whether we can find out whether, you know, it's viable to bring somebody on in, that's probably the consulting aspect that I would do.

Q And if I'm understanding your testimony on direct exam correctly, the primary reason for bringing the CRNAs into the gastro center was because it was too difficult to schedule the anesthesiologist who had their own practices and trying to get them into service the ambulatory surgical centers. Is that a fair statement?

A Yeah, that's probably -- I still think that was the driving force behind it is the fact that if the guy was on vacation, then endoscopy was shut down. If you couldn't get somebody else to cover it, it was shut down. If he was sick, it was shut down. If he had his own case or an emergency at the hospital, then you're shut down.

Q And at this time frame, or maybe even today, are there shortages of medical doctors in the Las Vegas area?

A Mostly primary care, yeah. We're probably -- you think you should have about 250 -- or 2500 population per primary care, meaning internal medicine, general medicine, or family medicine. And so if you look at the hospitals, all of the hospitals here, the HCA system and the Valley Health systems and the St. Rose systems are all recruiting primary care right now because they follow mandates based on population and zip code needs.

So if San Martin has a severe shortage, St. Rose Siena may not, the old -- the old St. Rose Hospital out in Henderson, they do. So even though they're the same system, two hospitals on either spectrum are shorted, and then one right here where all the doctors have congregated, they've actually got enough from a federal guideline, but the outlying two hospitals do not.

Q So the bottom line is you can get full coverage with a CRNA if they're a staff member in your ambulatory surgical center?

A What do you mean full coverage?

Q That you would behave -- your procedures wouldn't be disrupted. You could consistently operate your -- do your procedures if you have in-house CRNAs.

A Yeah, they're your employee, so you have much more control over them at that point in time.

Q And was it difficult -- is it difficult to get anesthesiologists to come in as a full time employee?

A Yes, back then it was.

Q Why is that?

A Well, because they had private practices. So you would have to, you know, go out and hire somebody outside and then generally you're only going to hire one doctor. He's going to need a CME time, he's going to need his vacation time. Then they would get here and they'd realize, well, I

can probably make more on my own, so I'm going to go out on my own or I'm going to join one of the three big groups. So there was a lot more risk by contracting it out than by eventually bringing it in-house.

Q Do you know if an anesthesiologist can make more money if they work in a hospital setting rather than an ambulatory surgical center?

A I would say they could because the complexity of the procedures that they're providing anesthesia for are significantly greater.

Q And would it -- so because there's a variety of different surgeries that are done in a hospital, they could work longer procedures?

A Well, a 14-hour hard case is going to be a lot more, you know, valuable to that guy billing it on out than, you know, 14 outpatient procedures.

MS. STANISH: Your Honor, I still have a lot to go. I don't know if you want to take lunch now or later.

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to go ahead and take our lunch break. We'll be in recess for the lunch break. We'll give you an hour and that'll put you at 1:05.

During the lunch break you're reminded recess 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, person or subject matter relating to the case. Do not do any independent research and please do not form or express an opinion on the trial.

Notepads in your chairs, and please follow Kenny through the rear doors.

(Jury recessed at 12:02 p.m.)

THE COURT: And, sir, during the lunch break you're not to discuss your testimony with anyone. Do you understand?

THE WITNESS: I do.

THE COURT: All right. You're excused for lunch.

Thursday morning, Ms. Weckerly, you said there was a situation?

MS. WECKERLY: Not for us. I --

THE COURT: No, no. I mean --

MS. WECKERLY: Yeah, my recollection was there was some issue with a juror for this Thursday where you wanted to start at 10:000.

THE COURT: Well, the guy with the crown is Wednesday was his dental -- oh, no, Tuesday -- well, no, Wednesday because remember that's when --

MS. WECKERLY: Right.

THE COURT: -- we're going to have the Petrocelli

hearing.

MS. WECKERLY: No, I thought it was a woman, but I can't remember what the issue -- I thought it was something where it was, you know, in the morning.

THE COURT: You know, you're right. Somebody did have a doctor's appointment in the morning.

MS. WECKERLY: And so I -- the only reason why I wanted to know was just to kind of keep the witnesses --

THE COURT: Scheduling. Let me ask Kenny when he comes back in and then we'll --

MS. WECKERLY: It's -- I mean, I don't need to know right now. It's not a crisis.

THE COURT: We'll do 10:00 or 10:30 then because maybe I'll just do my own -- Kenny?

THE MARSHAL: Yes.

THE COURT: Was there a juror who had a situation Thursday morning that we had -- that she had an appointment or something and we were going to start later?

THE MARSHAL: I believe so. I don't really recollect what time it was.

THE COURT: Just find out at the break.

THE MARSHAL: I will.

THE COURT: Find out and then get back which juror it was and what the situation was and then we'll start at 10:30 on Thursday. Okay.

MS. WECKERLY: Thank you.

(Court recessed at 12:04 p.m., until 1:12 p.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session.

And, Ms. Stanish, you may resume your cross-examination of the witness.

MS. STANISH: Thank you, Judge.

BY MS. STANISH:

Q Mr. Preston, we left off discussing the CRNAs. Generally, based -- in your experience -- well, let me rethink that. Do you get involved in contracting issues with healthcare providers?

A I could, yes.

Q Do you actually draft contracts, or do you rely on their attorneys to do so?

A Well, we never present a contract to the carriers or the insurers. They always have one for us, then we go through that.

Q Okay. So you may do contract review?

A Yeah, review, and then we send it to our attorney or whoever to see if there's anything that they would object to.

Q All right. Just so I'm clear, that the provider, your customer, your client doctor would provide a

proposed contract to you, and you would have your attorneys review it?

A No, I would review it and then send maybe my notes off back to the group and -- and/or their attorney if they wanted their attorney to look at it.

Q Okay. I misunderstood you.

A Yeah.

Q I thought you said your attorney. But you're working in a --

A The client.

Q Pardon me?

A To the client's attorney.

Q Okay. So it's more of a team effort to come up with a contract that's looked at by both the lawyer, the client, and you?

A Correct.

Q Looking for issues and addressing them?

A Right.

Q Do you know in the healthcare industry is it common to have a no compete clause with providers that a group may enter into an agreement with?

A Not a no compete, an exclusive.

Q What do you mean?

A Well, a non-compete is more of an employment thing that we use for employment terminology. An exclusive

would be they are going to have the single care for that provider to provide the care through that carrier.

Q And then not work -- and not work in other places at the time you're working for the business; is that what you mean?

A No.

Q No?

A Well, you're going to have to redefine. Are you talking about insurance contracts or are you talking about employment contracts?

Q I'm talking about, let's say, a partnership agreement within a group --

A Yeah.

Q -- where a doctor goes into contract with a healthcare entity.

A Well, again, you're -- you're trying to combine something that's separate. A partnership within a group, they all have a non-compete. They could have a non-compete, you can't, you know, compete. If you left that group you cannot compete within three miles or five miles or whatever it's going to be legally acceptable. But with a carrier, they can't restrict you for that. If that doctor left the group, they couldn't then hold that doctor, you know, from working elsewhere.

Q All right. I understand. So it depends on

the nature of the contract, if it's a partnership agreement versus employment.

A Employment agreement, yeah.

Q And are non-compete clauses subject to modification or renegotiation in your experience?

A Employment agreements are subject to renegotiation, yeah.

Q Same with partnership agreements?

A Generally, but they're -- I would say they're harder to modify depending on -- if you have two partners it's easy. But if you have ten partners, then you've got to get everyone to agree to the same modification.

Q Is that when the lawyers get involved?

A Yeah, that's when they get involved.

Q All right. I wanted to clarify a few issues with you because I know this was a long time ago for you and the -- I want to make sure I understand the timeline. You were involved with Dr. Desai when he -- Shadow Lane was in one procedure room; correct?

A Correct.

Q And were you also involved with him when the Shadow Lane facility expanded into the two procedure room?

A Yes.

Q And had you physically visited that facility?

A Yes.

Q And is it correct that in the same building at Shadow Lane, the medical offices, the so-called gastro offices are basically separated by a door, steps away from the procedure area?

A Well, they shared a common wall.

Q Okay. So if there is an emergency, someone can grab a doctor from the medical side to assist; correct? Do you know?

A Yes. If there was somebody over there they could, yes.

Q All right. And the procedure rooms, do you recall the setup?

A Yeah, they were -- depending on what angle you came into it, they were on the left side of the room. It was a room and a cleaner, sterile room, and then another room, and the recovery area.

Q And did you have anything to do with equipping the clinics?

A Not that I remember. I mean, we could have suggested a supplier, but I think most of that stuff all came in new when they went to the new facility.

Q Did they -- did they buy brand new equipment as opposed to buying used equipment?

A I don't know the details of that, but I would suggest they probably did, but there was -- there was not as

much out there then as there is today.

Q Well, there wasn't an inventory to buy used --

A Correct.

Q -- equipment. And do you recall that the procedure rooms were steps away from the recovery room?

A Yes, they were very close.

Q Did you assist in the establishing of the Burnham facility?

A Not the establishment of it, no.

Q What was your involvement with Burnham?

A It was just another site that they were opening up. You know, other than that they took over an existing space that Dr. Hogan had -- had been removed from the space or vacated his space, whatever it is, and then they had to go through and they had a very large clinic down there, then they -- they took a portion of the clinic. I remember that part of the details, but I don't remember negotiating with Ensemble or the hospital as to what was going on in the build out.

Q And I know I'm kind of jumping around here, sir, but did -- did you recall before going to the CRNA model that the gastro center had anesthesiologists working with them?

A Did they before they CRNAs? They did have anesthesiologists working with them.

Q And do you recall who they were?

A Baruca (phonetic) was the only name I think I -- you know, I remember.

Q Do you recall how many anesthesiologists they worked with prior to the CRNAs coming on board?

A Three or four, but I don't know their names.

Q Fair enough. I want to jump to the subject of something you mentioned. I was hoping you could elaborate on it for us. You talked about two occasions where you had to do assessments that dealt with administrative personnel.

A Right.

Q Can you elaborate on that, please?

A Well, Dr. Desai had called me up and he just felt that there was something wrong and wanted me to come in and look. You know, is it supervisory people not doing their job, is it they don't have the functions doing it, have they not set up procedures to -- to be able to monitor what's going on in the -- in the billing office or the front desk or whatever that is. And that was the first engagement we ever had with them.

Q And that -- and if that was the first engagement, would that have occurred in the '90s?

A Yes.

Q 1990s?

A Yes.

Q And it was more in connection with administrative matters?

A All of my matters were administrative matters.

Q Right.

A But this was a person who was his office manager and he just wasn't sure what she was doing was up to snuff.

Q Okay. And what about the second assessment that you did?

A It was the same thing, you know. Basically, he had another person there . He asked them to come back in and the first person I know didn't -- didn't stay after that assessment, but the second person did stay on.

Q And do you recall a time frame when that occurred?

A Not -- not even close.

Q Fair enough. Did -- clarify for me the evaluations for the sale of the business, if you can recall the timeline for that. And if it -- because years might be difficult for you, maybe it would be helpful if you could recall whether the Shadow Lane facility had one or two rooms at the time. Do you recall?

A I don't.

Q Okay. Fair enough. When -- the last time you had any dealings with Dr. Desai was in the year 2004?

A I couldn't tell you the year, but it was early in the 2000s. And they just decided that -- you know, gave me three months notice and said, you know, we just -- with everything we've got going on, we've got enough administrative staff here, we don't need the consulting services anymore. Very, very friendly about it and there was nothing unusual about terminating that relationship.

Q Would it -- would it be a fair statement to say that your business relationship ended at the time Tonya Rushing became an employee of the business rather than your onsite manager?

A No, it lasted a couple years after that.

Q Oh, okay. And what kind of services were you providing a couple years after Tonya went as an employee for the gastro?

A The same as we were doing prior to that. I mean, if he had a question about a contract coming up or, you know, do you -- you know, can you help me look for a doctor that's coming into town. I just want to make sure he's being told the right things, you know, does he -- if he has any questions I've got the background. I can, you know, help him go through whatever steps are necessary. So it was very -- very managerial, you know, general.

Q Do doctors in private groups generally have someone like you with whom to consult, if you know?

