean that for another week or so there would be 70, 75 patients coming in every day. If I was going to be in charge, I told them I want 60 only, never more and if there's more today, call the later patients in the afternoon, apologize and schedule them for another time. So from that moment on I wanted only 60.

Q And you know when a patient comes in it's -- it

sounds like what you said is the prep that their -- did they undergo some sort of prep before they come in?

A Yes.

Q And is that the thing where the drink this fluid and it makes them evacuate everything in their bowels the night before, that kind of thing?

A Yes.

Q That's a process I assume a patient has to go through, it takes some time?

A Yes.

Q Is that what you're talking about, you didn't want them to do that the night before if they weren't going to have the procedure until the afternoon the following day?

A Correct.

Q And you mentioned the staggering of the -- of the schedules so you wouldn't have all these patients arriving at -- first thing in the morning?

A Correct.

Q Had that been a problem up to that point?

A Yes. It had been a problem because the way the schedule occurred, it was not unusual to have -- walking in at 6:45, 10 patients already there, 12 patients already there getting ready for procedures.

Q More coming?

A And more coming because it had been stacked so

early in the first hour.

Q And who was the one in charge of -- of scheduling that kind of thing?

A Well, I wasn't in charge of the scheduling but the scheduling occurred from the scheduling people, the schedulers, but Dr. Desai had control over that schedule.

Q Did you ever talk to him, and I'm talking about before the stroke, did you ever talk to him about maybe doing what you said? Like hey, let's -- let's not have all these people waiting, let's stagger them out throughout the day?

A I did. I actually came up with it before I was actually assigned -- I came up with an idea to -- to make it easier for the patients and to make it more staggered and if -- if -- if it was necessary to scope more patients I -- I had the idea of having an evening session from five to seven p.m. So decreasing the daily schedule down to something reasonable, but having an evening schedule from five to seven with new staff, pay them for their time, another doctor pay him for his time, so that those patients could be done in a more satisfying way so that they could -- they know they're coming at 5:00, they can do their -- some of their work the -- on that day. And so we -- we instituted that to try to alleviate some of the pressure during the day. And for a while we did that and it seemed to work but after about a month it was decided it wasn't working.

Q Who decided it wasn't working?

A I think Dr. Desai thought it wasn't -- it wasn't working out.

Q So it changed?

A It changed back.

Q Okay. So now we've got him out of the practice, he's -- he's given the assignments, he's walked away or gone home, next day you institute what you told us?

A Yes.

Q Tell us how it goes.

A Well, from my point of view that was -- it was a good move. Patients were much -- much happier, the waiting room was much more manageable, the staff were happier and less stressed. The way we were able to process the patients through became better and easier. So the feedback that I received both from patients and from Jeff Krueger, the nurse manager, was that this was a good thing and the patients were happier.

Q So -- I mean is it fair to say that -- I mean, you had at least concerns about the volume beforehand and that's why you instituted this?

A Yes.

Q Now the concerns about the volume, what kinds of things does -- with the staff because you mentioned staff, stress and all that kind of stuff, what were the issues that

were coming up before with having all of those patients packed in to the -- you know, the fixed amount of time?

A I think that the -- the issues were that if you have that many patients waiting and patients are upset because their start times say 8:00, for example, gets pushed back to 10 or 10:30, patients get upset and they get frustrated and they -- and they get angry and they would tell us we're angry or upset, you've been -- we've been waiting here too long and I didn't like that. So I knew there was a better way to do this so that the wait time would be more reasonable.

Q Did you feel that the -- that it taxed the staff too? That -- I mean, that it was hard to process, actually physically process those -- that many patients in a day?

A I -- I believe that that's true. I believe that the processing of patients when there are that many right at the beginning was very difficult. Why? Because we have to check those patients in, we have to gather their information, we have to get them ready, we have to take their histories, we have to get IVs placed, we have to get oxygen on them, we have to EKGs on them. It's -- it's -- it's taxing when there are too many patients at once.

Q And is it fair to say that mistakes happen when people are stressed like that?

A Well, as a general rule I think so.

Q Now, you institute that, everybody seems to be

more happier about it, how long does that last?

A To the best of my recollection, about two, two and half weeks.

Q Tell us about that.

A Well, as best as I can remember, this was instituted, the patients were happier, staff was less stressed and Dr. Desai was able to come back into the office, not to assume patient responsibilities or see patients or do procedures, but he came back into the office to see how things were going. He looked better, stronger.

Q So this is about two weeks after --

A Right.

Q -- he -- he gives the plan?

A Right. So about two weeks after he gives this plan, he comes back to the office, calls me in and asked me how -- how is it going and I told him that it's going very well. And then he asked me about the number of the procedures that were being done and I told him that we had reduced it to 60 a day and that no patient could be scheduled unless I was told about it and it was absolutely an urgent thing to do.

Q What was his response to that?

A Well, his response -- he got angry at me. He was sitting at his desk, he was very upset with me and he said you don't do anything without passing it through me first. So I didn't say anything. So he was clearly angry that I had

done that even though it was better, I thought, for the practice to do it that way.

Q But he'd also given you the authority to do that?

A Yes. He gave me a carte blanche authority to run the show.

Q So up to that point he had not put any limitations on -- on what you could do as far as your -- asserting your authority in the practice; is that fair?

A Right.

Q And then he comes in and says now you don't make any decisions without running it through me?

A Correct.

Q Did that surprise you based on his response and what was going on at the time?

A Yeah, I was surprised. I was intimidated. I was -- I got quiet. I thought I was being shot down despite having done a positive thing. So, yes, I was -- I was surprised and I was taken aback because I was confused because I was just given the assignment to run the show and make decisions and yet I was being pretty aggressively castigated for it.

Q When you say aggressively castigated, I mean is he yelling, what's going on?

A He's raising his voice to me and pointing his

finger looking at me, you don't do anything unless you pass it through me first.

Q So he -- what -- what do you do? I mean, do you go back to the way it was?

A I didn't -- I didn't know what was going to happen but apparently Jeff Krueger who is the nurse manager who also was very pleased by the new changes was not willing to go back to the old way. So I wasn't present, but apparently Jeff and Dr. Desai talked about it and came up with a -- a number --

MR. WRIGHT: Can we have a foundation for the hearsay?

BY MR. STAUDAHER:

Q You said -- well, okay. I'll go back, certainly.

THE COURT: Yeah, kind of go back up a little bit.

BY MR. STAUDAHER:

Q The issue with the -- the issue with what you're just talking about now, was that ever raised with Dr. Desai at some point down the road? What Jeff and he had talked about with regard to the number?

A Did I ever talk to Dr. Desai about that?

Q Yes.

A Not that I recall.

Q How did you then know that this was -- was there

a new number that was given?

A Yes.

Q So who told you the new number?

A I think Jeff told me.

Q Did Dr. Desai -- did you ever have any interaction with him that that was the number that you were supposed to use?

A Not that I recall.

Q So, and just so I'm clear, what was the new number that was supposed to be used?

A Sixty-four patients.

Q Now, you weren't part of the conversation, don't know the details obviously, but is that what you went to is the 64?

A Yes.

Q So it matched up with what you were told?

A Correct.

Q How long did that last?

A Well, it's hard for me to remember exactly in terms of days and weeks that it lasted, but there came a time, maybe within a week or two that the number of 64 started to change a bit and get blurry. There would be 66 and then 68 and we -- we were wondering how did that happen. Well, there was a scheduling mistake --

MR. WRIGHT: Lack of foundation. Hearsay as to the

"we wondering." I just want the foundation. I'm not objecting to his hearsay.

MR. STAUDAHER: That's fine.

THE COURT: All right. I understand, Mr. Wright.

MR. WRIGHT: I'd just like to know.

MR. STAUDAHER: It's okay.

THE COURT: You know, if he says something that's ambiguous like we or -- just try to clarify what we're talking about, who we're talking about. All right?

BY MR. STAUDAHER:

Q Do you notice that the schedule changes?

A Yes.

Q As a result of seeing the schedule change, what do you do?

A On one occasion I did go back to the office and ask Dr. Desai why the number wasn't 64 anymore.

Q What was his response?

A It's hard for me to remember, but he said so sometimes there's scheduling mistakes, but that's it.

Q So he tells you scheduling mistakes. Do you go and check the schedule at all to see if there were mistakes?

A No, I did not.

Q Did you talk to any of the scheduling people about the plan that was in place that you wanted it to be that way?

A I didn't. After that, no.

Q So you just noticed that the schedule's creeping up?

A Yes.

Q After that conversation with -- with Desai, was he in -- back in the practice at that point or was he at home, where was he at?

A Yeah, he was coming in, he was coming in. Best I remember into the practice, overseeing things, going to the desk looking at papers, signing off on things. He was not seeing patients and he was not yet ready to do endoscopy because he had limitation on the use of his -- one of his hands.

Q And you say he's back in signing papers and doing things. Is he assuming the role of managing the practice again?

A Yes, he did.

Q I mean, were you in that role at this point?

A No, I was de facto out of that role.

Q Was that as of the meeting you had with him or did that just happen when he started coming back into the practice?

A I think it was as soon -- as soon as that meeting was over I was de facto and not running -- running the show anymore.

Q After that meeting, and this was about two weeks afterward, correct?

A Correct.

Q Is that when Desai started to come back in and sign things and take over the managing part of the practice again?

A Yes.

Q At some point did he start to do procedures again?

A Yes.

Q And did he see patients at some point?

A He started to see patients on a limited fashion. He started to do only upper endoscopies to begin with, which are easier, to see if he had good function. He seemed to be doing quite well and making progress.

Q When was he back -- I mean doing procedures, seeing patients, managing the practice?

A Unfortunately, I can't -- I can't give you a time frame for that. I --

Q Best estimate.

A Best estimate, within two months of that meeting.

Q So it was certainly much -- much sooner than when he said he was going to be out coming back; is that correct?

A Sooner than six months, yes.

Q So within a couple of months back to doing all the procedures and everything and within a couple of weeks back to managing the practice?

A Best of my recollection, yes.

Q Okay. So at some point during the time this is all going on, you said that you saw that the schedule was sort of incrementing up. Did it ever go, I mean, increment up a lot more, I mean back to where you were before?

A I don't remember that it went up to those numbers. It did creep towards 70.

Q Now the patients that were coming in, were they being -- did you -- did you ever go over and see how these patients were being added on to the schedule?

A No, but I -- I -- I inquired about how this was happening and I was told that it was just a scheduling mistake.

Q Now, this is Dr. Desai telling you this, right?

THE COURT: Yeah, he's doing that --

MR. WRIGHT: Foundation --

THE COURT: -- Mr. Wright.

MR. WRIGHT: Okay. This is Dr. Desai?

THE COURT: Dr. Desai told you this?

THE WITNESS: No, no.

MR. WRIGHT: Just tell us who.

THE COURT: Oh, okay. Then --

THE WITNESS: I inquired among the staff at the endoscopy center, you know, how is this happening --

MR. WRIGHT: Foundation.

BY MR. STAUDAHER:

Q And who were the people that you inquired with?