A Well, they must be because I've been in business for 21 years. So there -- there's half a dozen of us in town. There's probably three or so that do more what I do, and there's two that specifically have the same background. The unusual thing is to be in the hospital business and then the physician business. To understand the relationships between both of those is what makes me unique if that's what I want to do.

Q And just to return to the subject of the evaluation for sales. You've already gone into some detail about that and I don't intend to rehash that. I just want you, if you can, to clarify a few points in that regard. Number one, do you -- which -- which facilities exactly, if you recall, was Dr. Desai contemplating selling to one of these national organizations?

A Shadow, which is the 700 Shadow Lane, as well as the other facility that was still pretty new at that time on Burnham in the Desert Springs complex.

Q Desert Springs. Okay. So in your opinion, if you recall, did Burnham still have room to -- to grow?

A Yeah, it was very new at the time.

Q And it's a large facility; is it not?

A Yeah, it was larger than Shadow.

Q And do you recall Burnham only had one procedure room? Or, I'm sorry -- well, do you recall what

Burnham had?

A I thought it had two. I think it had two procedure rooms, as well.

Q All right.

A But it didn't have the established based that Desai had had for years at the Shadow Lane office.

Q Because it was relatively new?

A It was relatively new, yes.

Q Were you aware that Dr. Desai opened up a brand new facility in 2008?

A Which location?

Q Rainbow near --

A Yeah, I was aware of that. Yeah, by Oquendo or something like that? But anyhow, I know the facility. I went to the open house. I remember when that -- when they had an open house on that.

Q And ultimately did I understand you to say on direct exam that Dr. Desai decided I'm not going to sell the business to these national organizations?

A Well, of the offers that were -- that I was privy to, yes.

Q Have you provided any documents to the State or Metropolitan Police?

A No.

Q Have you any proffer agreement with them?

A What is that?

Q An agreement that says I'll come in and talk to you, and the things I tell you you will not use against me.

A No.

Q Do you have an immunity agreement with them?

A None.

Q Nothing further. Thank you.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: I have no questions, Your Honor.

THE COURT: All right. Redirect?

MR. STAUDAHER: None, Your Honor.

THE COURT: Any juror questions for the witness? No? No juror questions?

All right. Sir, thank you for your testimony. Please don't discuss your testimony with anyone else who may be a witness in this case.

THE WITNESS: Okay. Thank you.

THE COURT: Thank you, sir, and you are excused.

And the State may call its next witness.

MS. WECKERLY: The next witness is Lisa Falzone.

LISA FALZONE, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Lisa Falzone; L-I-S-A F-A-L-Z-O-N-E.

THE COURT: All right. Thank you.

Ms. Weckerly.

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Ms. Falzone, how are you doing?

A Okay.

Q How are you employed?

A I'm working as a registered nurse at Nellis Air Force Base right now, at the Michael Callaghan Federal Hospital.

Q How long have you worked as a nurse?

A It'll be 22 years.

Q And where did you go to nursing school?

A Buffalo, New York.

Q And what -- how did you end up out in Las Vegas?

A We moved out here at the end of November 2003.

Q And where did you work when you first came to Las Vegas?

A I worked at Spring Valley Hospital for about three months.

Q And after that, where did you work?

A And I worked at the Endoscopy Center of Southern Nevada.

Q And that was the center owned by Dr. Desai?

A Yes.

Q And that's 700 Shadow Lane?
A Yes.
Q You're -- you're an RN, right, not an LPN?
A RN, yes.
Q Okay. And as -- as an RN, who were you interviewed by to get that job at the endoscopy center?
A Tonya Rushing.
Q Anybody else or just her?
A I believe Jeff Krueger was one of the nurses, and I think he came in for the interview.
Q And when you were first hired, did you have someone who trained you or kind of oriented you to how they did things at the endoscopy center?
A Yes.
Q Who was that?
A Jeff Krueger and Maggie Murphy and Katie Maley.
Q Okay. And as an RN, did you ever work in the pre-op area of the clinic?
A Very, very little.
Q Rarely?
A Rarely.
Q How about in the procedure rooms?
A I did. Mainly just to cover lunches, though.
Q Okay. How about in recovery?

A Again, mostly to cover lunches.

Q And did you do the discharge, or was that where the LPNs work?

A That's where the LPNs worked. When I was first employed, the very first year that I worked there, I was the discharge nurse.

Q Okay. And you kind of described all those different locations as places that you worked for a little bit. What were -- where were you -- where you working primarily?

A Well, the very first year I was the discharge nurse that I worked there. Then I went to part time work where I worked three days a week. And my primary job was to review all the biopsies, make sure they were entered in a log, and get the doctors to sign them and make sure the patients had a follow up appointment for their biopsies.

Q And these would be biopsies, obviously, taken during the procedures.

A Yes.

Q And were you the only one responsible for that particular area?

A Mainly, yes.

Q And is that where you spent most of your time after that first year?

A Yes.

Q I want to talk to you about the pre-op area, though, because you did work there a little bit; is that correct?

A Yes.

Q And in the pre-op area, what are the responsibilities of -- of someone like yourself as an RN?

A Basically the -- we would put the charts together, and also sometimes we would start the IVs. But I usually -- I rarely worked there.

Q Okay. And you said sometimes start the IVs. If you didn't start an IV, who would start it?

A The anesthesiologist would in the room.

Q That's the CRNA?

A Yes.

Q So it wasn't always the practice that the pre-op nurse would start the IV?

A I think for the most part. It's just because I was rarely working in the pre-op area that it's hard for me to say who -- who started the IVs.

Q Okay.

A Yeah.

Q I mean, you're recollection is you didn't do it every time, is that fair?

A Yes.

Q And when you start an IV on the times you did

do it, can you walk us through what the procedure would be for yourself when you started an IV?

A Well, we've had the patient -- we had a tray with a Chux pad on it, and the patient would put their arm onto the tray. You would put a tourniquet on, have the patient pump their fist so you could see their veins. Once you found a vein you would cleanse the area with alcohol, and then you would go ahead and advance your IV catheter and take the metal part out, and then you would secure it with tape, and then go ahead and flush -- flush it to make sure that the IV was working correctly, that you were in the vein.

Q Okay. And you -- and the flush is a -- is that mean out of -- that's a saline flush?

A Yes.

Q And you flush that with like a new needle and syringe?

A Yes.

Q Do you have to use a new needle and syringe to flush an IV?

A Absolutely, yes.

Q Okay. Would you -- and when you flush it, how -- how big is that syringe? How many ccs, do you know?

A It's about a 3 cc syringe.

Q And is that pretty small or --

A Yes.

Q And if you flush an IV, have you ever had to go back and flush it more than once, or is that something nurses just do once?

A Well, we would just mainly do it once just to make sure it was in the vein, and then the patient was taken to the room, to the procedure room.

Q Did you ever flush an IV, go back -- with the same syringe go back into the saline bottle, and then go back and use the syringe on the patient?

A No.

Q Why wouldn't you do something like that? Could that potentially contaminate your saline?

A Yes.

MR. SANTACROCE: Objection. Leading.

THE COURT: You can't -- it was a little leading.

BY MS. WECKERLY:

Q Okay. Well, is it dangerous to use a syringe and needle in a patient, and then go back into a multi-use container?

A Yes.

Q Is that basic nursing?

A Yes.

Q Now, you said after you flush the -- the IV with saline, the patient would go to where? What part of the facility?

A They would be, I believe, taken to a bed, and then taken to the procedure room when it was their turn to be taken to the procedure room.

Q Okay. Now, let's move into your responsibilities at the times you covered which -- in the procedure room, okay.

A Okay.

Q And it sounds like you did that when people were on lunch break or that sort of thing?

A Yes.

Q And that was obviously in the middle of the day or --

A I think we started lunches at 10:30, so --

Q Because some people get there early?

A Yes.

Q And when you were in the procedure room, as that -- as that nurse, what were your responsibilities?

A In the procedure room we would get the -- we would have the patient's chart. The patient will be rolled into the procedure room and we would enter -- we would check -- we would ask the patient their name and check the chart, make sure we had the correct patient, name, date of birth, and then we would go ahead and enter -- we would find the patient in the computer because the patients' names were entered the day before.

Q Okay.

A And we would find them in the computer, then we would enter the doctor that was going to do the procedure, the CRNA, the nurse, and the tech that was in the room and the scope that was going to be used if the scope was there.

Q And you would enter all that into the computer before the procedure started?

A Yes.

Q And would you enter that information typically before the doctor came into the room, or once the doctor was there?

A Once the doctor was there because sometimes it might be a different doctor. They might start out with a certain doctor, and then it's a different doctor covering lunch.

Q Okay. So you had to wait until people were there before you could enter it?

A Yes.

Q When you were in the procedure rooms, how were -- how were all the providers' position? Like where were you standing in relation to -- I assume the patient is on a gurney.

A Yes.

Q Where were you in relation to the doctor and anyone else who might be in the room?

A The patient was in the center of the room, the CRNA was to the left, doctor was to the right, and I was -- and the tech was beside the doctor, and then I was more toward the back of the right of the room.

Q Okay. From where you were -- where -- from where you were positioned, what did you have the best view of?

A Let's see, just -- just an overall view kind of. I could look at the -- the heart monitor that the patient was hooked up to, and I could also look at the screen to see the procedure being done, and I could also see the patient.

Q Could you see the CRNA from where you were?

A Not very well.

Q Okay. Could you see their supplies or the things they were working with?

A They -- they had a little table, and they kept their supplies on the table.

Q Okay.

A But I didn't really focus on what they were doing.

Q Do you remember anything about the supplies that you'd see on their table?

A No.

Q Do you -- do you remember the drug or the anesthesia that was used at the time?

A Yes.

Q What was it?

A Propofol.

Q And do you remember the size of the vial or anything like that?

A No.

Q Okay. Do you remember if -- if you thought at the time it was multi-use or single-use?

A I thought it was a multi-use because it seemed a pretty decent size. It wasn't small.

Q Okay. And did you ever see it being used on more than one patient, a vial?

A I don't know. I couldn't really answer that.

Q Okay. The -- the techs that were in the room, what did they do that you observed? What were their responsibilities?

A They had the supplies set up for the procedure. They had the lubricant jelly there and they had the -- they would stand next to the doctor if the doctor needed supplies during the procedure, if the doctor found a mass or a polyp, they were there to assist with -- with that if that procedure needed to be done.

Q Okay. And that would be removing that and then maybe submitting it for biopsy, which was your --

A Yes.

Q -- what you kept track of; is that right?

A Yes.

Q Okay. Did the -- did the techs use a large syringe in the procedure room at all that you would observe?

A Yes.

Q What was that for?

A That was to flush the scope. If the patient wasn't cleaned out well enough, the doctor would ask for the saline flush to flush -- or water. I think it was water, actually, not saline. But he would ask for the syringe to use to go ahead and flush and try to clean out the patient better.

Q Okay. And these are large syringes used just only for the scopes?

A Yes.

Q And did you see whether those were changed from patient to patient?

A No, I -- not that I remember. I don't know what they did with them.

Q Okay. After -- well, let's move to post-op. When you were working in post-op, what were your responsibilities?

A Recovery?

Q I'm sorry.

A The recovery area?

Q Yes, I'm sorry.

A Okay. No problem.

Q Recovery. You call it recovery.

A The patient will be wheeled out to recovery. Either the nurse or the tech would go ahead and hook the patient, again, up to another heart monitor or vital signs monitor.

Q Uh-huh.

A And then we would -- we would observe the patient, make sure they were stable. We'd make sure they were passing gas so they wouldn't have cramping after the procedure.

Q And --

A And then we would chart.

Q And what were you charting?

A You were just checking the chart. I can't remember what we were charting at that point.

Q Okay. Do you know what pre-charting is?

A Yes.

Q And what is that?

A That's when you chart something before it happens.

Q Okay. Was -- was that part of -- did that happen at the endoscopy clinic?

A Unfortunately, yes, it did.

Q Okay. In what form? Explain how it happened.

A Well, unfortunately, things were -- I can't

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remember exactly what the chart looked like and what exactly we pre-charted, but we were just trying to move patients in and out, in and out. And so sometimes the charts were filled out ahead of time just to get the patients moving in and out. And so we were, unfortunately, charting that the patient was, I think, alert and oriented before -- before they were in the discharge area --

Q Okay. So like --

A -- or not at that point.

Q Yeah. Indicating like they're alert and oriented after their procedure, but they weren't in recovery at that point?

A Yes.

Q Okay. And you said that was because you were so busy or --

A Yes, unfortunately. We had so many patients that we were just trying to watch the patients that the charting kind of wasn't the priority and we just wanted to get the charts filled out.

Q Was it hard to keep up with the charting in conjunction with the patients sort of moving through the facility?

A Yes.

Q On -- on one of the charts there is a mark that says physician at bedside.

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A Yes.

Q Do you remember that?

A Yes.

Q In your experience, did the doctors come out to bedside a lot?

A For the most part no. No.

Q When you were working there during that time period, did you interact with Dr. Desai?

A A little bit.

Q Okay. What would you -- when you were in post-op, what would you see him do when you were in that part of the facility?

A In -- in the post-op recovery? I don't remember really seeing him in post-op recovery.

Q Okay. Did you ever hear him talk about supplies at all?

A I know sometimes we were only allowed to give the patient one sheet.

Q Okay. And --

A So if the patient was cold in the facility, we weren't allowed to give the patient another sheet to cover up.

Q And you heard -- is that a rule from Dr. Desai?

A He -- yeah. Sometimes if he seen you going you for another sheet, he would take the sheet away and like

save the sheet for the next patient, one sheet a patient.

Q Okay. Any other supplies that -- that he limited besides sheets?

A Also the lubricant jelly. I think the techs, they would be putting it out and he would be like, no, just a little bit, you know, don't put so much.

Q How about gowns?

A Gowns. If you, unfortunately -- we had small gowns and we had large gowns. And if you had a larger patient and you accidently gave them a small gown, he would get -- and the small gown didn't fit, it would have to go to the laundry and he would be upset because --

Q You kind of wasted a gown?

A -- we wasted a gown.

Q When you were in the procedure room with Dr. Desai doing the procedures, okay, which I know was rare that you were in the procedure room, did you ever do procedures with him?

A Yes.

Q Did you ever see him start a procedure before the patient was under the anesthesia?

A I believe so.

Q And from your observation, how did the patient react or what did the patient do?

A Well, usually the CRNA would be like, well,

wait a minute, wait a minute. I didn't give him the anesthesia yet.

Q And then what would happen?

A And then he would stop and he's let them give the anesthesia.

Q Were you ever in the -- well, did you ever observe Dr. Desai remove a scope from a patient?

A Not that I can remember.

Q Did you -- do you remember a nurse by the name of Janine Drury?

A Yes.

Q Did you ever hear or observe an argument between her and Dr. Desai about supplies?

A Yes. One day I was working and I was --

MS. STANISH: Objection. Foundation.

THE COURT: Do you recall about when that argument occurred approximately?

THE WITNESS: No.

BY MS. WECKERLY:

Q When did you -- when did you leave the facility?

A I left the facility in November of 2007.

Q Okay. And was Janine still working there at that time?

A Yes.

Q And did you start before she did?

A Yes.

Q If you use November as sort of when you left, obviously, how much before you left was this argument?

A I think about a year before, a year and a half.

Q Okay. So quite --

A I can't remember exactly.

Q -- a bit before?

A Yeah.

Q And where did it take place in the -- you know, so how were you able to hear it?

A She was in the procedure room and she was very upset, so I heard her yelling. So I went to the procedure room to see what happened, if someone needed help, and she had the biopsy forceps packaging in her hand and she was upset because she showed me on the packaging that it said for single use only and she had discovered that they were reusing the biopsy forceps. And it said right on there for single use only. And what we thought was we thought that they were using the biopsy forceps, they were taken to the sterilization room and being sterilized somehow, and then being used again and that that was okay. But on the packaging it says don't do that.

Q Was she yelling for you to come to her?

A No, she was just yelling and I heard, so I went to find out what happened.

Q And she has an accent; right? I mean, she's -- or she's loud or you could just hear her?

A She was loud.

Q Okay.

A She was loud.

Q And when you went to where she was, who else was there?

A I can't remember. I don't know if Katie was there. I can't really remember exactly.

Q And she showed you some packaging?

A Yes.

Q And that was on the forceps that are used in the procedures?

A Yes.

MS. STANISH: I'm going to object. At this point I have to assert a hearsay objection. It doesn't sound like Dr. Desai was present during this interaction.

THE COURT: Right.

MS. WECKERLY: Okay. Well, then, can I lay --

THE COURT: Yeah, if he was present or lay a foundation.

MS. WECKERLY: Okay.

BY MS. WECKERLY:

Q When you -- when you came up to Janine, you said you heard her yelling?

A Uh-huh.

Q Is that yes?

A Yes.

THE COURT: You have to answer yes or no for the record --

THE WITNESS: Yes, I'm sorry.

THE COURT: -- because it's taped.

BY MS. WECKERLY:

Q That's okay. And where were you when you first heard the yelling?

A I was just out on the main floor.

Q And would that be in the --

A Like the recovery area kind of.

Q And when you heard her yelling, could you tell which part of the facility she was in?

A Yeah, I knew she was in the procedure room.

Q Okay. Did you move pretty quickly in her direction?

A Yes.

Q What -- was she pretty loud --

A Yes.

Q -- I mean, for you to be able to hear her?

A Yes.

Q When you saw her face, without telling us what she said, was she very -- I mean, was she upset?

A She was upset because she said if this is happening I'm not going to stay here.

Q Was she crying?

A She could have been.

Q Then I think [inaudible].

MS. WECKERLY: Thank you. I'll pass the witness, Your Honor.

THE COURT: Cross. Who would like to go first?

MS. STANISH: I guess I will.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good afternoon.

A Good afternoon.

Q My name is Margaret Stanish. I represent Dr. Desai. Prior to coming to work for the gastro center, what kind of facilities did you work in?

A I worked at a doctor's office in New York City, and I also worked at the Metropolitan Museum of Art in the Health Department.

Q The museum, they have clinic?

A They have a health services department where visitors and employees can get medical attention if they need it. The museum had 5,000 employees and sometimes 20,000

visitors. And so they wanted to have a nurse in case --

Q I wasn't sure if I could --

A -- there was an emergency.

Q -- if I could look at dinosaur bones and then get my knee checked.

A No.

Q Okay. It was for employees?

A Yes.

Q Okay. And then you came to Las Vegas why?

A We wanted a change after 9/11. My father-in-law was in the buildings there.

Q Oh, I'm sorry.

A He survived.

Q Good. But you wanted to get out of New York?

A Yes.

Q And you said you came and you worked at a hospital for three months?

A Spring Valley Hospital.

Q What did you do there?

A I worked on medical surgical floor.

Q And why did you leave after three months?

A I didn't -- I didn't like working there. It was -- it was brand new at the time and it was very disorganized. And I hadn't worked on a medical surgical floor since I was a brand new nurse, so I didn't really want to do

that type of nursing.

Q All right. And so you ended up a few months later, I think you said February of '04 --

A Yes.

Q -- by taking a job at the gastro center?

A Yes.

Q How is it that you learned of that job?

A I read the ad in the paper.

Q And you -- you generally described your training as being done by, I think, Jeff Krueger, Katie Maley, and who was the third person?

A Maggie Murphy.

Q And what exactly did that training entail?

A Just basic --

Q If you remember. I'm sorry to interrupt.

A Just basically how to do the charting and basically what your responsibility was as far as charting in the room, the discharge nurse job part.

Q What about the procedure itself? And by that I mean things that you as a nurse did where you're touching the patient and doing something like putting in a heplock.

A Now, they didn't train us to do heplocks.

Q And is it a fair statement because you know how to do a heplock?

A Yes.

Q And why is that?

A Because you're trained in school and then you do it.

Q It's a no-brainer for you as an experienced nurse?

A Yes.

Q And the -- is it also based on your experience? And prior to coming to the gastro center you had been a nurse since what year?

A 1991.

Q So '91 to 2004. That's a lot of years. In your experience prior to coming to the gastro center, would you typically flush a heplock with saline?

A Yes. Saline, sometimes you would flush with saline and heparin.

Q And what's heparin?

A Heparin is an anticoagulant.

Q And the -- if you know this, do nurses sometimes miss the vein the first time?

A Yes.

Q Do -- sometimes when they put in a heplock, they have to -- as I understand it, you have to test the heplock to make sure it's in the vein; correct?

A Yes.

Q And that's part of the reason for the saline

flush; correct?

A Yes.

Q If the -- at that point after you do the flush, if it -- if it's not in the vein, what will happen? I mean, what's the --

A If it's not in the vein, then the fluid is going to go into the tissue.

Q And how would you know as the nurse that that's occurring?

A Well, you should see -- you should be able to feel that there's fluid in the tissue.

Q Okay. There's fluid in the tissue. All right. I think I get that. So you would -- if it wasn't properly in the vein, you would feel some kind of resistance on your --

A Yes.

Q What do you call that, the plunger?

A Yes.

Q Okay. And if it wasn't in the vein, you'd have to start all over again; right?

A Yes.

Q All right. And as I -- going to the syringes that you were using, if you recall, I understand from your description that they were relatively small, 3 cc syringes?

A Yes.

Q Did they come with a needle already attached to them?

A No.

Q Oh, you had to put the needle on?

A Yes.

Q I see. At -- when it came to the heplock procedure, were you ever instructed to reuse a syringe?

A No.

Q Were you ever instructed to reuse a needle?

A No.

Q I'm going to jump now to the -- well, I guess I'll stay here in the pre-op room. You were discussing about pre-charting.

A Yes.

Q And the -- as I understood it there were certain portions of the chart that you remember that it would be indicating that the person was alert when, in fact, they were not just alert at that point in time?

A Yes.

Q Was -- did your -- did the charting have anything to do with five minute increments?

A Yes.

Q Explain that to me.

A It's really hard to remember, but all I can remember is after the -- when we were in the procedure room we

got a strip from the heart monitor with the times on it that the patient was in the room. And then you -- you took that time off of the strip, and then you would say, okay, five minutes later they're in this part of the facility, five minutes later they're over here, two minutes later they're over here. But I really can't remember it exactly without the chart in front of me.

Q All right. So basically, if I'm understanding what you're saying, you would use as -- is it the start time of the procedure is based on the heart monitor strip? Is that what you're saying?

A Yes.

Q All right. And so the patient, just to -- so I understand the chronology, the patient is rolled into the procedure room. And I understand you're, you know, verifying the identity of the person and getting them inputted into the computer.

A Yes.

Q Is somebody else hooking them up to the heart monitor?

A The technician.

Q Okay.

A Or the CRNA.

Q All right. So it's all happening at the same time, basically. You're doing something with the charting and

inputting information. Somebody else is hooking the patient to the monitor.

A Yes.

Q And you are not at that point writing on the chart procedure begins at, oh, where's the clock, a certain time. Instead, you wait until the procedure is done, get that heart monitor time, and write the start time off of the heart monitor onto your chart?

A Yes, because there was so many different clocks in the facility, that that's the way they wanted us to do it.

Q Okay. And does that -- that seems to accurately reflect the approximate start time or the real start time of the procedure; correct?

A Yes.

Q And once you had that time established, you would then add five minute increments, is that what I understand you to say?

A Yes.

Q Would you go back and put -- fill in the time for when -- when they were in the pre-op room at all or, you know, to write down the time the heplock is in, or would the heplock nurse do that, if you recall?

A I can't remember.

Q Did the -- did the -- these procedures are

relatively short; correct?

A Yes.

Q All right. I guess I'm -- I'm puzzled. I mean, it sounds like you're using the heart monitor to indicate the beginning of the procedure. Are you using the heart monitor to record the ending of the -- the colonoscopy or whatever?

A Yes. Uh-huh.

Q Would -- during the procedure -- did you work with Dr. Desai often, or no?

A Sometimes. It's hard to say.

Q Well, were you there in the very early morning, or did you come later in the day?

A Well, my first year working there I worked there full time in the discharge room, so I was mainly in the discharge room. Then I went to three days a week, and I mainly did the biopsies and then I would fill in. If people called in sick, I would fill in in the procedure room or fill in for lunches.

Q Oh, all right. I understand. So from about 2004 to '05 you're a discharge nurse?

A Yes.

Q And then thereafter you're primarily doing biopsy reports?

A Yes.

Q Where were you physically located when you were doing that kind of work?

A We had a desk and I'd sit at the desk. It was like a long desk close to the discharge room.