A I inquired with Jeff Krueger, the nurse manager, Katie Maley, and I asked them, how is it that the patients are going back up again?

THE COURT: You asked them together or separate?

THE WITNESS: Separately.

THE COURT: Okay.

BY MR. STAUDAHER:

Q Did they give you the same response?

MR. WRIGHT: Date, time, month?

THE WITNESS: Don't recall.

THE COURT: I mean, can you kind of, you know, when did you talk to Jeff Krueger, when did you talk to the other person, as close as you can remember?

THE WITNESS: This would be, best I can remember, late October of 2007.

BY MR. STAUDAHER:

Q So within -- within a month then --

A Yes.

Q -- within that month after he comes to you and

says I'm out of the practice for six months; is that fair?

A Fair.

Q So you did make some inquiries. When the -- when the scheduling mistakes are being made -- now, I need to understand this, because you also talked to Dr. Desai about that and that was an explanation he gave at some point, correct?

A Correct.

Q Scheduling mistakes are being made. Does that mean that patients are just being scheduled?

MR. WRIGHT: Objection. Now he's interpreting what --

MR. STAUDAHER: I'm asking him --

THE COURT: Well, no, he's asking him a question and I think it's suggestive or --

MR. WRIGHT: -- well, I find he is --

THE COURT: -- or leading. Did you hear the question?

THE WITNESS: No. Can you repeat it?

THE COURT: All right, Mr. Staudaher.

MR. WRIGHT: Repeat -- ask him --

THE COURT: All right.

MR. STAUDAHER: I'll ask him again.

BY MR. STAUDAHER:

Q How -- how was the scheduling -- what kind of

mistake are we talking about? I mean --

MR. WRIGHT: What did he say?

MR. STAUDAHER: I don't think that's an improper question. What kind of mistake are we talking about, scheduling mistakes.

THE COURT: Okay, well, did you bring up --

MR. WRIGHT: I object, Your Honor. He's relating a conversation --

THE COURT: -- okay, Mr. Wright, all right. Well, did you ask about a mistake?

THE WITNESS: No, I was told of a mistake.

THE COURT: Okay. And was that clarified for you? Did someone say what the mistake was?

THE WITNESS: Yes.

THE COURT: All right. Go on.

BY MR. STAUDAHER:

Q What was the mistake?

A The mistake was on the scheduling side in the office.

MR. WRIGHT: Okay. Is this what he's -- objection. I'm unclear if the --

THE COURT: Well, Mr. --

MR. WRIGHT: -- still the conversation.

THE COURT: Okay. All right. I -- there does need to be more foundation. Some of that you can do on cross, but

give Mr. Staudaher an opportunity to clarify the conversation and what was said before the objection because he, you know, he may be in the process of trying to lay a foundation.

MR. STAUDAHER: That's what I'm trying to do.

THE COURT: -- and to you Mr. Staudaher, just be mindful, you know, when -- when did these conversations occur, who's speaking and, you know, where did they take place.

MR. STAUDAHER: Let's -- let's go ahead and start with that.

THE COURT: All right.

BY MR. STAUDAHER:

Q I thought the time frame that you mentioned was in October, late October; is that fair?

A It's the best to my recollection.

Q And the people that were involved in it were whom?

A Jeff Krueger, Katie Maley, these are the people in charge of nurses, and also Audrey whose last name I don't remember.

Q And who is she?

A Audrey's a person that's in charge of scheduling people.

Q She actually does the scheduling?

A She helps with the scheduling, does it and helps the schedulers.

Q So these are the people that you talked with about that issue?

A Yes.

Q At that time period?

A As best I can recall, yes.

Q And now this -- this scheduling, just so we're clear, is that adding patients to the schedule beyond what was agreed to as the maximum?

A That's correct.

Q And did you go and inquire with those individuals as to how that was happening?

A Yes.

MR. WRIGHT: I'm going to object; that's hearsay. I'm not objecting to the conversation with Dr. Desai. I'm now objecting to hearsay as to these conversations now with Audrey, Jeff, Katie.

THE COURT: All right. That's overruled.

BY MR. STAUDAHER:

Q So, how --

A So we -- I called Audrey to ask how this could be, what's happening, why are there more patients than 64? Why are there patients coming for procedures that are not on our printed schedule. And she told me that, well, it seems to be, quote from her, a mistake by the staff pressing F1 on their scheduling keyboard and when they do that, when they

press this -- whatever this number is, F1, the patients will get a sheet saying you're scheduled for a procedure on such and such a day but it doesn't turn up on your schedule. So well, can you fix that? She says I'm working on it and that's how it -- and that's how it ended.

Q Did it ever get fixed?

A It would -- it would vary, it would go up and down. It would come back down towards 64 and come back up into the high 60s, 70s, didn't get corrected completely.

Q Let's move forward a little bit. Were there ever times -- and I'm talking about Dr. Desai, okay, so we're clear on this, where you're working on the medicine side of the practice --

A Yes.

Q -- and you're seeing patients and Dr. Desai enters your room and makes some instruction about shifting patients from the medicine side to the endoscopy side?

A Yes.

Q Can you describe that, tell us about that?

A Sure. So I told you before that the two entities, the medical side and the surgical side, are connected through locked doors with little keypads, codes on them. So sometimes when I was seeing patients on the medical side in the room with the door closed interviewing the patient, sometimes the door -- there would be a knock at the

door and Dr. Desai would be there and he'd open the door and he'd say to me that he needs more EGDs or upper scopes to be done at the center next door, which meant he wanted patients right then and there to have their procedures that day rather than get scheduled for another time. Sometimes he would say I need five or I need ten more EGDs because he was concerned that the schedule number had fallen to a level he didn't like. That happened on many occasions.

Q So let's talk about that. He was asking -- he wasn't asking for a colonoscopy, correct?

A That's impossible, the patient's not prepared.

Q The upper endoscopy is possible.

A Possible.

Q Now, when you're seeing patients on the medicine side, are you actually having them not eat the night before when they come in to have a consult with you or anything like that?

A No.

Q So they're not, as they say, without taking any fluids or food in? They might have some stuff in their stomach?

A Correct.

Q Would it be appropriate to go back and do procedures like he wanted you to do with patients who had eaten anything that day?

A No.

Q Why would that be?

A Well, because if a patient has any food in his or her stomach prior to eight hours, at least eight hours from the last meal to the procedure, the patient's at risk for vomiting and aspirating that content and that can be a very ominous event.

Q So when you say "aspiration," what does that mean?

A That means that the patient, under sedation, if there's food in the stomach, could vomit it up and then swallow it into the lungs; that's called aspiration. And any food content that's aspirated into the lungs can cause immediate issues with breathing and/or result in pneumonia.

Q So they could end up in the hospital just because of that?

A Yes.

Q Is that something -- have you ever been on procedures where cases were actually canceled because patients had admitted to eating something before the procedure?

A Quite frequently.

Q And I'm talking about that were going to have anesthesia where an airway issue would be a problem?

A Yes. It's part of the pre-op evaluation.

Q When he came over and did that, asked you for

five, ten more patients, whatever, did you ever -- did you -- did you think that that was appropriate?

A Well, I never thought it was appropriate so I never did it.

Q So you didn't do it but you were party to it when he actually came into your room with patients and told you these things?

A Yes.

Q Did that occur before his stroke?

A Yes.

Q Did it occur after his stroke?

A I don't recall if it occurred after his stroke.

Q Now with regard to those types of things we're talking about, the scheduling and so forth, at the -- you know that the CDC comes in, we're talking about -- we're moving through the end of the year of 2007 into --

MR. WRIGHT: Objection. Leading.

BY MR. STAUDAHER:

Q -- the beginning of 2008.

MR. STAUDAHER: Just setting it up, Your Honor.

THE COURT: Well, I think -- I think he's just --

MR. WRIGHT: I didn't know --

THE COURT: -- set up the question.

MR. WRIGHT: He's telling him, the witness, he knows the CDC comes in. I haven't even heard about this yet.

THE COURT: Mr. Staudaher, you can ask him were you aware that at some point in time the CDC came in.

MR. STAUDAHER: Okay.

THE WITNESS: Yes, sir.

THE COURT: All right. And then when did -- when did you become aware that CDC had come in?

THE WITNESS: Early January of 2008.

THE COURT: And is that the time the CDC came in?

THE WITNESS: Yes.

THE COURT: All right. Go on, Mr. Staudaher.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q So I'm talking -- that's the time frame I'm talking about, back from the stroke and back in practice up to that point. Okay?

A Okay.

Q During that time -- are we talking about the number -- and I'm talking about the numbers. You originally talked about the 64 or 60 and then the 64, did the numbers accelerate back up before the CDC came in?

MR. WRIGHT: Objection. Asked and answered.

MR. STAUDAHER: Before the CDC came in.

THE COURT: Overruled. He can answer the question.

A It -- it's hard for me to remember if the numbers went back up to where they were before. Can I say to

you there was 75, 80 again? I just don't remember, but I remember they did creep up again above 64.

BY MR. STAUDAHER:

Q So they were higher than what you -- what you thought the smack ceiling was?

A Yes.

MR. STAUDAHER: Court's indulgence, Your Honor.

THE COURT: That's fine.

BY MR. STAUDAHER:

Q Do you remember testifying before the grand jury on that -- on that very issue at one point?

A Yes.

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q Would it refresh your recollection -- your memory -- your recollection to possibly read a portion of the grand jury testimony?

A Sure.

Q For counsel's sake, it's page 41, spilling over to 42. And again, you can read as much of this as you need to before or after to get context. Specifically on this page here and if you need to read some more.

A Okay. I read this.

Q Okay. Does that refresh your memory a little

bit about the numbers that they went up to?

A Reading right here?

Q Well, I'm -- go ahead and read it and tell me if that refreshes your memory.

A Yes, it does.

Q Okay. Can I have that back?

A Sure.

Q Thanks. What did you at least testify to -- and this was a long time ago, right?

A Right. Again, I testified that the numbers began to creep up. It's hard for me to remember exactly how many, into the high 60s, low 70s.

Q Would you say that they went up to 70, 75, 76?

A I said that in my testimony.

Q So clearly more than 64 though?

A Yes.

Q Now, as far as the -- when -- when Desai would come in and ask for additional patients, did you feel -- I mean how did -- let me ask you, how did you feel? Did you feel any pressure or anything like that to try and comport with -- or comply with what he was requesting?

A Well's there's implicit pressure when that kind of demand is made but it doesn't mean that I'm going to comply with it, I just didn't do it.

Q Do you know if anybody else did, personal

knowledge?

A Personal knowledge, no.

Q Now when he had his stroke, you said -- obviously he was going to take himself out but did -- what part of his body, if any, did it affect?

A Well, to the best of my recollection when he came back and was starting to do procedures, one of his hands wasn't working well. I remember him constantly exercising either his right or left hand because one of them had become weak from the stroke. So the principal thing I remember is weakness in one of the hands.

Q And if you're -- if you testified in the grand jury that it was his right hand, would that be --

A I think that's correct.

Q Okay. Now as far as the actual other things like difficulty speaking and thinking and communicating, did he have any issues with those?