Q Okay. So the discharge nurse is sitting in a room adjacent to the long desk where you worked?

A Yes.

Q I understand. Did you have anything to do with patient surveys?

A No.

Q Do you know who did?

A I think Katie did.

Q You had mentioned that when you were -- going back to the procedure room, back into the procedure room, you had mentioned that you really couldn't see very well what the CRNA was doing. Why is that?

A The room was dark and I was more focused on the patient.

Q And, I don't know, this is going to be hard to explain, but you're -- you're focused on the patient. You're also -- are you also doing some paperwork in connection with biopsies?

A Yes. Yes.

Q And do you have like a separate lighting source that you can work under?

A No.

Q Okay. So is there some kind of dim light that you work under?

A Just a dim light, yes.

Q All right. And the -- that is right over where you're working?

A Yes.

Q And on the other side of the room, as I understand it, is the CRNA?

A Yes.

Q And it's -- it's -- you can't see very well that far what that person is doing?

A No.

Q And you're busy with your own work?

A Yes.

Q Is it the case that you've never seen a CRNA carry propofol from one room to the other?

A I can't remember seeing that.

Q Do you remember being interviewed by the Metropolitan Police some time ago?

A Yes.

MS. STANISH: Court's indulgence. Sorry.

THE COURT: That's fine.

BY MS. STANISH:

Q Okay. I think I have the wrong document.

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I'll come back to that in a moment.

A Okay.

Q And I understood you to say that you never witnessed Dr. Desai start a procedure while the patient was still awake.

A No, I remember that happening.

Q Oh, and that's when you said that the CRNA said, whoa, he's not under yet, and the doctor stopped?

A Yes.

Q All right. Did Dr. Desai communicate with the CRNAs during the procedure?

A Sometimes.

Q And what would that typically involve?

A I can't remember.

Q Was it patient safety issues?

A I can't really remember.

Q All right. Fair enough. I think I'm almost done. Hang in there. Thank you. Going back to the procedure room and you were describing the flushes of the scope that would occur if the doctor found that the patient had it cleaned properly.

A Yes.

Q All right. That flush was basically pushing water into the scope; is that correct?

A Yes.

Q It's not pulling out, is it?

A No.

Q Because that would be gross.

A Yes.

Q And the scope -- the scope itself, did it have a port that would flush out the water, if you know or remember?

A I believe it did, but I can't remember.

Q Okay. Fair enough. All right. All right. I have nothing further. Thank you, ma'am.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: Thank you.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Ms. Falzone.

A Good afternoon.

Q I represent Ron Lakeman. You know Ron; correct?

A Yes.

Q How long have you worked with Ron?

A Well, he wasn't there when I started in 2004. I can't remember when he started, but I think it was the whole time he was there.

Q And is it fair to say you had a good working relationship with him?

A Yes.

Q I want to go back over -- I don't want to go over what was already covered, but I want to go over some of the procedures that you witnessed. Starting with the pre-op area, you testified that you didn't work in there very often; is that correct?

A Yes.

Q In 2007 do you recall how often you worked in that pre-op area?

A Very rarely. Very minimal.

Q And on those rare occasions when you worked in the pre-op area, you would start a heplock; correct?

A Yes.

Q And you would flush that heplock every time; correct?

A Yes.

Q And what you didn't tell me was the -- the saline that you used was in -- was multi-use; wasn't that correct?

A Yes.

Q So that saline that you used to start that heplock was reused on another patient; isn't that correct?

A Yes.

Q Who was primarily in charge of the pre-op area starting heplocks?

A I think Janine Drury ended up working back there at one point. I -- I can't remember exactly who --

Q Do you know Lynette Campbell?

A Yes.

Q Was she one of the ones that --

A Yes.

Q -- would start heplocks?

A Uh-huh.

Q And she would flush them; correct?

A Yes.

Q And use saline to do that?

A [Nods head yes]. Yes.

Q You need to answer yes --

A Yes.

Q -- or no. Okay. And do you know Jeff Krueger?

A Yes.

Q And he would start heplocks; correct?

A Yes.

Q He would flush them?

A I believe so. I didn't sit there and watch them.

Q Well, I mean, from what you observed.

A From -- yeah, I --

Q You would say yes?

A Yes.

Q Would there be any charting done in the pre-op area?

A Yes.

Q Tell me what would be done in the pre-op area.

A They had an LPN Pauline that worked in the pre-op area and she would put the charts together.

Q A what? An OPN?

A Yes.

Q Or an LPN you said?

A Yeah, she was an LPN.

Q Okay. She would put the charts together, but what would those charts be? Tell me what would be on those charts?

A All the paperwork that was -- that the patient had filled out in the waiting area.

MR. SANTACROCE: Court's indulgence.

BY MR. SANTACROCE:

Q I'm looking for a specific file, but I'll hand you this file, which is one of the patients on September 21st. It's Stacy Hutchinson. Can you look through that file and tell me what paperwork would be filled out in the pre-op area?

A So it would be page 3.

Q Can I see that one? Okay. I'm going to switch files on you now --

A Okay.

Q -- because I found the right file.

A Okay.

Q And this is the Patty Aspinwall file and I'm giving you this file because you were the nurse that took care of Patty Aspinwall on September 21st; isn't that correct?

A Yes.

Q So take a look at the -- again, the same question, in the pre-op notes.

A Yeah, so --

Q Okay. So let's take a look at this on the screen so everybody --

A Okay.

Q -- can see it, and then you can explain what's on here. Let me see if I can zoom. Does that help at all? You can see it on your monitor there.

A Yes.

Q This is what would be filled out by the pre-op nurse?

A Well, part of it. I don't know if it was the whole thing. I don't think it was the whole thing, but pre-op would fill out the date.

Q Okay. Point to it. You can touch the screen.

A Oh, okay.

Q You can push --

THE COURT: Yeah, if you touch it it'll make a mark on the screen.

THE WITNESS: So the date.

BY MR. SANTACROCE:

Q Okay.

A What kind of procedure they were having.

Q Okay.

A How the victim arrived -- victim. I'm sorry. Patient arrived.

Q Where is that at? Okay.

A Patient arrived.

Q I see it.

A Consent signed, pregnant, review of H&P, I think that's review of -- whatever that says, history of previous surgery, allergies, medications, reason for the procedure, family doctor, and then sometimes they would fill in all this part right here.

Q Okay. Can you tell who filled that out? Is that your handwriting?

A I don't think so.

Q Okay.

A I filled -- I filled out this here. The height and weight and the vital signs I filled out.

Q And can you sort of -- just touch the screen real quick.

A Sure.

Q Let's wipe that out.

A Right here.

Q No, just --

A Oh.

Q I want to get rid of all the other red marks.

A Oh, I need to do something?

THE COURT: Yeah, if you touch the bottom of your screen it should clear it.

BY MR. SANTACROCE:

Q Oh, sorry.

A Sorry.

Q Right here. Maybe I'm not doing it right.

THE COURT: Well, I touched my -- okay. There.

THE WITNESS: There we go.

BY MR. SANTACROCE:

Q Okay. So now tell me what you filled out that you can tell from your writing.

A The height and the weight and the vital signs.

Q And where would you get this information from?

A The patient would come to the gastro center and they would have a history and physical done, and so the height and weight would be on there.

Q Then you would just take it off of that?

A Yes.

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A But as long as you start the anesthesia, then you get that time started. Whether even -- even if the procedure is not done, which did happen in cases, the anesthesiologist still got to bill for that or the CRNA still got to bill for it if the patient then wasn't going to be able to have the procedure done on them because they started the anesthesia.

Q So when you saw these bills coming in from Dr. Desai's clinic for the CRNAs --

A Uh-huh.

Q -- I'm not talking about anesthesiologists --

A Okay.

Q -- and they were all in that same range of the 30 minute range, and I'm talking about the -- because you would get -- you said you would get a pay sheet, which was what?

A The demographics.

Q Okay. Would you get also the anesthesia record?

A Generally not because it was on the superbill.

Q So what came to you from the clinic specifically for billing?

A I think the demographics so we would know who the patient was, what their insurance was, what their address was, their sex, and all the normal things we would have to

fill in to bill out to an insurance company. And then we would get a superbill. And the superbill would tell us the ICD9, the CPT code, and then we would be able to bill that out for the anesthesia time.

Q And when those were all the same --

A Well, I don't know they were all the same because it was a box. I didn't really check to see if the box was checked or not. I mean, whether it was every time was 0 to 30 and every other one was 31 to 60, I couldn't tell you the distribution of that.

Q When you worked for any of the insurance -- or billed any of these insurance companies, did any of them require that you actually put the start and the stop time down on the procedures?

A In subsequent, yes. Originally they used to not do that.

Q Okay. In those instances when a start and a stop time was required --

A Uh-huh.

Q -- on the superbill would it have the start and the stop time so you could put those in?

A I think it subsequently did, yes. I don't think initially it did.

Q So subsequently when those bills would come in they would have a start and a stop time on them for that

insurance company.

A Uh-huh.

Q Is that fair?

A Correct.

Q Okay. In those instances where you saw a start and a stop time, were they always roughly the same, 32, 31 minutes, 33 minutes?

A I couldn't tell you.

Q Anything about any of that that called into your mind any question about what was going on?

A No.

Q So you just sent it off to the insurance company and got the billing -- or got the -- and they got the reimbursement?

A Correct.

Q And you took your fee; correct?

A Right.

Q So we're clear on that, if you had knowingly gotten something from the clinic that you knew had false information on it, any false information, would you have forwarded that on to the --

A No, I would --

Q -- insurance company?

A -- have instructed our staff to return it.

Q As far as your -- the other aspect of your

practice, the valuation of businesses, things like that --

A Uh-huh.

Q -- did you do that kind of thing for Dr. Desai at some point?

A Yeah, we did it twice.

Q And when, roughly, are we talking about?

A 2004 to 2006 or '07 range. Maybe 2005. I couldn't tell you. I know I had two separate evaluations.

Q From 2004 on somewhere -- somewhere; is that right?

A Well, yeah. There was -- there are a couple of national companies that had come on in and wanted to purchase his endoscopy centers, and so we had to do an evaluation for that. And when we did that we try to look at what they would be offering and whether or not our valuation would then be reasonable to what they were offering. In other words, in most cases our valuation came up with higher numbers than they were willing to pay.

In one case they came up with pretty much spot on what they wanted to pay, but then they wanted him to stay involved with it and they didn't want to take -- they only wanted to take a controlling interest in it, not a -- not -- not buy it out 100 percent. They wanted them still to have 49 percent of the business. And he was saying, no, if you want to buy it, buy it lock, stock, and barrel and then, you know,

we can send our cases to you or whatever we would need to do, but we're not going to -- we don't want to be half in and half out.

Q Which business was this or businesses?

A Well, at the time the gastro center was just one entity, and then they eventually end up forming the endoscopy center as a separate entity. And the first one was at the -- the Valley Hospital complex, then I think the Burnham office, then -- then I think they were going to one out on the southwest part of town, and then one out on the Centennial Hills Hospital at the time all the outbreak happened.

Q Okay. Now during the time that you're doing this, I mean, he wants you to do these evaluations, or valuations I guess I should say. Which entity was it for? Was it for the gastro center or was it --

A No.

Q -- for the endoscopy --

A It was only for the individual endoscopy centers because they had different partners for the two that we had done, for the one at Burnham and the one at -- at Shadow Lane in Valley Hospital's complex.

Q So he planned on keeping endoscopy center, but he wanted to sell off the -- or excuse me, the gastroenterology center, but he wanted to sell off the

endoscopy center, is that --

A Well, I don't know if that's what he wanted to do, but all they wanted were the endoscopy centers because they were -- that's what they specialize in, surgery centers.

Q So how did that -- how did you know about that? Did he approach you and say, hey, look, I want to sell this or there's some guys that want to buy it?

A Yeah. That's exactly what he -- he gave me a call and said Larry can you come on in and take a look at, you know, whether or not -- what do we need to do to prepare, you know, an analysis to see what -- what we're going to be able to sell this for. And if they came back with an analysis and you review the analysis to see if they're -- you know, what's their strengths or weaknesses in their analysis.

Q And as far as the analysis is concerned, what kind of factors go into that?