A I did not perceive any issue there.

Q And you communicated with him clearly, right?

A Yes.

Q Any other problems? Could he -- could he walk okay?

A Yes.

Q And he came back to the practice pretty much fully I think you said within about six weeks or so?

A To the best of my memory.

MR. WRIGHT: Objection. It was two months. As he asks these questions he keeps bringing it down.

THE COURT: Okay. Well, Mr. Staudaher, A, don't lead and B, Doctor, if Mr. Staudaher says something, as you know, you don't have to agree with it, just answer the questions as truthfully as you can.

BY MR. STAUDAHER:

Q Would it refresh your memory to look at a copy of your grand jury transcript?

A Yes.

Q Page 44 for counsel. I want to make sure I'm not inserting something that isn't actually accurate at all here. Page 44.

A Okay.

Q Does that refresh your memory a little bit?

A Yes.

Q Okay. And what did you tell the grand jury the time frame was for when he took over, when he was seeing patients, and when he was fully back?

A I told the grand jury that he was back within that two-week period when we had that meeting and seeing patients within five or six weeks.

Q And what about doing -- fully back to doing procedures?

A Can I see that, fully back to doing procedures?

Q Okay. So what did you tell them about fully back to doing procedures?

A Five to six weeks after that meeting when he told us about the stroke.

Q Now, let's move to another -- another area. Are you familiar -- have you ever been sued?

A Yes.

Q And I'm talking about sued for in a medical malpractice sense?

A Yes.

Q Who was the plaintiff in that case?

A I had one lawsuit here in Las Vegas in 2005, Mr. Kevin Rexford.

Q So we're going to refer to that as the Redford -- Rexford lawsuit so we're clear. Okay?

A Okay.

Q So during the Rexford lawsuit were you ever deposed?

A Yes.

Q And when -- what is it being deposed?

A Being deposed is being interviewed by an attorney and your own attorney about a case at hand regarding issues and questions about the care of that patient and if there -- if there was any reason to believe something occurred

that's malpractice.

Q And at some point during that -- I mean, do you get information about other people that have been testifying? Would you get transcripts? Do you talk to your attorney, things like that about what takes place during the process of a lawsuit?

A Yes.

Q At any point during that process, did you get a call from anyone that gave you some concern?

A Yes.

Q Can you describe that? First of all, what was the time frame if you remember? When was this all going on?

A This was happening in February of 2008.

Q Okay. And who was the CRNA involved with you in that lawsuit?

A Ronald Lakeman.

Q Go on.

A So during this lawsuit that I had, I would be updated with -- by my attorney about things that were occurring as different witnesses were being deposed, and he called me about the testimony that he had just heard from the CRNA who had been the one who sedated the patient in question back in 2005. And he told me that there -- it went very well and that he had nothing but good things to say about me, talking about me, but there came a strange moment in the

deposition where there was questions about a policy of billing 30 minutes for each procedure.

Q Now up to that point had you ever heard anything like that before?

A No.

Q Did you ever hear any concerns about any billing practice that was questionable or anything like that in the practice?

A The only time I had any confusion was a phone call that occurred back in 2005.

Q What was that about?

A There had been -- I was doing a procedure in one of the endoscopy rooms and somebody came into the room and said that there was a phone call for Keith Mathahs, one of the other CRNAs from Pacific Care and they wanted to talk to him about anesthesia.

Q What happened?

A Huh?

Q I mean what happened then?

A Then just Dr. Desai took that phone call and -- behind closed doors in his office by himself to manage or deal with whatever that was about.

Q So the insurance company was Pacific Care?

A Yes.

Q The nurse anesthetist involved -- that was

receiving the call was Keith Mathahs?

A Correct.

Q And Dr. Desai intercepted the call and went behind closed doors and dealt with it?

A That's how I remember it, yes.

Q Let's take a -- I'm going to step away since you mentioned that and go to that issue for a moment. Prior to that call, was there any issue about how Pacific Care patients were handled in the practice at all?

A No.

Q I mean, as far as order, things like that?

A No, not to my knowledge.

Q Did that change after that call, to your knowledge?

A After that phone call there -- once in awhile when I would go into a room to do a case I would hear, usually Keith Mathahs, wondering or grumbling or concern that there had been another Pacific Care patient in the room, patients that we never wheeled out, the patient came out and had the procedure done. I didn't understand what the concern was or why he was wondering about that and I didn't ask.

Q Did you eventually see a memo that had anything to do with that issue?

A I did.

Q And what was it about?

A I saw that memo long after 2008 during a deposition, it was provided to me. I never saw it during the practice time.

Q Did that give you some insight as to what that issue was?

A Yes.

Q Now, let's go back to the Rexford lawsuit.

A Okay.

Q 2000 -- in February of 2008, I think you said is when this is going on.

A Yes.

Q Not the event, but the depositions and the like?

A Yes.

Q Is this before the CDC comes in and talks to you or afterwards?

A This is afterwards.

Q So after CDC but you're involved in this lawsuit?

A Correct.

Q When you get this information about this 30-minute issue that comes up, what do you do?

A I -- I went to Dr. Desai to ask him about it.

Q What does he say when you ask him?

A So I went into his office and I closed the door and I sat down with him and I told him about the phone call

and that there was this issue of a potential policy of billing 30 minutes for every endoscopy case for anesthesia and is -- I asked him if it was a billing problem and he answered there is no billing problem, I left it at that.

Q Did he seem confused, surprised, anything when you said --

A No. He seemed very straightforward and very sure, there is no billing problem.

Q But you actually raised that as a billing issue?

A Yes.

Q Move forward in time. Anything come of that after that conversation?

A Yes, although again, it's hard to remember exactly the time frame --

MR. WRIGHT: Foundation. I mean, just, we're moving ahead in time. I'd just like better --

BY MR. STAUDAHER:

Q How long -- how far in time are we talking about when the -- when the next issue comes up relating to this?

A About a week and a half to two weeks.

Q Okay. So --

MR. WRIGHT: I'd just like the date of the conversation in the office.

THE WITNESS: I don't have the dates.

BY MR. STAUDAHER:

Q You said it was February of 2008, correct?

A Yes.

Q And is that in the same proximity as when you had the conversation with Dr. Desai in the office?

A Yes.

Q And then a week and a half after the conversation is when the second issue arises?

A About that, yes.

Q Okay. So tell us what happened.

A There had come a request, a written request, into the office that was shown to me by the attorney representing Mr. Rexford that he wanted us to send him all the anesthesia sheets, all the records, including the anesthesia sheets where the anesthesiologist -- the nurse anesthetist records the vital signs and the -- and the patient's experience. He wanted all of those from that day in 2005 to be sent to his office for review. So I went to Dr. Desai and I asked again, this is what's happened, this is their request and why would this request be made? Why is this -- why is the attorney so interested in the anesthesia sheet. And again, I said is there a billing problem. And he said to me there is no billing fraud.

Q Now you just quoted his words; is that right?

A Right. Correct.

Q Did he actually use the word fraud?

IN THE SUPREME COURT OF THE STATE OF NEVADA

DIPAK KANTILAL DESAI, Appellant, vs. THE STATE OF NEVADA, Respondent.	)	CASE NO. 64591

APPELLANT'S APPENDIX VOLUME 11

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question did you see certain things, but you did see him carry that with supplies that he used on patients from one room to another room during the day?

A Yes, sir.

Q Okay. Did he always take it with him or was this just on some occasions?

A Some occasions.

Q But you did see it?

A Yes, sir.

Q Did you ever hear Dr. Desai ever complain that the CRNAs specifically were using too many supplies?

A Not that I can remember.

Q Would it refresh your memory to look at a copy of your transcript?

A It would help.

Q Sure.

MR. STAUDAHER: Page 26 for counsel.

BY MR. STAUDAHER:

Q And you can actually -- the first part about the tackle box is up there too if you want to refresh your memory about that.

A Yes, sir.

Q Okay. I'll ask you that question again. Do you remember Dr. Desai ever complaining to anyone that the CRNAs were using too many supplies?

A On occasion.

Q Did you ever see any of the CRNAs re-use a syringe on the same patient for administration of anesthesia, the propofol?

A Yes.

Q Did you describe to the police a specific word that you used regarding what you thought Dr. Desai was in relation to the use of supplies?

A I think it was anal I believe.

Q Did you ever specifically remember Dr. Desai specifically say anything about using too much propofol? It was on that same page so I want -- I'm just asking.

A I'm sorry.

Q Do you want to look at it one more time?

A I'm trying to understand the question, sir.

Q Oh, maybe it was a bad question.

THE COURT: Maybe state your question --

BY MR. STAUDAHER:

Q I can -- I'll state it again. Did Dr. Desai ever make a comment about how much propofol was used or being used in the facility?

A Yes.

Q And this was in the context of using too many supplies, correct?

A Yes.

MR. STAUDAHER: Nothing else, Your Honor.

THE COURT: Cross?

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Mr. Sukhdeo.

A Sir.

Q I represent Ron Lakeman. Do you know Mr. Lakeman?

A Yes, sir.

Q Have you worked with him, done any procedures with him?

A I believe so, yes, sir.

Q How many procedures would you say you've done with him?

A I couldn't give you a specific number, sir.

Q Well, you testified that you started work at the clinic in August of 2007; is that correct?

A Yes, sir.

Q And I'll represent to you that Mr. Lakeman left the clinic in October of 2007. Do you remember working with him during that time period?

A Vaguely.

Q You vaguely remember?

A I did work with him, yes.

Q In a procedure room?

A A couple times, yes, sir.

Q You testified that when you first got to the clinic you did mostly cleaning of scopes, correct?

A When I --

THE COURT: When you first started working there?

BY MR. SANTACROCE:

Q When you first started working there?

A Scopes didn't come until later, sir.

Q Okay. So you started in the procedure room?

A Actually I started out on the floor.

Q When did you go into a procedure room?

A I'd say about late September, early October, if I remember correctly.

Q I'm sorry?

A If I remember correctly.

Q You testified that you saw Mr. Mathahs take a tackle box from room to room?

A Yes, sir.

Q Did you ever see Mr. Lakeman take a tackle box from room to room?

A No, sir.

Q You -- do you know what was in that tackle box?

A I couldn't say for sure.

Q It wasn't propofol, was it?

A I didn't stop to ask what was in his box.

Q Well, you testified or you gave an interview to the police and you told the police you never saw propofol being moved from room to room; isn't that correct?

A Propofol wasn't my concern.

Q But do you remember telling the police that?

A I would like to think so.

Q I'm sorry?

A I would like to think so but.

Q Well, look at page 25 of your interview. Do you have it up there?

A No, sir.

Q Well, I don't have a copy of it. The DA is looking at it.

THE COURT: Can you use Mr. Staudaher's?

MS. STANISH: I've got one. You can use the one I've got.

BY MR. SANTACROCE:

Q I'm directing your attention to the bottom of page 25 and the top of page 26.

A Yes, sir.

Q Does that refresh your recollection?

A Yes, sir.

Q That was specific -- specifically asked if -- by the detective if you saw propofol go from room to room and your answer was no.