A Gross revenue, operating costs, I mean, same thing, profitability, you know, future, you know, what -- what are the expectations. Like if the one center was maxed on out, then its -- its upside was not real good. I mean, it doesn't mean it's not -- couldn't stay profitable, but the Burnham was a new center, it had larger space, it had more upside, it had capacity. So if its operating level was $100,000 profit, it had a lot easier chance to get into 200,000 than -- than the other center that was maxed out at

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$200,000 profit. It wasn't even going to go to 300,000.

Q So when you're looking at valuing, I mean, those types of things, when you're looking at future potential, what -- how do you determine future potential?

A Capacity. Mostly capacity.

Q And what do you based that on?

A Is that a trick question?

Q No.

THE COURT: No.

THE WITNESS: I mean, capacity -- okay. If -- if you -- capacity, if you could do 100 and you're doing 50, then your capacity is 50 more. So you're potential is you could increase your profitability by doing another 50. And that 50 that you're going to do is not going to have as much cost as the first 50 you're doing because your rent is not going to change, but your capacity is going to increase. But you're going to have increased supply cost, increased staffing cost. But your base isn't going to change. So each new one that you add should be able to add a little higher per -- per procedure profit than the previous ones.

THE COURT: So, I mean, what are you looking at? Are you looking at the size of the facility, square footage, empty beds, available physician -- I mean, labor? What do -- what -- I think that's the question.

THE WITNESS: Yeah.

THE COURT: What do you -- what factors --

THE WITNESS: All of those things.

THE COURT: -- are you looking at?

THE WITNESS: Yeah, you'd look at everything, supply cost, labor cost, insurance, malpractice, is that going to go up, do we have the doctors to do that? You can have capacity but you don't have the doctors to do it. So just because you build it doesn't mean they'll come. So if you've got the capacity to have three doctors working at the same time, that center is going to do more work than a center that only has a capacity having two doctors work at the same time, or the original center that only had one doctor who could work at a time.

BY MR. STAUDAHER:

Q When you look back on them -- and how far back in time -- I mean, when you're trying to see if you're -- if you're increasing your business, if you're able to get that capacity, how far back in time do you typically look when you're trying to valuate a business?

A Three years.

Q Three years?

A Yeah.

Q So what has happened over the -- if I understand you correctly, what's happened over the business in the prior three years is primarily what you look at?

A Correct.

Q Is there a window of time within that that is more important to look at, a narrower time range?

A Well, in a valuation we do a valuation for sell and a valuation for partnership. And he had both of those going at different times during the organization's history. And when you're trying to bring a partner in, you're generally going to value it a little differently and probably lower because you want one of your juniors to become a senior partner and -- but he's going to have to buy into that. So he's also going to be one of the guys who's going to be doing the procedure.

So if you're selling it you're going to be, you know, shooting for the moon. You're going to say, look, the capacity is here, we're running it eight hours a day. If you came in here, why not do two shifts? It's not going to cost you a nickel more in overhead for rent, you know, for your fixed cost, just your variable cost of your supplies and your time. But now you've got to go out and find the doctors that are willing to work that second shift, which is kind of hard to do nowadays.

Q Does it matter if you -- if you can show that over like the prior three year period that in one year you did 50 cases, the next year you did 100 cases, the next year you did 150 cases to show that, hey, look, we -- we're getting

more efficient, we're adding doctors, we're adding capacity, my business is going to be worth more down the road?

A No, spot on. That's exactly what you're looking for. But then you've got to know if you went 50 to 100 to 150, if you can't do anymore cases, then 150 is where you're maxed out of. That's usually when the determination was to open up the second center. We've got -- we don't have enough space here to do more cases, so let's open up another center.

Q So in the prior 12 month period, if you're looking at three years and you're trying to show the trend and how much it's making, would the prior 12 month period be an important period of time to look at?

A Well, the most critical is the last six months.

Q Okay. So you've got --

A But you do -- you take a look at your three-year period, but you've got to also look at your month to month tracking, too. So if you want to -- want to go on it is did an anomaly happen in month six of year three that causes a big spike in something, I mean, what happened there, did we open it up on Saturdays? Which we started doing, you know. You know, you can open up more times. And then the doctors wouldn't do it anymore, so then you would track on back down. So you try and look at everything over that 36

month period to see what was consistent and what was opportunity for -- for, you know, increased volume.

Q So --

THE COURT: Mr. Staudaher, I'm sorry. I'm going to interrupt you. I think we need a break.

MR. STAUDAHER: Okay. That's fine.

THE COURT: So we're just going to take our morning recess for about ten minutes.

And, ladies and gentlemen, during the morning recess 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, person or subject matter relating to the case. Do not do any independent research and please don't form or express an opinion on the trial. If you'd all follow Kenny through the rear door.

(Jury recessed at 10:53 a.m.)

THE WITNESS: Can I just stay here? Can I ask a question? Are there five people back there? Are the other two attorneys back there?

THE COURT: No.

THE WITNESS: I just don't know who people are.

THE COURT: Dr. Desai has two attorneys, and the other defendant Ronald Lakeman --

THE WITNESS: Oh.

THE COURT: -- has one attorney.

THE WITNESS: Okay.

THE COURT: And the State has two attorneys and a police detective.

THE WITNESS: All right. Thank you.

THE COURT: All right. If you folks need a break, you know, 11:05.

MR. STAUDAHER: Okay. Thank you, Your Honor.

THE COURT: And, sir, if you do choose to take a break, don't discuss your --

THE WITNESS: I'm just going to stay right here.

THE COURT: That's fine.

(Court recessed at 10:54 a.m., until 11:06 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 Mr. Preston, when we left off before the break you were talking about -- or we were talking about the month to month changes that might occur. I think you said that if there was aberration in a month you'd want to be able to explain that or have to explain that if you were trying to

valuate for someone. Is that fair?

A Correct.

Q Okay. So when you're looking at it over that three year period you said the most six -- the last six months or the closest six months was the most important.

A Correct.

Q Now, when you're looking back over that time, if you see an aberration, and I think your -- your aberration was a spike you said --

A Right.

Q -- something like that. But if you saw an aberration in the sense that there was a drop, would that also be a concern?

A Correct. Yeah, we would usually go back and look and see if it was a doctor on vacation, you know, was there a site survey being done, was there something that closed the facility down like a water leak has happened in the past that you could explain why that phenomenon occurred.

Q If you had a situation where you were looking back over the three years and the numbers and procedures for whatever reason, doctors --

A Right.

Q -- expansion, whatever, it was going up, up, up the whole time. And all of the sudden they got to a point and flattened or actually went down and stayed that way, would

that be a problem?

A Well, it all depends from the buyer or from the seller. From the seller's point of view, then he's probably not going to get the -- the highest value out of that if it starts to go down unless we can explain why. If it was from the buyer's point of view, that's good because now you can offer less because it looks like the trend is starting to level off or -- or it's going to drop.

Q From the seller's perspective, though, that would be -- that wouldn't be something you would want; correct?

A That is correct.

Q In going through this sort of work that you did for Dr. Desai, was -- now, you said there was at least a couple of offers that came out during the time period?

A Yeah.

Q Do you recall what the offers were roughly, ballpark range, or what they were for the clinic?

A 5 or $6 million.

Q Now, that was for what? What would -- what would the buyer get for it?

A He would buy the endoscopy center, therefore he would have a going concern, a licensed going concern, which is not -- you know, that could take a year to do. So he enters the market right away. That could also allow him then

to open up other centers. That's why mostly the people that were looking at it were national chains that didn't want to go through the process of starting one up themselves and going through all the licensing not understanding the regulations. Buy one that's existing and then you can replicate that.

Q And that was for one center, or was that for all the endoscopy centers?

A Well, at my time it was only just for the one center mainly which was on -- on the Valley Hospital's campus. And then eventually it was for the second center on Burnham. I didn't have anything to do with the other two as they were opening or in stages of opening.

Q So as far as that was concerned, obviously there was never a completed agreement; correct?

A Yes, that is correct.

Q Now, during the time that you were talking with Dr. Desai about this, did you tell him the kinds of things that we're talking about here with what we need to look at and how we'll value it and so forth?

A Oh, yeah, absolutely.

Q So was he -- he was involved with that process?

A Yes.

Q As far as the profits and losses when you looked at -- and I know that you weren't there for the whole

time --

A Yeah.

Q -- correct? I mean, you were there for a snapshot window. But did you ever during the time you talked to him and dealt with this, did you ever abandon that and say, you know what, I've decided I'm not going to do anything with it at all. I have no interest in selling the business at all?

A Yes.

Q So tell me about that.

A Well, just several times. As the offers came on in it just -- dealing with corporate America was very taxing, I mean, very trying and very time consuming. And they would just, you know, try and nitpick you down, answer all the questions, and then you wouldn't hear back from them for 30 days. And then they would come back with another set of questions. Then I'd have to go through, you know, can they get regulatory process, can we do this, and -- and sometimes it was just like, look, I just need a decision. Do you want to go forward or do you not want to go forward?

And the two centers at that time had different structure. So they were -- they were licensed independent of each other. They had some commonality of ownership, but they had different ownership. So you may be able to get one group of guys saying, yeah, let's just go ahead and sell it. And the other group of guys saying, no, we're still growing, we're

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going to hold out and make it more profitable and, therefore, we can sell it for more down the road.

Q So when the offers came in they didn't meet whatever the requirements that he expected. He was like, no, we're not doing that?

A Correct.

Q Okay. But you were still at least trying to follow along and value the business for him for a potential sale?

A Correct.

Q Okay. When the issue came up about selling that portion of business, and I'm talking about the endoscopy center portion of the business, was there -- was he still planning to retain the gastroenterology side of the practice?

A Yes, that had never been talked about in my -- to my knowledge of selling that side of it off.

Q In any of the negotiations was there any sort of companion agreement where, you know, the feed of the patients would be from the gastro side to the endoscopy center?

A No. Legally they couldn't do that unless they retained ownership.

Q So they would have had to have done -- did the offers that came in try to get ownership in some way of the gastro centers?

A No, they wanted -- they wanted the doctors to retain 49 percent of the -- of the endoscopy center business that way they could refer and they could -- they could continue to have their patients there. And it gave the potential buyers comfort to know that these guys had a vested interest in maintaining their business there.

Q So these million plus, whatever the millions of dollar offers that were out there, those -- did they all contemplate that there would be some kind of retention, that Desai would still be involved --

A Well, I think --

Q -- with the clinic?

A I'm sorry.

Q That he would still be involved in the clinic somehow?

A Yes, I think most of them wanted it that way.

Q And Desai wanted it just to be bought outright and be done? He didn't want to be essentially under someone else. Is that fair?

A Correct. That's -- that was what our initial, you know, goal was is to just sell it outright and -- and not be an owner in it. But that doesn't mean you couldn't negotiate to do that.

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

THE COURT: All right. Thank you.

Cross.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good morning, sir.

A Good morning.

Q My name is Margaret Stanish. I represent Dr. Desai.

A Okay.

Q I want to first start, Mr. Preston, with your background because you sure sound like you're in a very specialized profession. What is your educational background?

A All right. I've got a Bachelor's degree in accounting and a Master's in business administration.

Q And do you have any specialized training in healthcare administration?

A You mean other than 40 years on the job?

Q 40 years on the job I assume you --

A Yeah.

Q -- attended --

A I mean, I have other certifications if that's what you're asking about.

Q Okay. What are those, sir?

A Well, I'm a member of the Healthcare Financial Management Association. And somewhere back in the '80s I got a couple, you know, certificates. I think one is a certified

healthcare financial manager, and the other one is a certified manager care professional, and then those had been rolled into a fellowship program. And so I think I've had my fellowship now in HFMA since about '87 or '88.

Q HMA is?

A Healthcare Financial Management Association. It's about 35,000 members nationwide, and mainly for people dealing with the healthcare aspects -- or financial aspects of healthcare.

Q So as I understand it you have a business background by training, but on the job training to specialize in healthcare management?

A Correct. Yeah, I've been in the hospitals from 1973 to 1990, and then 1991 to present in healthcare consulting. In '91 I started my own business.

Q How long have you been in the Las Vegas area?

A Since May of 1983. And I still have the sunburn from Reno to prove it. We hadn't had sun for months, and I came down here and the first day I was red as a lobster.

Q All right. I -- I'd like you to explain to us if you can in layman terms the evolution of healthcare in Las Vegas form hospital setting procedure surgeries to ambulatory surgical centers. Do you understand what I'm trying to get at?