A Yes, sir.

Q Is that a correct answer at the interview?

A At the time, yes.

Q So at the time when you gave the interview you never saw propofol go from room to room, correct?

A Yes, sir.

Q Now you testified on direct examination that you heard Dr. Desai get on the CRNAs for using too many supplies. Was that your testimony?

A I believe so, it was.

Q Do you remember in your interview you were asked by the detective and you told the detective you only saw that once or twice?

A If that's what I said.

Q Do you want to see your interview?

A No, sir.

Q I'm sorry?

A No, sir.

Q Did he say yes or no?

THE COURT: He said no.

THE WITNESS: No.

BY MR. SANTACROCE:

Q I'm directing your attention to page 20 --

THE COURT: I guess you're going to look at anyway.

BY MR. SANTACROCE:

Q Oh. Did you say no?

A I said no.

Q Sorry.

THE COURT: You can still show it to him if you want to.

BY MR. SANTACROCE:

Q If he agrees that that's what he testified to, I don't have to.

MR. STAUDAHER: What was that? If we could just have clarification because I -- I didn't hear that. I'm sorry.

BY MR. SANTACROCE:

Q That you only saw Dr. Desai get on the CRNAs once or twice about using -- about supplies; is that correct?

A If that's what I said then, yes.

Q Well, I don't want you to guess what you said then. I'll be happy to show it to you. Do you want me to show it to you?

THE COURT: He's going to make you look at it so just --

A It's hard to remember anything I said four years ago.

BY MR. SANTACROCE:

Q Well, is your testimony different today then what you testified to four years ago?

A No, it's the truth.

Q Okay. Which one?

A Everything.

Q Okay.

MR. STAUDAHER: Objection, Your Honor.

THE COURT: Overruled.

BY MR. SANTACROCE:

Q Showing you page 26. Is that what you said?

A Yes, that's my interview.

Q Well, why don't you just hold on to that for a minute. Now, when you did these procedures and you -- you testified that you were in some procedure rooms and I want to know how many times you saw the CRNAs induce propofol into one single patient in one procedure.

A At the beginning of the case, sir?

Q During the whole time.

A I know they would administer the propofol to put the patient to sleep.

Q Okay. And would they induce another application of propofol?

A During the procedure, sir?

Q Yes.

A I believe I may have witnessed it once or twice.

Q How often would you witness that?

A I can't be sure it's -- I don't remember.

Q Look at page 24 of your interview.

A Yes, sir.

Q Does that refresh your recollection?

A Somewhat, yes.

Q Specifically on the top of 24? Your -- you told the detective that normally they would just give it one time; isn't that correct?

A Yes, normally they would.

Q And do you recall if the vials that you saw in the procedure rooms were small vials or big vials?

A I'm -- I'd have to have something to compare it. But I never handled propofol so I can't --

Q You're a pharmacy tech, correct?

A I was.

Q And as a pharmacy tech are you familiar with how propofol is packaged?

A I never encountered it before.

Q You encountered it at the endoscopy center though; isn't that correct?

A Yes, but I never handled it or --

Q Do you know what 20 cc is?

A About that much.

Q Small?

A Just guessing.

Q Okay. What would be your -- I don't want you to guess.

THE COURT: Well, don't guess.

BY MR. SANTACROCE:

Q Do you know or not know?

A 20 cc, I mean 20 cc, it's a 20 cc vial or syringe.

Q Compared to 50 cc, how -- how much would 20 be, how much would 50 be?

A Well, 50 would obviously be larger than 20 so.

Q More than double, right?

A A little bit more, yes.

Q So what did you see in the procedures rooms, smaller bottles or bigger bottles?

A The small bottles I believe.

Q Small bottles?

A I never held propofol so I can't tell you how many cc are in each bottle.

Q You gave the interview to the detective and you were specific about this. Do you recall that?

A It's been awhile.

Q Well, I want to know what you recall today.

A Well, I don't remember entirely.

Q You don't remember. Look at page 24.

A Yes, 20 cc syringe.

Q Syringe and what were the vials?

A I believe the detective was -- was quoting the

20 ml bottles.

Q And what do you say?

A I said no.

Q So what were they?

A They could have been 20 or 50, I --

Q You're not sure?

A I'm not sure. I never handled propofol.

Q Now, when you were in the procedure room, what was your job?

A Assist the doctor.

Q And tell me what that entails.

A Just handing the scope to him at the start of the procedure, making sure all the supplies were there for him when he needed it.

Q Was it dark in the room?

A Yes.

Q How many people were in the room?

A I believe me, the doctor, the nurse and the patient, about four.

Q And CRNA?

A Yeah, the nurse.

Q Was there another nurse besides a CRNA?

A Yes, taking -- doing the chart.

Q So how many people were in the room?

A Five I would believe.

Q And the machine that you were controlling or operating or maybe you didn't -- I mean the scopes were connected to a computer --

A Yes, sir.

Q -- a television screen?

A Yes, sir.

Q How far away from you were -- were you from the CRNAs?

A They were across -- about -- maybe a little closer than where you are now.

Q Okay. So what 10 feet?

A They were just on the other side of the patient.

Q So were the CRNAs at the head of the bed?

A Yes.

Q And you were at the foot of the bed?

A Yes, toward -- in the back of the wall, yes.

Q And the doctor was between you and the CRNA?

A He was usually to my right.

Q And you would be -- your attention would be -- I guess directed on the doctor; is that correct?

A Yes, sir.

Q And you would have to be directed on the doctor because he would ask you for things throughout the procedure, correct?

A Yes, sir.

Q And he'd be handing you things, correct?
A Yes, sir.
Q And you'd be handing him things, correct?
A Yes, sir.
Q So is it fair to say your attention was not on what the CRNAs were doing?
A Yes, sir.
Q I want to talk to you about the cleaning room a little bit. You said that you -- I believe you learned by observation --
A Yes, sir.
Q -- is that correct?
A Yes, sir.
Q Were you aware that there was a manufacturer's recommended guide for cleaning scopes?
A Not at first.
Q At some time did you?
A Eventually, yes.
Q How long after you were there?
A Maybe a month or two.
Q And did you read that guide?
A I don't believe so.
Q So the procedures you employed in cleaning these scopes and bite blocks and whatever else you cleaned was done through observation of someone else, correct?

A Yes, sir.

Q And those procedures I believe you testified changed after the CDC visit; is that correct?

A Yes, sir.

Q Specifically, the change that you remembered was changing the water in the blue buckets --

A Yes, sir.

Q -- more often?

A Yes, sir.

Q Was there any other recommended changes by the CDC?

A If they did, I wasn't aware of them. That's the only one I remember.

Q So other than changing the water in the buckets, you continued to clean the scopes as you did prior to when the CDC was there?

A As I was instructed, yes, sir.

Q As you were instructed?

A As I was taught.

MR. SANTACROCE: I don't have any further questions. Thank you.

THE COURT: All right. Ms. Stanish, is it you?

MS. STANISH: Yes, Your Honor.

CROSS-EXAMINATION

BY MS. STANISH:

Q Hi, my name's Margaret Stanish. I represent Dr. Desai.

A Ma'am.

Q Am I right to believe you -- you're a conscientious person?

A I'd like to think so.

Q And if I ask you a question and you don't recall the answer, would you let me know so that you can refer to that document to refresh your memory?

A Yes, ma'am.

Q Because I'm with you, four years ago was a long time. May I have that?

MS. STANISH: May I approach, Your Honor?

THE COURT: Sure.

BY MS. STANISH:

Q I'm not going to go on and on about the Medivator and feces, but I did want to clarify something on the photographs we saw and --

MR. STAUDAHER: Margaret, there's more -- there's more pictures down there, just so you know.

MS. STANISH: Okay. That helps. Thank you.

BY MS. STANISH:

Q Can you see this, what looks to be a chart propped up above the cleaning machines. Do you see that?

A Yes, ma'am.

Q What is that?

A To be honest, I don't remember.

Q Do you see the colors on it?

A Yes, ma'am.

Q Does it have something to do with the testing or is it instructions, if you know?

A It might be. I mean -- yes, I mean, it's look like -- it's been awhile.

Q You can't tell from this picture?

A Kind of taken at a distance, yes.

Q It is.

A Yes, ma'am.

Q But would that cart have been there on the day -- let me ask you. Were you there when the police came and took items from the facility?

A No, ma'am.

Q Was this item normally there?

A I don't remember.

Q What about this item that looks to be hanging from a hook near the sink, do you know what that is?

A I can't be sure, no, ma'am.

Q Were -- do -- can you tell us whether there were quick reference guides on how to operate this machine?

A I don't remember, to be honest with you.

Q Where did you work before you worked at the

endoscopy center?

A The Surgical Center of Southwest Medical Associates.

Q And could you speak up? I'm sorry.

A I'm sorry. I worked as an anesthesia technician for Southwest Medical Associates.

Q He sneezed and I didn't hear you.

THE COURT: Can you please say it again?

A I was an anesthesia technician for SMA.

BY MS. STANISH:

Q All right. And what kind of surgeries were done there?

A Hip replacements, knees, all sorts of varying procedures.

Q When you worked at that location, did you waste medical supplies?

A No, ma'am.

Q Is it unusual in your experience -- well, let me ask you. How long did you work at that facility?

A Not long.

Q Okay. Dr. Desai didn't like to waste supplies either; is that correct?

A Yes, ma'am.

Q By the way, when you were interviewed by the police, were you nervous?

A Yes.

Q You're nervous now?

A Terrified a little. I've never done this before.

Q That's good.

A Hoping you'll be lenient.

THE COURT: It will be over soon.

BY MS. STANISH:

Q It will be over soon. When you worked in the cleaning room, did you ever let an item leave that room that was dirty?

A No.

Q If you noticed an item that was unclean, what would you do?

A If I felt that a scope was dirty, I would let someone know that I felt the scope was dirty and have it cleaned again.

Q And how many times did you say you actually assisted Dr. Desai in performing any procedures?

A A couple, not many.

Q Two times?

A I mean it was more than two.

Q You don't remember?

A I didn't -- I didn't work with him in that way a lot, so I can't give you a specific number.

Q And by the way, these Medivators, is that what -- is that the right term?

A I believe so, yes, ma'am.

Q You yourself didn't change the solution, correct?

A Yes, ma'am.

Q And -- and how long did you work in that room?

A Just on and off, not every day.

Q And do you know if somebody else changed the fluid?

A If they didn't, I mean, I never saw anyone change it but it's not to say that it wasn't changed.

Q Correct. Was -- by the way, was there a log or something where you had to write down if you changed the fluid?

A I believe so.

Q And -- or did -- did the machine itself -- I can't tell from the pictures, but did the machine itself have any kind of logging system like a -- or a --

A Not that I -- excuse me, not that I remember, ma'am.

Q So there would have had to have been filled out -- just a handwritten log on when the fluids were changed?

A I can't -- I'm not entirely sure, but I believe there was something to that extent, yes, ma'am.

Q When you were doing that function, would you use those test strips just to make that the disinfecting fluid was something that could still be used?

A Yes, ma'am.

Q Were you in the military?

A No, ma'am.

Q You sound like you were. When you worked in the patient area you said it would sometimes get crowded in there?

A Yes, ma'am.

Q What did you mean by that?

A The patient waiting area, yes.

Q Oh, I -- I don't mean that. I meant that diagram in -- where we saw pictures of like four or five beds, the recovery area --

A Yes, ma'am.

Q -- and you said sometimes it would get backed up so someone would have to wait before being moved into a recovery area --

A Yes, ma'am.

Q -- that's -- what's that area called?

A I call it the patient bays.

Q Okay, patient bays. What did you mean that sometimes that gets crowded?

A Well, if we were coming out of a procedure room and all the bays were full.

Q Was it also crowded because there were staff members circulating in the area?

A There was always people coming and going.

Q Staff members?

A Yes, ma'am.

Q Was -- in that recovery area, did you observe nurses circulating in the area and checking on patients?

A Yes, ma'am.

Q And you changed the solution in the buckets after every two scopes, did you say?

A I tried to, yes, ma'am.

Q Oh. Did -- you said you had one or two days of training, but was that -- what room were you referring to? You had one or two days of training in the cleaning room?

A Yes, ma'am.

Q Did it take long to learn how to clean a scope?

A I'd like to think I learned quickly just watching it over and over.

Q You wash dishes at home, right?

A Yes, ma'am.

Q And this, of course, is something you have to be more careful with, correct?

A Yes, ma'am.

Q And do you feel like you -- were you comfortable doing that job?

A Yes.

Q Did you feel like you were doing a good job?

A To the best of my ability always.

Q If you felt like you needed more training, what would you do?

A I would let someone know that. If I had a question or concern I would just let someone know that.

Q Okay. Did you ever have questions or concerns?

A I would maybe ask if I was -- to ask someone if I was doing it right.

Q Were there experienced people available to you so that you could have questions answered?

A There was usually another GI technician around. As to their experience, I can't say to -- I can't say to the extent of their experience, but there was always a technician around to ask.

Q Okay.

MS. STANISH: Court's indulgence. I just --

THE COURT: That's fine.

MS. STANISH: -- have to review this since I didn't have much time with it.

BY MS. STANISH:

Q The subject of KY Jelly, even though this is not a prosecution about KY Jelly, am I right to understand that every doctor had a different preference as to the amount of KY

Jelly that was to be applied?

A Yes, ma'am.

Q I think we about covered everything. Thank you, sir.

A Ma'am, thank you.

THE COURT: Any redirect?

MR. STAUDAHER: I just have a couple -- just about three, Your Honor.

REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q Ms. Stanish asked you about the two scopes. There was two scopes, you said you tried to do that, but in reality you told the police it was more like three or four, correct?

A Yes. Yes, sir.

Q Okay. Patients started and ended in the same place? Just so we're clear, the recovery area was where you kind of staged them, go in a procedure room, come back out to that location; is that right?

A Yes, sir.

Q Okay. And the last thing, when counsel was asking you about the tackle box with Keith Mathahs and being asked about the propofol bottles, you answered that in relation to being asked about the propofol bottles saying that his -- he kept his stuff with him and he carried this tackle

box from room to room --

A Yes, sir.

Q -- is that correct?

A Yes, sir.

Q Is that right?

A Yes, sir.

Q Okay. So what -- you didn't necessarily see him carry a bottle from room to room, but you saw him carry a tackle box with stuff that he used like his anesthesia stuff, which may have included the propofol?

A Yes, sir.

Q Nothing further.

THE COURT: Any re-cross, Mr. Santacroce?

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q You didn't see any propofol bottles in the tackle box, did you?

A No, sir.

THE COURT: Ms. Stanish?

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

THE COURT: Mr. Staudaher?

MR. STAUDAHER: Nothing further, Your Honor.

THE COURT: Do we have any juror questions for the witness? No? Oh, we do. I'll see counsel at the bench.

(Off-record bench conference.)

THE COURT: All right. We have a couple of juror questions up here. A juror would like to know, what technique was used in order to get the scopes from the Medivator to the sterile area once, you know, the Medivator had cleaned them or whatever, then how did you move them from the Medivator to the sterile area?

THE WITNESS: After the Medivator was finished, I would apply clean gloves, open the lid, detach the attachments that you saw, take the scope out and place them onto the sterile area and then dry them down. After they were dried down I would then take it and hang it up in the adjoining closet.

THE COURT: Did you always put on fresh gloves before taking them out of the Medivator?

THE WITNESS: Yes, ma'am.

THE COURT: Okay. And then under your procedure, could the sterile scopes have accidentally touched anything, you know, like your clothing or the outside of the Medivator or anything like that?

THE WITNESS: I don't believe so. They were wrapped in a coil and I took them out.

THE COURT: Okay. State, any questions based on those last questions?

MR. STAUDAHER: No, Your Honor.

THE COURT: Ms. Stanish, any questions based on those?

MS. STANISH: No, thank you, Your Honor.

THE COURT: Mr. Santacroce, any questions based on that?

MR. SANTACROCE: No, Your Honor.

THE COURT: Any additional juror questions before I excuse the witness? All right, no additional juror questions. Sir, thank you for your testimony. Please don't discuss your testimony with anyone else who may be called as a witness in this case. Thank you, sir, and you are excused.

THE WITNESS: Thank you.

THE COURT: Counsel approach. And just follow the bailiff from the courtroom. Thank you.

(Off-record bench conference.)

THE COURT: All right, ladies and gentlemen. We're going to go ahead and take our evening recess at this time. We'll reconvene tomorrow morning at nine a.m.

During the evening recess you are reminded that you're not to discuss this case or anything relating to the case with each other or with anyone else. You're not to read, watch or -- watch or listen to any reports of or commentaries on the case, any person or subject matter relating to the case. Do not do any independent research by way of the Internet or any other medium and please do not form or express

an opinion on the trial. Where'd the bailiff go? All right.

MS. STANISH: He went home.

THE COURT: I guess we're running too long. See what happens when you get an easy day?

MS. STANISH: We have ten minutes to spare.

THE COURT: Ladies and gentlemen, did any of you leave your belongings in the back? Okay. So we do need the bailiff to come back. Here he is. All right. Ladies and gentlemen, notepads in your chairs and follow -- I couldn't let them go because they need to go in the back. Nine a.m., sorry.

(Jury recessed at 4:49 p.m.)

THE COURT: I'm just waiting for them because they go past this door. That's why I'm sitting here. I'm not -- oh, you want to put something on the record?

MR. WRIGHT: Yeah.

THE COURT: All right. Are both doors shut? All right, Mr. Wright, go ahead.

MR. WRIGHT: The -- we approached the bench on the tackle box question and in my opinion it -- it's not -- I think it's an effort to impeach Mr. Mathahs without having asked Mr. Mathahs. And so I think it's improper impeachment if the State intends to thereafter argue like in closing if Mathahs carried propofol in his tackle box back and forth between the rooms. You can't sandbag your own witness by not

asking, then bringing in a different witness and asking them a question like that. That's pure improper impeachment, sandbagging. If they wanted to know, then ask Mr. Mathahs if he had done that. He was their witness and they should have done it. Now -- so that's what -- that's what my concern was and it will remain so and I object if that's what their intentions are.

THE COURT: Mr. Staudaher?

MR. STAUDAHER: Well, first of all, it's not impeachment because I was not confronting him with a statement that this witness had made. I did ask if -- the best of my recollection, I did ask Mr. Mathahs, did you ever carry anything from room to room, take supplies, anything like that and his answer I believe was, I don't remember ever doing that. He didn't completely discount it, but he didn't remember. This witness had a direct observation. There's not impeachment there, it's his observation of what he observed, what he saw and it's completely proper. There's not foundational basis for it being an improper impeachment or anything else of that nature.

THE COURT: All right, here's the deal. Anything else Mr. Wright on that point?

MR. WRIGHT: I -- I -- no. I just -- I just want the objection --

THE COURT: Okay. All right. Mr. Santacroce?

MR. SANTACROCE: Just joining in that, Your Honor.

THE COURT: All right. Here's the deal. He can -- Mr. Staudaher can ask the witness what he saw, what he observed in the clinic and that's not impeachment. You know, he's free to testify. Now, I don't recollect exactly what Mr. Mathahs said either. So since it's a dispute, I suggest somebody -- I don't know if we'll have a transcript of that part or not, check your notes or whatever. You're certainly free to argue based just on the testimony of the witness. This witness observed Mr. Mathahs carrying a tackle box between room and room of supplies.

Obviously, you can't say it had the propofol in it based just on his testimony because he said he didn't know what was in it. But, you know, they can draw whatever inference they're going to draw from that but you can't stand up there and say, he had a tackle box with propofol or we know it had propofol or anything like that based on what we've heard so far number one.

Number two, without, you know, going back over the testimony, you can't use the testimony to somehow discredit Mathahs unless we find that he in fact did say he didn't carry anything from room to room. Then, of course, if that's contradicted then you can point that out. At this point I don't remember if that was asked and -- I mean, I remember there was no testimony from Mathahs that he's carrying a

tackle box back and forth, that I do remember. Whether or not it was asked, did you carry anything back and forth and he said no, not really. I think it was, I'm not sure, but he definitely -- so I mean you can't discredit him --

MR. STAUDAHER: I know I asked him something like that.

THE COURT: -- unless you ask the question. But again, you're certainly free to ask any witness what did you observe and then comment on that in your arguments.

MR. STAUDAHER: That's exactly what I intend. I just want to be able to show that there's evidence before this jury that not only did Mr. Mathahs move from room to room, but it was at least observed on other occasions that he carried something with him from room to room. So what it contains, we know it -- we know based on his testimony, Mr. -- however you pronounce his name, that it contained anesthesia supplies, that's what he said.

Other than that, that's as far as I would go with it. I mean, I think there's an inference that if it contains anesthesia supplies, it's in the context of the fact that he's being asked about propofol that it's conceivable that it could contain it but I'm not going to say that --

THE COURT: Right, well --

MR. STAUDAHER: -- it absolutely did.

THE COURT: -- I will comment on that. The fact that

he was asked about propofol and he said well, he did carry supplies and he said he doesn't know what was in the box, you know, you didn't really impeach him, oh, he did know it was propofol or, you know, whatever. I mean the testimony is he carried supplies, you know, whether it included propofol or not it could have, could not have of.

MR. SANTACROCE: But I asked him.

THE COURT: I mean, it's kind of -- yes.

MR. SANTACROCE: I asked him specifically, did you see propofol in the tackle box and he said no.

THE COURT: Well, if he didn't see anything in the tackle box, then he didn't see propofol in it, you know, he didn't see your cat, he didn't see gauze, he didn't see anything. That doesn't mean there wasn't gauze in the tackle box. That doesn't mean there wasn't propofol in the tackle box. If he doesn't know what was in the tackle -- you know what I'm saying? If you ask somebody, well, what -- did you see what was in the tackle box, no. So you didn't see propofol in the tackle box, no. Because he didn't see it, he doesn't know. And I think that -- that's my recollection of the testimony. He knew it was supplies but he didn't know the specifics of the supplies. That's how I heard it.