A Well, I don't know on the evolution.

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Ambulatory centers obviously are outpatient. Hospitals are for acute. And in the last 40 years things that would never be done on the outpatient setting are now being routinely done on the outpatient setting. Acute care hospitals have really changed their whole mode of how they're doing business.

You know, you used to be able to take a patient and you couldn't do an arthroscopic knee or an arthroscopic surgery in the hospital. Now you can do them on an outpatient basis. Heart procedures are being done on an outpatient basis that would never have in the '70s and '80s and early '90s couldn't have even thought of that.

So the technology is changing and evolving constantly so more unfortunate, you know, pressure is being put on the insurers to move these things from an inpatient which is significantly higher in cost to an outpatient that's significantly less in cost.

Q And let me focus more on the Las Vegas area. As I understand it in the early -- well, in the early '80s you're in the Las Vegas area.

A Right.

Q And you actually meet Dr. Desai in -- is it the early '90s when he's at, what is it, North --

A North -- well, it's now called North Vista Hospital. It's morphed into three or four different names in the last 30 years.

Q Okay. And you met him there in the early '90s?

A I think it was in the -- well, I was there from '83 to '85, so that's the first recollection I thought that he was -- I met him at the hospital there, and then at UMC I would have run into him, his name if not his activity. But my first real more detailed encounter was with an outpatient setting when one of our clients was in the same campus on Valley Health facilities building area.

Q And at that time the hospital had its own outpatient surgical center; is that correct?

A Yeah, I think they did at that time. They still do as far as I know.

Q All right. And is that where you met Dr. Desai?

A No, in his office.

Q Okay.

A So the hospital and the parking lot is, you know, 40 yards apart between his medical office building at 700 Shadow Lane and the first floor to the hospital's ED department and L&D and stuff like that. So he just --

Q And I understand. So I was just trying to get some idea of the time frame here.

A Yeah.

Q He had -- he was at the Shadow Lane locations

and doing procedures in the hospital outpatient surgical center when you were there or --

A I don't know.

Q -- in the hospital?

A I assume he was, but, you know, we met him because of our client sending patients to his 700 Shadow Lane office.

Q And at that time when you first met him, did he actually -- do you know if he had the procedure rooms up and running -- a procedure room up and running at the Shadow Lane --

A For --

Q -- location?

A -- endoscopy?

Q Yes, sir.

A I don't recall.

Q At some point in time you recall he did?

A Yes.

Q As you described, a smaller facility --

A Right.

Q -- and it was a one room procedure area; correct?

A Correct.

Q In the Las Vegas area at this time frame was there a development of ambulatory surgical centers in the

'90s?

A Yes.

Q And can you educate us a bit on what's the difference between an ambulatory surgical center and an outpatient surgical center at a hospital?

A Well, the hospital is -- is mainly cost. It's also the hospital is going to staff it probably with a higher level of, let's say, nurses. They've got -- obviously they've got the emergency room doctors there full time for backup, but their cost structure is significantly higher. So when you were to look at -- if you were a specialist like the gastros, if you were looking at trying to set up a center, then you could set up a special center for endoscopy only, or you could set up a center that can handle anesthesia and pain only.

You could set them up for multi-specialty cases that you can do all of those, but you have to get equipment, so that's why the specialty ones are generally a little more profitable, a little easier to manage because they're focusing all the equipment on the same type of procedures that are going to be done versus a general outpatient surgical center. It may have cases for a c-arm that they're doing for injections to the back or something like that that a gastro doctor would never need something like that. And those can be 150 to $200,000.

Q So if I'm understanding your explanation, the

ambulatory surgical centers are more -- they can operate more efficiently because they were focused on a certain type of procedure; is that correct?

A Yeah, that's a reasonable assumption.

Q And what kind of things factor into that efficiency? You've already described some of them. Are there any other things?

A Well, you're -- you're buying volume. So like if you're buying material, you're buying a specific material. So if you were buying 100 boxes of something versus 1,000 boxes, you're probably going to be able to negotiate a better deal. You know, that's -- you know, the cost of a -- of a building is generally cheaper.

I mean, back then I the '80s we were probably paying 75 cents a square foot to $1 versus $3 a square foot now. The build out cost in a hospital because of pumping in oxygen and everything else, being accredited by the joint commission on hospital accreditation, you're talking about four or $500 to $1,000 a square foot versus you could build it for 55 to $75 back then a square foot. So you're talking about huge differences in -- in the way in which a hospital operates and maintains themselves versus an independent center could -- could do the same thing.

Q And what about the staffing at an independent surgical center? How does that contract with a hospital

staffing of its outpatient facility?

A Well, generally a hospital's outpatient facility is going to have more room. They'll still probably have RNs. They probably in today's environment wouldn't use NAs. An outpatient facility could use NAs, but they'll still have to have registered nurses. But they could use, well, a step down in staffing. They probably don't pay as much as a hospital pays, so, you know, people work for a lifestyle. In a hospital you could be required to do night shifts, weekend shifts. Generally in an outpatient setting you're not required to do that.

Q In contrast to the hospital setting, would the independent ambulatory surgical center staff be more specialized than the staff at a hospital-based outpatient clinic?

A Generally, if it's a single specialty center, then yes. Just over time they're going to become more proficient at it than something in an ambulatory setting that is -- is doing multiple types of procedures.

Q And in the 1990s, in the early 1990s or I should even say in the 1980s, is it a fair statement that those were the good old days for Las Vegas, we were in a population boom?

A Well, good old for what? I mean, yes, the economy was booming and you could make money a lot easier, you

got higher reimbursement than you have today, staffing costs were lower, expectations were lower.

Q Well, I'm probably not making myself clear, but there was a population growth getting 3,000 to 5,000 new residents a month --

A Right.

Q -- moving to Las Vegas. Is that a fair statement?

A Yeah, it was over 5,000 for years a month.

Q And that's what I meant by, I suppose, the good old days when we were in a growth economy and not a recession. Did the population growth in the Las Vegas area set the stage for the growth of independent ambulatory surgical centers, if you know?

A Well, it was a contributing factor, but I think the capacity in the hospitals was more of the factor, that they just couldn't -- they did have availability of OR time. So if you can't get your patients in there, then, you know, the obviously answer is to build more hospitals, which we did. You know, in the '80s we had like five hospitals, now we have 13 acute hospitals here.

The wheel and spoke effect happened. You know, you had -- here -- here almost everything was between Desert Springs, Sunrise, and Valley, UMC, those four hospitals pretty much managed everything. And now you've got the other eight

hospitals that are all on the outside and in the suburbs now. But capacity is a big issue, and at that time it was easier to open up an outpatient surgery center than it is today.

Q And as far as independent ambulatory surgical centers, how did the -- if it did, how did the population growth or, I guess, supply and demand in the Las Vegas area in the '80s and '90s, did the factor into the growth of ambulatory surgical centers?

A I think it had an impact, but it was more because there wasn't availability in the hospitals to take over that excess -- or, you know, the capacity that was needed out there.

Q Oh. So if I'm a specialist, a doctor, a GI doctor --

A Right.

Q -- and I got, you know, thousands of patients or potential patients moving into the Las Vegas area, I can't get time to treat them to do the procedure in the hospitals because they're booked.

A Right. That was -- that was one of the hospitals' big challenges back then.

Q And that -- and am I correct in understanding that ambulatory surgical centers are typically operated by independent doctor groups?

A In this town that's -- that's more common. In

bigger cities like Chicago, New York, you're -- you're going to have more of the national chains here and there.

Q And why is that the case in Las Vegas that it's more oriented towards private ownership?

A Well, because we have less than 2 million people, and those cities have 20 million people, so efficiencies. If you can have five surgical centers, you can end up with one regional manager and a couple, you know, other people that have two surgery centers. Just economies of scale, it's a lot easier to do business that way.

Q Now, let me move to the topic of your initial dealings with Dr. Desai's clinics. At some point in time you end up entering a business relationship with him; correct?

A Right.

Q Do you have any idea time frame wise when that occurred?

A Not really. I would say it's in the mid-nineties, but I couldn't tell you for certain.

Q And then you recall that it went up to 2004; is that correct?

A Well, in the 2000s.

Q Somewhere in the --

A Yeah.

Q -- 2000s. Fair enough. And -- and as I understand it, when you are operating Professional Medical

Consultants, that's when you start working with him as a healthcare consultant?

A Correct.

Q And I'd like you please to educate us more on what kind of services you provided to Dr. Desai's clinic.

A Well, initially it was more human resources. He would come in and ask us can we evaluate your -- you know, what our practice administrators are doing, our supervisors are doing. And --

Q And let me just take it one step at a time because I -- I want to understand your relationship and the services you extend to him. So if you would, sir, would you please elaborate on what does that mean because we don't really know that much about the business of healthcare and I'm -- I'm asking you to educate us on that point. What kind of things would you do with respect to staffing?

A Well, I wouldn't -- mostly it was his billing, he had his own billing department for his GI stuff. Obviously they had front desk people, and you'd have your -- your administrative people who's paying your bills, who's doing your payroll, functions like that. So anything that's non-clinical is where we would get involved in things. If it's clinical, I don't have the background or the expertise nor the desire to want to know how those parts work. So I can look at it from the business aspect of it.

So if you're looking at a patient coming on in and you've got two windows and you've got 40 people trying to come in here, that's going to be a backlog, you know, can we add more windows to that, can we have better registration times, what is your registration form looking at, why are you getting denials on your bills, you know, to the insurance companies? Mainly because you're not collecting your information properly up front.

So when we walk into a facility, what we look at is we walk in and try and look at it for operational efficiencies, what's -- what other -- what other opportunities, whether they're strengths -- like a SWOT analysis, you know, strengths, weaknesses, opportunities, and threats. So if somebody else is opening something, does that mean you should open up something? Well, not necessarily. In medicine you don't want to be like the Jones's. So you kind of -- what's -- what do you have the capability of doing and managing properly to -- to expand, you know, what your business model wants to be.

Q So would your -- your service would also include helping them devise the forms that the patients would actually fill out?

A The demographic side of it, yes.

Q All right. Would it have anything to do with the records that are used to document the flow of patients

through the procedural side of the house?

A No, generally not.

Q Okay. Because I wasn't sure. You had mentioned something about the anesthesia records more in respect to the billing aspect of the business and how due to changes in the billing requirements, the forms would have to be changed.

A Well, there's a superbill, and that just, you know, has a patient demographic, you know, synopsis of the demographics, not all of it. And then it has, you know, the level of service, they type of care, the doctor or the nurses would write down what the ICD-9, so the diagnosis and the procedures that are going to be billed out for that. And that's -- that's a non-clinical form per se.

Q All right. Just to clarify some of the terms, I'd like you to educate us on that. The superbill, what's that look like? Is it a submission by the clinic that lists all the procedures done for a particular day with the appropriate billing code identified?

A Well, back then it was probably pre-printed. So the only thing that the computer printed out was the patient's name and, you know, the reason for the visit. And then it would have a host of other things the doctor can go through, do they need an EKG, do they need any lab work, have they had, you know, any follow ups? And the doctor could

write that on the -- on the form, which is completely separate from his notes and the nurse's notes that go into the chart.

Q Now, and then you mentioned various codes. CPT, what does that stand for?

A Current procedural texts. So every year the AMA, the American Medical Association gives us this wonderful book and tells us here's the codes that we believe you should use to stay in -- you know, in a guideline or a format that's a generally accepted format. You don't have to use it. The insurance companies don't have to use it.

Generally, Medicare follows those rules and regulations. But then each set of insurances have their own rules and interpretation of that. So most try and follow Medicare guidelines, but some feel that Medicare guidelines are too liberal in the payment, so then they restrict what they do. Others just abide by whatever the book is. But you use that as kind of your template, your baseline.

Q And it's up to the various insurance companies as a matter of contract with the provider as to whether they want to set up their own separate rules that might be different from that template?

A That is correct.

Q And then what was the other abbreviation you used?

A ICD-9.

Q What are --

A International --

Q What's that?

A -- Classification of Diseases, Version 9. So we're about ready to go to Version 10. We're the only country, I think, in the world right now that's not on 10. Most everyone else is starting to go to 11. But it's just -- it's diagnosing like, you know, if someone has, you know, a broken finger. Well, under 10 and 11 they're going to say which part of the finger, right hand, left hand. So we're going to go from approximately 13 codes to 80,000 codes. So it's going to change the entire software. I mean, billions of dollars. It's been delayed five years because it's such a dramatic shift in the way in which we code, the way in which doctors document.