MR. SANTACROCE: But he -- he said anesthesia supplies. If -- how did he see that?

MR. STAUDAHER: He saw that, he just couldn't say it

was --

THE COURT: Okay. I'm sorry. If he takes the tackle box and he opens it and he sees him taking things out of it and using it on the patient, he's going to -- he's going to assume it's anesthesia supplies. He may not remember the particulars, was it needles, was it syringes, was it, you know, alcohol wipes, was it, you know, new tape, I don't know. You know, I mean, but it's a reasonable inference without necessarily knowing the specifics that if somebody opens their tackle box and they're working on a patient and you see them reach in and get something that that's what they're getting, you know?

I mean he's not getting a sandwich. I think it's a reasonable inference without, you know, knowing exactly. You know, again, before argument, you know, maybe we can pin down better what he said. But, you know, again, Mr. Staudaher's free to comment on the witness's testimony. He just can't, you know, add things to the testimony that weren't --

MR. STAUDAHER: I don't intend to say that he absolutely -- that this guy got up and testified that propofol went from room to room. He just -- Mr. Mathahs, by his observation, carried a tackle box --

THE COURT: A tackle box of supplies.

MR. STAUDAHER: -- with anesthesia supplies from one room to another. That's it.

MS. STANISH: If I may, what I find to be problematic and this tackle box is a prime example. After cross, after we've gone over somewhat ad nauseam the fact that he didn't see the propofol, you -- Mr. Staudaher closes or tries to wrap up his testimony in a lengthy discourse and throws in there and it may have contained propofol and then sits down or something to that effect.

MR. STAUDAHER: I didn't say it contained propofol. I said it --

MS. STANISH: You said it may --

MR. STAUDAHER: -- was in context of being asked if you ever saw propofol moved from room to room. And if you read it says -- he's asked that and then he says well, I saw him carry anesthesia -- supplies, anesthesia stuff from room to room. He did not specifically say that he saw a bottle move from room to room to room. I didn't ask him that question, he didn't say that, I'm not going to argue that.

THE COURT: All right. That's the only thing I'm saying is he didn't say it. You know, he said he didn't know. I mean, he said it was supplies, so it may have contained propofol, it may not have contained propofol. Like I said, I think it's reasonable, he would have opened the tackle box and been reaching in and taking things out and using them. I mean, I -- I think it's reasonable. It wasn't, you know, unrelated things. And so what the -- that was, the witness

apparently didn't remember or never bothered -- you know, he was preoccupied with what he's doing, not really paying attention to what exactly -- and that's reasonable, that's believable. He's not really paying attention to whether or not, you know, he's taking out a -- a new syringe or a new needle, you know, but he sees him reach in a tackle box and pull something out and work on the patient. To me that's kind of the gist I think of the testimony as I heard it.

The suggestion did come from the question, as Ms. Stanish pointed out. I just caution Mr. Staudaher that if you look at the whole thing in context, he wasn't saying, oh, yeah, propofol moved from room to room. He's saying well, I did see him carry a tackle box of supplies. Not clarifying -- I mean I think that's consistent with what he said. Not clarifying whether it was propofol or not propofol. So, you know, that's -- that's what we know. We know there was some movement from room to room of something that was used on patients. Yes?

MR. WRIGHT: Yeah, one other thing, Your Honor. I apologize to the Court for being late during the recess. I would like to give an explanation because normally I don't just hang around out there. I was talking to Dr. Desai at the end of the hallway because I couldn't -- Margaret was using a rapid reading and I didn't want to talk and interrupt her because she was reading Subdepot's testimony.

So I -- I was truly conferring with him. I should have come in and asked for more time and said that, but I wasn't just fooling around out -- running around in the courthouse or something. I -- I was discussing because he couldn't remember -- Dr. Desai could not remember the direct and cross that took place on Monday afternoon of Herrero and I was questioning him about a supposed partnership or physician meeting at the time 50 cc vial decision was being made. And my -- my client wanted -- I wasn't -- I had time to talk with him, that isn't my complaint, I'm just explaining why I was late coming back in.

THE COURT: All right, that's fine. I mean, like I said, you know, let's just try to be --

MR. WRIGHT: I understand.

THE COURT: -- mindful in the future.

MR. WRIGHT: Yes.

THE COURT: You know, of the times and, you know, I think to make sure this moves along swiftly, one of the things we all need to do is, you know, make the breaks as short as possible. And like I said, if it's a 10-minute break and somebody needs to use the restroom, that means, you know, go at the beginning not waiting. And I know sometimes you want to mark exhibits and things like that, but I also know that jurors get frustrated.

I mean, I haven't spoken with these jurors, but I'm

saying jurors generally get frustrated when, you know, they're kept waiting for long periods of time. And sometimes I think it's actually almost better even if they have to sit in the courtroom while we're moving through some exhibits than, you know, making them wait out in the hallway or something like that while we're -- you know, if that's not done ahead of time.

Now, if you need Ms. Husted to be here early and you have exhibits, she'll be here earlier than her start time. And you folks get here early. She starts at seven so -- right Denise? And she's here at like, I don't know --

THE CLERK: 6:20.

THE COURT: 6:20. So if we have exhibits and things like that, you know, and you want to coordinate with Ms. Husted, please do that because she's here in the morning waiting around twiddling her thumbs at her desk with nothing to do, waiting to start. So, you know, let's try to just be mindful to, you know, when we are in session, move it along as -- as quickly as we can and get the exhibits organized ahead of time. Like I said, you know, the staff is here. They get here early so coordinate, you know, with them when you can so we can make this as swift and efficient as possible. All right, we'll see you tomorrow.

(Court recessed for the evening at 5:03 p.m.)

CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

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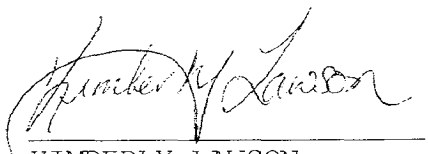

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA, Plaintiff, vs. DIPAK KANTILAL DESAI, RONALD E. LAKEMAN, Defendants.	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT NO. XXI **TRANSCRIPT OF PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 16

THURSDAY, MAY 16, 2013

APPEARANCES:

FOR THE STATE:	MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys
FOR DEFENDANT DESAI:	RICHARD A. WRIGHT, ESQ. MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN:	FREDERICK A. SANTACROCE, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

I N D E X

WITNESSES FOR THE STATE:

CLIFFORD CARROL

Direct Examination By Mr. Staudaher 4

Cross-Examination By Mr. Santacroce 145

Cross-Examination By Mr. Wright 175

LAS VEGAS, NEVADA, THURSDAY, MAY 16, 2013, 9:11 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: Well, I must explain, since I admonished everyone about being late yesterday, that a juror was late. That's why we're starting a couple minutes late. So is anyone ready?

MR. STAUDAHER: Yes, Your Honor.

THE COURT: All right. Kenny, go bring them in. And who do we have for today?

MR. STAUDAHER: Just one, one witness.

THE COURT: Just it's Dr. Carrol all day today and all day tomorrow?

MR. STAUDAHER: Well, it depends on how far we go. Obviously, that's what we have scheduled.

THE COURT: Okay.

(Jury reconvened at 9:14 a.m.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the Deputy District Attorneys, the presence of the defendants and their counsel, the officers of the Court and the ladies and the gentlemen of the jury.

And Mr. Staudaher, the State may call its next witness.

MR. STAUDAHER: The State calls Dr. Clifford Carrol

to the stand, Your Honor.

THE COURT: Right up here, please, next to me. Just up those couple of stairs and then please face this lady right there who will administer the oath to you.

CLIFFORD CARROL, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And, sir, would you please state and spell your name?

THE WITNESS: Clifford Carrol, C-l-i-f-f-o-r-d, C-a-r-r-o-l.

MR. STAUDAHER: May I proceed, Your Honor?

THE COURT: Yes, you may.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Doctor, what do you -- what do you do for a living?

A I'm a gastroenterologist.

Q How long have you done that work?

A Since 1995.

Q Can you go back and give us just a general background of your training and experience that got you to where you are today?

A Sure. I did my medical training at Beth Israel in New York City as a medical resident and chief resident. I did one year at St. Vincent's Hospital as a radiology resident but decided not to pursue that career so finished up in

medicine. Applied for and went to Stony Brook University in New York for gastroenterology for three years. Took a job back in Buffalo, New York where I went to medical school for a year and a half and then came to Las Vegas in 1997 to join Gastro Center of Nevada.

Q When you say Gastro Center of Nevada, what -- what is that entity?

A Gastro -- Gastroenterology Center of Nevada is a single specialty gastroenterology practice that had advertised for physicians and that's based here in Las Vegas.

Q And who was in the group when you came to work at that time?

A At that time in 1997 I was the sixth physician. The principal physician was Dr. Desai, followed by Dr. Carrera. There was Dr. Sharma, Dr. Faris and in May of 1997 Dr. Sood and myself joined the practice.

Q So when you say Dr. Desai, which Dr. Desai are you talking about because I understand there's a couple of them.

A Dipak Desai.

Q Do you see him in court today?

A Yes, sir.

Q Do you -- can you point to him, describe something that he's wearing for the record, please?

A Dr. Desai is sitting to my left and he's wearing

a dark suit, light shirt and wearing glasses.

MR. STAUDAHER: Let the record reflect the identity, Your Honor.

THE COURT: It will.

BY MR. STAUDAHER:

Q And before we get too much further in to your testimony, I want to just get something out that -- to make sure that you're clear on this and -- and everybody's clear on this. Before you came in, you actually testified to the grand jury at one point; is that correct?

A Yes.

Q Before you actually provided testimony to the grand jury, did you have an attorney with you that represented you at that time by the name of Frank Cremen?

A Yes.

Q And did you ask for and were granted immunity from prosecution related to the events that you were testifying about at the time?

A Yes.

Q Is that your understanding to this day that you still hold that?

A Yes, sir.

Q As we go forward, if in -- if at any time -- because -- did -- did a different Desai at some point, beside Dr. Dipak Desai that you pointed out in court, did another

Desai enter the practice at some stage?

A Yes.

Q What is his first name?

A Snehal, S-n-e-h-a-l.

Q Unless you have something specific about him, I'm assuming that you're going to be referring to Dipak Desai through your testimony?

A That's correct.

Q If -- if that changes, if Snehal Desai is the focus of when you say Desai, would you please let us use -- or please use his first name so that we know that that's who you're talking about?

A Yes, sir.

Q Otherwise it will be Dipak Desai; is that fair?

A Fair.

Q So let's go forward. You said that you came out in 1997 to work in the practice. What was the role that you were going to assume at that time?

A Well, in May of 1997 when I came out to Las Vegas I joined the practice as an employee physician with a salary with the understanding that I'd be a salaried physician for three years and then after three years I could be a candidate for a partnership in the practice.

Q So tell us the differences in the physicians as far as employee, partner, whatever within the group.