Q So just to kind of distinguish between the two codes, the CPT is more of the procedure code, the code that's going to be used to describe, for instance, the colonoscopy.

A The procedure itself, yes.

Q And then the --

A The diagnosis code.

Q -- is to describe what the --

A That's the medical terminology.

Q And it's to assign a code to the medical issue that's being addressed by that procedure?

A Right. Like if you have, you know, shortness of breath, there's an ICD-9 for that, but there's not a procedure for that. So that procedure would be equated to an office visit. So you use the two to be able to send out your billing to the insurance companies, and then their matrixes determine how they're going to pay you.

Q What's a billing modifier?

A A modifier could be something like place of service, so that would be a billing modifier. Back then the modifier was for an anesthesiologist -- or, I'm sorry, a nurse practitioner or PA doing the service. I think the modifier was 85. You could have a subsequent-to or incident-to modifier. So the patient came in and said that their right shoulder was hurting them, but you end up x-raying their ankle and the insurance company wants to deny it. So you put a modifier saying that's not what the patient came in here for. But once they got there, they told us, oh, by the way, I also broke my ankle or I think I broke my ankle.

But the insurance companies kind of want you to know what you're supposed to do to the patient once you walk in the door, so you'd use a modifier to tell them this didn't -- we didn't know this was what -- what the reason why the visit was, but it became an incident once they got there that we could then additionally bill.

Q So the modifier somehow gives a more detailed

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explanation of the procedure code?

A No, it just tells if there's an aberration to a normal billing and why was there an aberration.

Q Is -- are C -- do CRNAs, do they have a modifier in billing if you recall?

A They did because they had what they called a cut down. So they got paid less up until two years ago. I think they only got paid 85 percent by Medicare of what a physician would get billed.

Q So if an ambulatory surgical center wanted to make more money on anesthesiologists, the most profitable thing for them to do was to bring in medical doctors, anesthesiologists, as employees so that they could bill the larger amount?

A Well, employees or contracted, independent contractor, yes. They would make more money at 100 percent than 85 percent.

Q All right. I know -- it sounds like this billing is very complicated. Is that a fair statement?

A It is absolutely literally impossible it's so complicated because every insurance company has their own rules.

Q So every insurance company has its own rules, and -- but layered on that is also the federal government; correct?

A Federal and state government, so, yeah.

Q State government, as well?

A Yeah.

Q Is that in connection with Medicaid?

A Well, yes, Medicaid, but you have your Nevada Revised Statutes that have certain limitations on what you can do, you know, physicians, you know, self-referral laws, we have our, you know, the federal version is called Stark. They have a Stark look alike. That was implemented back in the early '90s, you know.

Q Stark laws are something federal regulation as well as mimicking state laws that controlled how doctors do business; correct?

A Correct. And it's -- whichever one has got more restrictive to your particular case is the one you've got to follow the guidelines. Because some of our state laws contradict the federal laws, but if they're more restrictive, then we follow the state laws.

Q And these CPT codes, do they change every year?

A Every single October they give us a shout out telling us how many codes they're going to change, how many have been added, deleted, interpretations. So, yeah, so we get to go to wonderful seminars and try and figure out what's -- what's new, change all of our billing forms if there's

necessary changes to that, and then you've got to go to your insurance companies, are you going to follow those guidelines.

Q And you said there's an issue with interpreting the procedure codes. Can you explain that to us?

A Yeah, well, just because someone wrote out something generic doesn't mean that everyone is going to understand it the exact same way. So, unfortunately, a lot of it is -- is up to interpretation. You can have a nurse reviewer at an insurance company that says I don't agree with the doctor. Then you appeal it to usually a physician review committee, and then they'll go, no, I understand that. That makes sense. That's what the doctor would do.

Well, the nurse has never been the doctor, so from her point of view, the way she's looking at it, or he, they would say, no, I'm not to agree with them. But then you get a practicing physician who is now in an administrative capacity with the insurance company, they may sit there and say, no, I understand that's exactly what you would have to do. So you have to go through an interpretive process.

Even, you know, if you look at the American Coding Association, the American Association of Procedural Coders, there is a half a dozen groups out there. They can't even agree on interpretations that -- and they now work with the AMA to write these rules and it takes them usually two years to get a new code pushed through the system so everyone can

believe that we're trying to make the code as simple as possible and -- and the least restrictive in interpretation. But it's -- they -- they don't even agree with it once it's published.

Q Does the interpretation of the procedural code become an issue when trying to figure out the billing of a procedure done in a hospital setting versus an ambulatory surgical center?

A Well, not so much because from a professional fee it's pretty much the same, but the hospital is more on a DRG, they have cap rates, they have different contracts, so a DRG that Medicare pays them as diagnostic related group. And then I think they're on the third version of that. So they pay them a set fee for a type of diagnosis. You come in with COPD you're going to get $7,000. The patient comes in there and dies two minutes later, you still get your 7,000. They stay in there for 30 days, you get $7,000. You know, you do multiple procedures or no procedures, you get $7,000.

Q Well, let me discuss with you the anesthesia time billing that you debated during the direct exam. The -- it sounds -- as I understand your interpretation of the billing -- billing codes for anesthesia, they depend on how long the patient is within the control of the medical provider. I'm not stating --

A Well, I use the --

Q -- that right, am I?

A -- terminology -- I like the liability. As long as that doctor still had the liability or the CRNA had the liability, then they had a responsibility and -- and that's the way I thought the interpretation should have always been written. Once they're out of your liability, then you're -- you're off, you know, into either private or you're into another section of the, you know --

Q So you're talking about -- and I think you used the term billing follows the liability.

A Right. That's -- that's my -- that's the way I would always advise somebody is that, to me, the billing should follow the liability trail.

Q And how is it that you -- is that just something you yourself came up with, or is there something --

A Could have been.

Q Let me finish my question. You attended training and conferences and you do that constantly at the time you were operating billing?

A Right. Yes, I was going to seminars every year. And, you know, now you can do webinars, but, you know, then it was all face to face and you would ask other people how are they doing it, when does time start. So you try and, you know, see if there was what commonality did most people have? What did our insurance companies think was common?

Q And so when you are saying billing follows liability, that's not just something you got out of a Cracker Jack box. That's something that you learned over time in conferring with insurance companies, other billing professionals, and during conferences; correct?

A Yeah, I would say that's -- and, again, it's my interpretation, you know.

Q And your interpretation is what you would have advised Dr. Desai's clinics?

A Well, we didn't do a lot of advising on the billing side of it. I mean, they had their protocol. But if someone would ask me the question, that's probably what I would have recommended.

Q Did Tonya Rushing at one time work for you?

A Yes, she worked for me for a short period of time while we had the contract at the gastro center.

Q And how long did she work for you, sir?

A I couldn't tell you, a year or so. And then when the contract -- when we sold our billing company, then Dr. Desai didn't want to have that -- that entity that purchased us do his billing and didn't want to have that entity have her as an employee. So I released her employment agreement with me, and then he hired Tonya on as their -- as their billing manager or operating manager.

Q So I'm clear on the chronology, Tonya Rushing

worked for you at a point in time.

A Uh-huh.

Q And what was her job at that point when --

A She was the --

Q -- she worked for you?

A -- office manager for the gastro center.

Q So even though she worked for you, she served on a contract basis with the gastro center as an office manager?

A Correct. Right.

Q And do you -- do you know what -- could you detail for us what her responsibilities included under that contract?

A Well, under our contract was the non-clinical aspects of it.

Q Would it include billing?

A I think it would have. I mean, they had their own billing department at the time, so, again, I don't know when that sort of started. So anesthesia didn't get billed out with the GI work.

Q They had a -- at the time you had the contract and Tonya was working for you and she was like the onsite manager --

A Right.

Q -- at the gastro center --

A Right.

Q -- if you recall because I know this was a long time ago, so just, you know, if you recall, do you recall that the billing was in-house for the procedure itself, the colonoscopy, the endoscopes?

A Yes, all the GI and endo stuff at that time was all under one structure.

Q Okay. And so that was done in-house?

A Correct.

Q You don't recall that your service was doing the billing?

A Oh, I know we did not do that billing.

Q Would Tonya have had involvement in assisting the, if you recall, would she have some involvement in assisting or advising the gastro center on how to do billing?

A Not under our contract, but she would have had to work with those people. So if they had questions, you would try and go backwards and say, okay, well, what -- where does your question start, what was the result, what are we missing here? So between the billing manager and her, they probably would have gone into, you know, some sort of conference and said, okay, where have we got these changes and stuff like that. But they had their own billing manager.

Q Okay. Now I think I understand. So in-house, the actual act of billing the, what I assume is massive

paperwork that is involved in billing is done in-house?

A Correct.

Q But to the extent that there is an issue on -- on billing, Tonya would get involved and there could be consulting with insurance companies to figure out something? Is that what you mean?

A Well, yeah, but you had a pretty good billing manager in there, too. So, I mean, whether they certified procedural coders at the time or whoever, they would -- they would come back at it. Usually our involvement and Tonya's involvement would be are we getting rejections, are we getting questions, what are the questions and why are they coming up? Is it front desk related, is it documentation related, is the doctor not -- not, you know, providing enough information, are the nurses not putting any information in there? That type of thing. But the billing manager was, you know, for a long time was onsite, and then they moved offsite.

Q Do you know who that was?

A No, I couldn't tell you.

Q Okay.

A Not even close.

Q But so basically Tonya's job would be troubleshooting if there were issues with billing?

A Well, she would work in -- in conjunction with the billing person to try and figure out, you know, between

the two of them what are the issues and what -- what part of it is somebody going to solve? If it was front office, like they were getting denials because they just weren't getting enough demographics in, then that would be the front office supervisor who Tonya -- who reported to Tonya.

Q All right. And then eventually you, I think, because you didn't, as I understand your direct testimony, you didn't want to deal with the -- the massive regulations with billing, you sold your billing practice?

A Correct.

Q And at that point Tonya became an employee of the gastro center?

A Yes.

Q You released her from her contractual obligation with you?

A Well, actually, it was a contractual obligation with the gastro center.

Q Oh, I understand.

A Yeah.

Q Okay. Now, I want to move to the topic of the CRNAs, the development of the gastro center in hiring CRNAs. Is there anything bad about having CRNAs provide anesthesia services rather than MD anesthesiologists?

A My opinion, no. But, I mean, I'm not the physician. I couldn't tell you that. The physicians are

going to probably say, you know, they want to do it because they're taking away work from the physician.

Q And are you aware of there being some, I don't know, animosity or at least some professional disagreement between anesthesiologist MDs and CRNAs?

A There's disagreement with every doctor about anybody who is taking business away from them. It doesn't matter what their -- their degree is.

Q Not at all like the law?

A Not at all. Not at all.

Q All right. So fair statement that the -- well, let me ask you. Did -- has there -- how long have CRNAs been around, do you know?

A Well, I'm almost 58, and as far as I know they've been around most of my life, and physician assistants have been around forever through the -- mainly through the armed services. That's where we seem to get the vast majority of them.

Q Fair statement --

A Now you have students here at Touro University, you've got the University of Nevada that's got the CRNA -- or not the CRNA, but the nurse practitioners, and then you have CRNAs, so you really have three mid-levels that are providing a wealth of service here in town because we have a lack of primary care physicians and specialists.

Q You said that CRNAs are predominantly in the military; correct?

A No, physician assistants are predominantly in the military. CRNAs are used in the military, as well.

Q I mean, are you aware that nurses administered anesthesia during the civil war?

A No, but I've seen some great anesthesia in the civil war relics, though, but, no.

Q The military relies on nurses to administer anesthesia; is that correct?

A I don't know that for a fact.

Q Okay. I'm not sure I under -- maybe I misunderstood.

A They're in the military, but if they rely on them, I don't have a clue.

Q All right. I understand. All right. In your experience as a healthcare provider -- or, I'm sorry, a healthcare consultant, have you seen over the years an increase in the use of CRNAs versus anesthesia -- anesthesiologist MDs?