A When you first join the practice you are an employee physician, which means that you get paid a salary every two weeks with a W-4 and -- and taxes paid each two weeks just like any other salaried position. Each year the salary went up by a little and then at the end of three -- well, actually three-and-a-half years, if all worked out and the practice liked you and you felt comfortable, then you could become a partner. And as a partner you don't get paid a salary, you get paid a distribution or some monies left over after all the expenses are paid as a partner physician.

Q Now, were there different partners, different types of partner within the group?

A There are -- were different types of partners within the group, yes.

Q Can you describe those or explain those to us?

A I was a general partner in the group. As to my understanding, Dr. Desai was the senior partner and founding partner of the group. So the two major distinctions were founding partner and regular partner.

Q At the time that you became -- did you become a partner, let me ask that?

A Yes. Yes, I did.

Q When you became a partner, what kind of authority, power, whatever did you hold within the group?

A I didn't hold any more authority or power than I

had had as a employee physician. I just was now a partner. So I didn't have any new role or new assignment or new position of status in the group as a partner. I wasn't labeled as someone who would manage or someone who would be in a position to direct others because of being a partner.

Q Did you make decisions on a day-to-day basis for the practice?

A Not for the practice. Day-to-day basis for a patient, of course, but not for the practice.

Q And that's -- I'm not talking about you dealing with an individual patient, deciding whether to prescribe them a medicine or not or whatever, I'm talking about things that would be substantive within the practice, hiring, firing, ordering supplies, entering into contracts, negotiating, things like that, anything?

A No. I didn't have those -- those roles at all.

Q Who did? Who was the one that controlled that? Or persons that controlled that?

A Dr. Desai controlled that as the managing partner.

Q Okay. Now when you come in, you said there were other partners as well.

A Yes.

Q Did you have group meetings at various times to discuss the practice, things like that?

A Throughout the years there were group meetings on intervals that Dr. Desai would usual call. Those meetings usually involved physicians, maybe some managerial staff. They weren't set in a specific date or a specific interval, but they would be called here and there and we would have them in the office.

Q Okay. During those meetings, who ran them?

A Dr. Desai ran those meetings.

Q Was anybody else at -- during the time that you are talking about now, and I know we're going to get to down the road a little bit, but initially when you become a partner, anybody else a co-equal or that has any real say in the group?

A At that time, no.

Q Now, let's move forward to the end. How long were you with the practice?

A I was with the practice from 1997 to 2008 when the practice had to dissolve.

Q So until the end after the CDC came in?

A Yes.

Q During that entire time, did the structure you just mentioned change at all? Meaning who was in charge, who made the decisions, things like that?

A Predominately, no. Dr. Desai was the -- was the managing partner and in charge of our practice. There did

come a time when there was talk of someone to replace him if he were to retire. At that time there was actually a group meeting and a vote to determine who could take his place in the event if he did retire.

Q And who would have been the person to take over if he would have retired?

A The voting process ended that Dr. Sharma, my friend and colleague, would take over the practice when Dr. Desai retired.

Q We've heard a couple of different Sharmas. Is this Vishvinder Sharma?

A Yes.

Q So did that ever happen?

A No, it didn't happen officially. Dr. Desai didn't retire. Dr. Sharma became an assistant manager, but he didn't take over the practice.

Q Do you know what -- what managerial or authority he had in the practices as assistant manager to Desai?

A No. No, I don't. I know that he was being taught and trained how to take care of a large practice like ours. Dr. Desai was teaching him how to do that. Not me because I wasn't voted into that position. I don't think he ever actually took over or made decisions, to the best of my recollection.

Q Well, you were part of the various meetings and

minutes -- or not minutes but the different partnership meetings, correct?

A Yes.

Q Was there ever a time when Dr. Sharma stood up with Desai present and asserted some sort of authority within a -- a partners meeting?

A No.

Q At anytime did he indicate or did you ever receive memos or any kind of thing from any source within the practice that came from Dr. Sharma that he was directing activities within the practice?

A No.

Q Now, tell us, if you can, because I understand that there were different parts of the practice. There was sort of a medicine side. There was a procedural side and that you had different locations around town.

A Yes.

Q Can you tell us about those? First of all, where were you scattered around town, and what's the difference between those two things?

A At our practice we had office buildings where patients were seen for consultations. Anything from a routine visit to get a colonoscopy done to treatment of hepatitis C, Crohn's disease, a variety of gastrointestinal problems. That's where we met patients in an office with six, seven or

eight examination rooms behind closed doors and did consultations and decided with the patient what the next step was.

Attached to that office building, through a walk-in corridor, was the endoscopy center. There were -- they were separated by locked doors but you could unlock those doors and walk into the endoscopy center where procedures were done. And in that procedure room where -- or -- from 2004 forward, there were two operating rooms and then recovery beds. That was a separate place and a separate distinct office area.

We had the same arrangement at another location, again an office attached to an endoscopy center. We did have a couple of offices that had no endoscopy center but they were -- like they were offices around town, North Las Vegas, Henderson, that didn't have associated endoscopy centers.

Q Okay. So we've got the mix and there are different places where people worked?

A Yes.

Q Now along those lines, did -- did all of you work at all of the facilities around town?

A For the most part, people seemed to rotate at some point at most -- at the facilities. Now, is it possible for me to say that every one of our physicians did procedures at each and every one of our surgical facilities? No. But for the most part we were split. A certain number of

physicians were assigned to endoscopy one, which is the first center, while other physicians were assigned to the other endoscopy center. But sometimes we crossed coverage, people on vacation, people sick, we would mix that around.

Q So I'm not talking about necessarily a week here or a day there to cover, I'm saying predominantly, did you work out of one location for the most part?

A For the most part I worked out of one location and occasionally rotated to another.

Q What was the location that you worked out of?

A My predominant location was the one at 700 Shadow Lane.

Q You mentioned endo one, endo two, things like that. What was that location?

A We called that one, that 700 Shadow Lane endo one.

Q Now, did it have one of these gastroenterology medicine practices adjacent to it as well?

A Yes.

Q So did the -- and was there another one? Endo two was located where?

A On Burnham near Desert Springs Hospital.

Q Did it also have a medicine component as well?

A Yes.

Q And -- and there was one at Rainbow I think?

A The -- the last one that had been constructed was on Rainbow near Spring Valley Hospital.

Q At the time that the practice closes, what is the status of that Rainbow facility?

A The Rainbow facility is brand new, opened -- had just opened. Did have an attached medical side to it, beautiful facility. It had actually opened and was operating slowly at the time that the -- the crisis occurred.

Q Now, when you say open and operating, are we talking about both the medicine and the endoscopy side or just one?

A To the best of my knowledge, both were -- had been opened and some procedures had been done at the -- at that location.

Q You say some procedures. Does that mean it was not a -- a fast and going sort of operation?

A No, it was just starting.

Q Now, you're located at the -- at endo one, which is 700 Shadow Lane --

A Correct.

Q -- predominantly? Who was out at Burnham if -- if there was somebody predominantly?

A Well, predominantly out at Burnham were Doctors Herrero and Dr. Mason. Dr. Snehal Desai also did procedures there. And others would do procedures there as well, but

predominantly Herrero and Mason.

Q What about the Rainbow facility that was just starting? Who was either starting to work there or going to be the one in charge --

A The principal --

Q -- not in charge but the person who is the principal?

A The principal physician there was Dr. Vish Sharma. He was going to sort of take that operation and get it going.

Q So during the time that you worked at 700 Shadow Lane, I know that's where you're focusing your time predominantly, as far as Dr. Desai was concerned, which facility or facilities did he operate out of mostly?

A He operated predominantly out of the 700 Shadow Lane facility.

Q Now, although he -- he is not operating, I assume based on what you just said, out of those other facilities, who controls it? Does Dr. Mason or Dr. Herrero control the Burnham facility and Dr. Sharma control the Rainbow facility?

A Well, they -- they certainly were there every day doing procedures and making decisions; but in terms of managing those facilities, it's -- Dr. Desai managed them.

Q So he managed everything?

A Yes, sir.

Q Even though he didn't necessarily go out to those facilities very often?

A He went out occasionally, just like I went out occasionally but that was occasionally when needed to cover.

Q As far as the -- the time, let's move to just Shadow Lane because that's where you and Dr. Desai are predominantly at. Okay?

A Okay.

Q Tell us what kinds of procedures you would do on the endoscopy side.

A On the endoscopy side we did colonoscopies and upper endoscopies predominantly. And then at least 95 percent of what we did were those two things. They're very straightforward, simple procedures. Sometimes we would do a feeding tube placement, tube into the stomach for someone to get food. Sometimes we would do what's called a Bravo pH study where we would insert a device into someone's esophagus to measure the acid reflux for 48 hours. We removed polyps during a colonoscopy, we took biopsies of abnormal tissue. From a gastroenterologic point of view, standard, straightforward, relatively easy procedures to do.

Q If there was some more complicated or something that required surgical intervention, would it occur at that -- one of those facilities?

A No.

Q What would happen to a patient if for some reason, and just hypothetically, you're doing a procedure, you get a perforation, you poke the scope in and cause an injury to the bowel, what would happen? What would you have to do?

A Well, if a patient suffered a complication such as a perforation or an uncontrollable bleed from removing tissue or even a medical complication, asthma, something's not right with breathing, chest pain, that patient would be immediately transferred to the hospital, which was directly across the street, Valley Hospital.

Q So you weren't equipped to handle those kinds of things in-house?

A No.

Q Was the center set up to do that in any case?

A No.

Q So it was just strictly to do these outpatient procedures, people come in, people leave after the procedure?

A Correct.

Q Now, during the time -- and you said predominantly I think 95 percent were the colonoscopies and the upper endoscopies?

A I would say that's accurate.

Q We've had some of this before, but can you explain to us the difference between the two?

A Well, not to be long-winded but it's relatively straightforward. The upper endoscopy is where we take a long thin camera, about as thick as my pinky, about three feet long. It's inserted over the tongue, down into the esophagus and stomach, into the intestine looking for diseases of one of those three areas.

The colonoscopy is a similar instrument. It's thicker and longer. It's about five or six feet long. As a matter of fact, when you hold it, it straps over your shoulder it's so long. It's inserted into the rectum, guided through all the twists and turns of the colon to the end of the colon. It's about on average four to six feet long. And during that procedure we're looking for polyps, cancer, colitis or any other disease.

Q So the two scopes, are they the same or are they different types of scopes that are used?

A They're different and dedicated -- different types of scopes.

Q So one's five or six feet long and the other one's about three feet long?

A Correct.

Q Ever a situation where you could use a colonoscopy scope for an upper and then turn around and use the same scope for a lower?

A You -- there are situations where that could

occur. For example, if we needed to find some disease further down in the intestine than the standard scope could reach, we might use a pediatric colonoscope, which is thinner, to find our way deeper into the intestine looking for a disease. But this would be a specific reason looking for a specific problem.

Q Did you ever have a situation where you used a colonoscopy scope, not a pediatric one, but the standard one for an upper endoscopy?

A I don't recall ever using a standard colonoscope for an upper endoscopy; it's too thick.

Q So they were pretty much dedicated to their purpose?

A Yes.

Q Now, as far as the timing of the procedures, do they -- do they vary, the upper procedures and the lower procedures? I mean the upper endoscopies and the colonoscopies?

A Yes. On average an upper endoscopy is a much shorter procedure. It's not as complicated. Colonoscopies are the ones that vary. They can be easy. The anatomy is not challenging. Or it can be quite challenging and take a long time to negotiate that camera through the twists and turns of the patient's colon. Why? Patients have surgery, patients have different anatomies, it's not all the same. So the

colonoscopies are much more variable. The upper endoscopies tend to be much more consistent and much shorter.

Q Average person, I'm not talking about a really complicated one or one that just is really, you know, it's so easy that it just is -- anybody could do it essentially. I'm talking about the average time, in your estimation, for doing an upper endoscopy versus a colonoscopy, what were they?

A I would say for a trained gastroenterologist like me, who's been to a university program and trained to do this, the average time for an -- for an upper endoscopy is four to five minutes, three minutes perhaps, three to five minutes. Whereas a colonoscopy truly varies anywhere from 10 to 12 minutes to 15 to 18 minutes in there.

Q Okay. And for the average -- so average one we're talking about a range of -- of what then?

A For an average colonoscopy?

Q Yes.

A I'm going to say an average colonoscopy would be about 10 minutes to 15 minutes.

Q Okay.

A With the caveat that some take longer. Some might even take shorter when the anatomy is so easy to navigate, it can take less time than that.

Q Have you ever prided yourself on how fast you could do them?

A No. I didn't pride myself on how fast I could do them. I did pride myself on how well and how efficiently I could do them, but not on how fast.

Q Was speed ever a factor for you? I mean, did you try to do them as fast as you possibly could or did you just try to do the best job you could?

A I tried to do them as well as I could and as efficiently as I could. I never tried to do them as fast as I could.

Q Did you ever hear anybody brag about how fast they could do procedures?

A Yes.

Q And persons or person that you heard brag like that?

A Well, Dr. Desai would sometimes brag that he was very, very good and could do one faster than anybody.

Q Now, I want to talk to you about the procedures themselves for a minute and we're going to -- then we're going to come back to the issue of your sort of position to practice. Okay? Just as a road map, procedure takes place in one of these endoscopy suites; is that right?

A Correct.

Q You said that there were two of them at the Shadow Lane facility.

A Yes.

Q Now you were there in 1997. Were there always two facilities -- two endoscopy suites?

A No. In 1997 when I arrived, there was an office and there was an endoscopy room center that was much smaller. It only had one room, a small recovery area and some -- an area for charts. It wasn't until 2004 that that changed.

Q 2004 there's a change in the actual physical makeup of the facility?

A Yes. That room that I just described became a chart room and a break room. And the -- we were able to obtain more space on the same floor and expand the endoscopy center to two rooms and five recovery bays.

Q And just so we're clear on this, I want to show you what has been previously admitted as State's 10 -- well, actually starts -- start off with 104 and we'll zoom out on this so you can see the whole thing as much as possible. And I'll represent to you this is not something that's to scale, it's a -- it was a general layout of what is believed to be the medicine side of the practice. Does that look to be familiar to you in general?

A In general, yes.

Q Now, I'm going to show you 103, which I'll represent is the endoscopy side of the practice. Does that look familiar to you?

A This looks like the layout before the expansion?

Q No. This -- we've got a procedure room one, procedure room two --

A Oh, I'm sorry, I didn't see that. Yes, that looks familiar.

Q Okay. So is this in general what we're talking about after the expansion took place?

A Yes.

Q Now with regard to the procedures themselves since now you have two rooms after 2004, how would you -- you -- you worked there you said most of the time, correct?

A Yes.

Q What time of day would you typically go in and work and how long would you work for?

A Well, if I was the assigned physician for the morning slot time to begin, I would be there by around 6:45 in the morning to start for a 7:00 start time.

Q The procedures would start about --

A Seven a.m.

Q Seven o'clock?

A Sometimes a few minutes early if the patients were ready.

Q Okay. So they start about seven. When are you, I mean, whether there's patients still in the facility or not, when is the -- the time of the procedures you try to stop them or not do any more after -- during the day?

A For me personally?

Q In general, the facility?

A Oh, the facility. The facility averaged -- it -- it changed. Sometimes the procedures would be done around three or 3:30 in the afternoon, sometimes the procedures would take longer, sometimes even until six p.m.

Q So we're talking about a range, but you start to try and taper it off around 3:30 or so?

A I would say around 3:30, 4:00.

Q And so sometimes procedures went past the 5:00 hour but was that more often than not or was it where you tried to be done with the actual procedures by about 5:00?

A We would try to be done by about 4:30, 5:00.

Q Four-thirty, 5:00, okay. Sometimes they would go a little bit later?

A Yes.

Q Now, as far as the procedures themselves during the day, how -- how are the patients moving in and out of the rooms? How many doctors are there, that kind of thing?

A Do I have a pointer here?

Q I'm sorry?

A Can I point to this?

Q Yeah, you can --

THE COURT: You can touch the screen. It makes a mark.

BY MR. STAUDAHER:

Q Yeah. Just so you know, if you use your finger, because you're going to be doing this as we go, you can just draw on it. If you need to clear it, you just tap it right down there. Okay?

A Sure.

Q So how would -- I mean how would it work as far as you're in the -- is there -- when you start out on the day, how many doctors are there, how many, you know, physicians are ready to go?

A Well, if you can imagine a morning and it's 6:45 in the morning, and it's one of my days to do endoscopy, I would be there and ready to go. So I would come in through this door right here ready to go and the staff members would have been there before me, maybe around six, 6:15 in the morning to get the facility ready. Sometimes there would be a patient ready for a procedure here and here or maybe just one or sometimes none. They just weren't quite ready yet. The patients would have come through the waiting room, checked in here with information, insurance information, primary care doctor information, and then be escorted into this area to get ready for the procedure. This was the restroom and locker area where a patient would get changed into the gown getting ready for a procedure.

Now, once the patient comes back here, either the

patient is directed into a room or is coming back to this pre-op area to get the IV placed to get ready to be sedated because sedation requires an IV. Now, in the early morning it might be that that is occurring in the room, in the actual operating room. But as the day starts to get busy, then patients will be directed here where we had three chairs in here for patients to sit and have a -- a nurse placed the IV or the heplock to get ready for the procedure.

Once this procedure over here was finished, whatever it was, an upper scope or a lower scope, the patient would come out of this room into one of five recovery bays over here that were curtained off back here. Each one of these bays had a monitoring area with oxygen, oxygen monitoring, so the -- the patients were being monitored and observed here. Once that patient came out, this patient would then have a procedure done while another patient came in over here getting ready.

Q Why don't you go ahead and clear that because it's getting pretty busy on the screen right now. Now the -- what you just described -- so it sounds like, if I'm -- and please tell -- correct me if I'm wrong, it sounds like that it was not an unusual thing for the first patient or two, depending on how it went, to not -- to bypass that pre-op room down here and actually just go straight into the procedure room to have the IV placed?

A That would not be unusual early in the day.

Q A patient comes into -- into the procedure room and let's just say that that's happened, they're both -- they're both loaded in the rooms, so to speak. You come in to do your procedure. Is it the kind of thing where there's another doctor there in the morning or are you hopping between rooms typically?

A That varied. Sometimes there would be two physicians ready to go. Sometimes there would be only -- only one. For example, if I was the only one assigned, then I would move back and forth between these two rooms through these front doors over here, from patient to patient.

Q Silly question, but when you go from patient to patient, do you ever stop and maybe wash your hands or anything like that?

A There would be -- I'm wearing gloves for every case. So when I'm doing a procedure, an endoscopic procedure, my hands are gloved. Every single time those gloves came off and new gloves came on. I can't say to you that every single time I washed hands because I just had them gloved. A gown may not be changed if I was just doing an upper scope and there was nothing on my gown. But if there was any material on my gown, that would come off and a new gown would come on.

Q We're going to talk about that in a little bit so I don't want to get into that yet. But that's the process,

you go room to room, change your gloves, wash or some combination thereof, but you go from one place to the other?

A Right.

Q And is it -- was it typical to have a single doctor there in the -- in the morning hours and then other doctors come in the afternoon?

A That was typical, that's how we figured it was most efficient. I was there on time. I was ready to go 6:45 every morning. So in terms of efficiency it was -- it was -- worked reasonably well that if I got there early and did procedures and started, I would be relieved at some -- a few hours later to do -- to go see patients in the office.

Q Who were the CR -- or what -- what was the anesthesia, was it a doctor there, was it a CRNA, what -- who -- who did that work?

A The sedation was always provided by a Certified Nurse Anesthetist.

Q What about when you first started back in '97?

A When we first started back in -- when I first started in 1997, we would give our own sedation, which would be a Valium like medication or a Demerol like medication to make the patient sedated. So the doctors would instruct the nurses, please give this much medicine. Then over time we started to use actual anesthesiologists to come in to the facility and provide the sedation rather than us provide the

sedation. We started this because when I -- when I was starting to do complex procedures at the hospital and asked an anesthesiologist to assist me, it was quite amazing how much better the patient did because the anesthesiologist can provide medicines that I'm not allowed to give as a regular doctor. So the patients were better sedated, more quickly sedated, didn't have as many respiratory problems. It was -- being monitored by an anesthesiologist.

So I was free to do what I had to do and not think about how much sedation to give the patient and all those other problems that are associated with sedating someone. So over time that became more and more of a -- of a common practice in our -- in our group and in Las Vegas for endoscopy procedures to be accompanied by an anesthesiologist to give the sedation.

Q A couple things you mentioned. You said that -- that the anesthesiologist could give medications that you couldn't?

A Correct.

Q What kinds of medications are you talking about?

A Principally the anesthesiologist can give propofol to a patient to sedate a patient. Well, why can't I do that? I'm a doctor but I'm not allowed to do that because I'm not a trained anesthesiologist or anesthetist. When you get -- when I used to be in training and we gave Valium and

Demerol, if I gave too much I could reverse that. I could tell the nurse please give the patient Narcan to reverse that Demerol, I gave too much. Or please give the patient Romazicon, I gave too much Valium or Versed.

But with propofol there is no such reversal agent. I can't reverse the effects of that. So therefore, Medicare has made it mandatory that if that kind of medication is going to be used for sedation, someone who's trained to do it and rescue a patient in case something goes bad gives the medication. So that's why we have anesthesiologists and nurse anesthetists to give that medication.

Q Obviously, you know what propofol is?

A Yes.

Q But is it fair to say, based on what you told us, that you did not feel competent and comfortable, whatever, in actually utilizing that medication yourself?

A I think that's extremely fair. I would never give that medicine myself, inject it into someone because then I'm immediately practicing outside my limit of training because I don't really have the skills to intubate a patient, rescue a patient if it goes bad. So I would never do that and I've never done that and I'm not trained to do that.

Q Are you aware of what happens to a patient if they're given too much propofol at any one time beside the fact that you can't reverse it?