A I haven't seen an increase, but they're more -- I think it's more prevalent. And it's going to be even more prevalent in the new Obamacare coming into 2014. It's just what's happening in our healthcare delivery system. The midlevels are going to become more and more important in the

new healthcare delivery model.

Q And you already mentioned that there's training facilities for CRNAs that are growing programs for that; correct?

A Yeah. In Southern Nevada there are PA and nurse practitioner programs. I don't think there's a CRNA program.

Q Were you -- getting back to Dr. -- to the gastro center, were you involved at all in helping to locate CRNAs to work there?

A I would guess I would have been. I don't really recall, but I know if they would have come in from out of state I probably would have interviewed them for the doctor and made sure that they had whatever credentials they had. My guess is I probably would have given them one of the contracts that he had to make sure they would be understanding of the contract for the employment agreement.

Q That -- the employment agreement for CRNAs, was that a form that you believe you provided?

A I doubt that, but it would have been one that we probably could have got from the hospital or we could have got from another organization or maybe they could have had. They -- some doctors, some of them have brought in their own forms and said, hey, this is a really nice form to use. And as long as it met, you know, the criteria that we wanted and

enough regulation, you know, you've got to have enough to satisfy the state and the feds on what they can and can't do, so we would put that in there.

Q Do -- were -- did you work with Dr. Desai's business attorney Alan Sklar?

A I've -- I don't know if it was through his dealings. I've been dealing with Alan for years.

Q And Alan specializes in health law?

A Well, I'd say he's probably one of the top four or five guys in this town in healthcare, you know, understanding the -- the complexities of healthcare law, yes.

Q And the -- and you have already mentioned that the CRNAs, before the gastro center could bring in CRNAs, they had to ensure that they were complying with the Medical Board of Examiners, the Nursing Board, and -- correct?

A Well, the CRNAs would have been under the -- the Nursing Board, but it's -- you would have to have state compliance, and you'd also have to have medical liability approval, so, you know, malpractice. Your broker would have to fill out an application, and the broker would send it up to an underwriting. Underwriting would say, yes, this guy has got a clean record or this person has, you know, an issue, but, you know, we believe it's okay. But you would have to clear that hurdle, too, before you could bring him in the group.

Q And would there be other hurdles as far as the federal government?

A No.

Q No? So it would just be a matter of state regulation?

A Yeah, they have to have a state license and you have to have medical malpractice coverage and it has to be approved for that. Because if someone gets denied for whatever reason, it could be training, it could be education, it could be too many medical malpractice cases, for whatever reason the underwriter couldn't insure them, then we couldn't offer the contract.

Q Would it be various insurance companies also have to be dealt with?

A Yeah, every one of them. They get to go through a credentialing process and some of them had more stringent rules than others. Some of them would not give you a contract for a CRNA, so you'd bill it out under the physician's name. We'd put the modifier on it. They wouldn't care. So it would be dependent upon insurance. There was no consistency, unfortunately.

Q Right. And what was your role, to the best of your recollection, in brining -- bringing a CRNA presence into the gastro center?

A Other than discussions whether we can do it,

Q So after you learned the results, did -- did the Health District ask you or the CDC ask you for additional blood, a blood sample to send to the CDC?

A Yes, they did.

Q And you provided that?

A Yes.

Q At some point after that did you see a specialist for the -- for hepatitis C?

A I went to Dr. De La Torre.

Q And under Dr. De La Torre's care did you institute some sort of therapy or treatment?

A Yes, I started therapy in the beginning of 2009.

Q And do you know what it's called the therapy?

A I went through Pegasys. I took Pegasys --

Q Interferon?

A -- interferon, yes.

Q And describe the course of that treatment. What is it like?

A It lasts for about 50 weeks. It's one shot a week that I give to myself either in the stomach or in the leg, plus after I began the treatment my white blood cell count dropped so I had to go to the Cancer Clinic of Southern Nevada to get Neupogen shots three times a week.

Q And I just didn't hear you. What kind of

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shots?

A Neupogen.

Q And that was because of a low white blood?

A Yes.

Q And is that a side effect of the interferon treatment?

A Yes, it is.

Q Your white -- your white blood cells drop?

A Uh-huh.

Q And the treatment you said lasts for about 50 weeks?

A Yes.

Q And you have the shots. And do you have to take pills, too?

A I don't recall taking any pills. No, that's not true. I did take pills. They were big. I don't remember how many times a day, but, yes.

Q Did you find the treatment difficult?

A At first I was tired and then I developed about two or three weeks of suicidal tendencies. The doctor had warned me about that, so whenever I felt that I would just climb into bed and watch TV? Then --

Q Was it frightening, though, to have that kind of side effect?

A Because the doctor had informed me it would

come, I was prepared mentally.

Q Okay.

A But it was not a good feeling, no.

Q Any other side effects that you experienced?

A After awhile, you know, like I said, I was very tired all the time. I started feeling like I was catching a cold all the time. I still feel that way. And then after a few months when I was taking school I started noticing my vision was having a little bit of problems, so I went to get my eyes checked, got a pair of glasses. I thought that was all that -- I thought I was just getting older. And then after class one day I went to drive home and I had the opposite problem. I couldn't read the signs on the freeway to get myself home.

Q So at one point you were having trouble, it sounds like, with smaller print?

A Yes.

Q And then you noticed that your vision kind of switched --

A Yes.

Q -- and then you had trouble with distance?

A Yes.

Q Okay. So what happened with that?

A Then I went to my doctor. Dr. De La Torre suggested I get off of the medication for a few days. I went

to an eye doctor to be sure that my -- that the pressure hadn't ruptured behind my eye, and it hadn't. So then we -- the doctor felt it was time to start me back on the -- the medication, so I continued.

Q And -- and completed it?

A Yes.

Q At this point do you know what your status is in terms of whether the hepatitis C is detectable in your blood?

A It is low and detectable.

Q Low and detectable?

A Yes.

Q And when was the last time that you had your blood tested?

A It was about a year ago. I currently have no insurance, so I haven't been wanting to pay the almost $800 to get it checked.

Q Okay. And are you able -- is it hard to get insurance with that diagnosis?

A Currently I tried two insurance companies and they both turned me down. One I had already been at. And so I've been waiting for the federal care to take over.

Q Okay. But in the -- in the one a year ago it was low but detectable?

A Yes. I was still on student insurance at the

time, so I got that taken care of.

Q Thank you, sir.

MS. WECKERLY: I will pass the witness.

THE COURT: Thank you.

Cross, Ms. Stanish?

CROSS-EXAMINATION

BY MS. STANISH:

Q Good morning, sir.

A Good morning.

Q My name is Margaret Stanish. I represent Dr. Desai. Have you interviewed with any law enforcement people prior to your testimony today?

A No, I had not.

Q I assume you spoke with the DA --

A Yes.

Q -- just to prepare --

A Yes.

Q -- for your testimony; correct?

A Yes.

Q But you didn't have a separate interview with anybody in law enforcement?

A No. I previously -- I had appointments, but they always got cancelled.

Q By the police?

A Yes, that was about five years ago, four years

ago.

Q Did -- did you ever provide any of your medical records relating to your care before going to the gastro clinic as well as afterwards? Did you -- did you provide your medical records to the State is what I'm asking.

A Yes, I believe so.

THE WITNESS: Didn't I through my lawyer? Did they?

MR. STAUDAHER: I don't recall getting his medical records, but I can certainly look that up.

THE COURT: Okay. You didn't personally --

THE WITNESS: No.

THE COURT: -- give them to Mr. Staudaher --

THE WITNESS: No.

THE COURT: -- or Ms. Weckerly --

THE WITNESS: I'm --

THE COURT: -- but your understanding was if -- if they asked your lawyer, your lawyer would have given that?

THE WITNESS: Correct.

THE COURT: Okay.

THE WITNESS: Okay.

BY MS. STANISH:

Q As far as you were aware, the State was interested in getting those medical records?

A That would be my assumption, but I don't speak for the State.

Q Well, when you were scheduled -- were you scheduled to speak with the Metropolitan police more than once?

A I don't recall. It was many years ago.

Q Sure. Sure. All right. You, of course, provided your medical records to your attorney?

A Yes, of course.

Q Did you ultimately file any lawsuits connected to this hepatitis C issue?

A Yes.

Q And are those still pending or have you settled them?

A I still have an HMO case pending.

Q And by HMO do you mean you have a lawsuit against your insurance company and you're trying to recover money from your insurance company?

A Yes, I believe so.

Q And so that's still pending --

A Yes.

Q -- correct? And have you -- you said you have lawsuits that have settled?

A Yes.

Q And how much have you personally received in the way of settlements from those lawsuits?

A 2.58 million.

Q And can you -- were those -- was that -- those lawsuits that you settled for a total of $2.58 million, against who -- who paid you those moneys? Who was the defendant in the civil case, if you will?

A The drug company.

Q The drug manufacturer --

A Yes.

Q -- of propofol --

A Yes.

Q -- was sued? Was that Teva?

A I believe so, yes.

Q And did you receive money from the medical malpractice insurance of the clinic?

A Not that I remember. It was one of the nurse's settled.

Q Do you know how much you got from the propofol manufacturer?

A Separately from the total? No, I don't remember.

Q Was that the substantial --

A Yes.

Q -- bulk of the money you received was paid by Teva?

A Yes.

Q Are you currently working?

A I am not currently working. I just graduated recently from university. I was going full time as a student.

Q You're in Las Vegas or elsewhere?

A I started in Las Vegas and then transferred to the University of Hawaii.

Q Oh, nice. What are you studying there?

A I was double majoring in Asian studies and Korean language.

Q Where are you from originally?

A Los Angeles.

Q And let me draw your attention to your September 21st when you were at the clinic. It sounds to me like you don't have a very good recollection of what occurred. Is that a fair statement?

A Yes.

Q Let me just run you through a few things and see if you have any recollection or not. Just tell me if you -- what you recall. I don't want to put words in your mouth. A nurse put an IV in your vein; is that correct?

A I don't remember that.

Q I thought I wrote down that a female nurse put an IV in your -- into you. Do you remember that?

A I don't remember that. I do remember at a different time I've had the IV put in here and it's very painful.

Q Okay.

A So I remember that being painful. I do not remember any painful IV being put in at this clinic.

Q And you don't remember talking to the CRNA beforehand?

A No.

Q And you don't remember talking to the doctor?

A I remember briefly meeting the doctor.

Q And what do you remember about that encounter?

A Just an introduction.

Q Just to identify you?

A Yes, saying he's my doctor and he'll be doing my procedure. That's all I remember.

Q And you woke in the recovery room; correct?

A Yes.

Q And someone was -- someone at some time visited you while you were in the recovery room?

A After I got out of the bed and I went over I saw the women. They asked if I was okay and ready to go.

Q Okay. You were taken to a room where you were -- where you changed back into your street clothes?

A Yes.

Q And after you were there, were you taken to a discharge nurse who made a follow up appointment for you?

A I don't remember that.

Q Do you remember having a follow up --

A No.

Q -- appointment? Is it a matter that it didn't happen or you just don't remember?

A I don't remember.

Q Would that be in the medical records that you believe were provided to the -- to your attorney to give to the State?

A It might be.

Q All right.

MS. STANISH: Court's indulgence.

THE COURT: That's fine.

MS. STANISH: Nothing further, Your Honor.

THE COURT: All right. Mr. Santacroce.

MR. SANTACROCE: Just a couple questions, Your Honor.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Your endoscopy medical records seem to indicate that the nurse anesthetist that gave you the anesthesia was a Keith Mathahs. Do you have any reason to doubt that?

A No.

Q And this nurse that you settled with in your civil lawsuit, do you know who that was?

A I don't remember the name, no.

Q Was it an RN or a CRNA, do you know?

A I don't remember. Sorry.

Q Well, your medical records indicate that you were treated by a Linda McGreevy. Would that name ring a bell?

A That sounds somewhat familiar.

Q Or a Veronica Nelson?

A I don't --

Q Or a Keith Mathahs.

A I don't remember the names. Sorry.

Q Okay.

MR. SANTACROCE: That's all I have. Thank you.

THE COURT: Any redirect?

MS. WECKERLY: No, Your Honor. Thank you.

THE COURT: Any juror questions?

Counsel approach.

(Off-record bench conference.)

THE COURT: We have a juror question. A juror would like to know, you said that you worked the evening prior to your colonoscopy and that's why you were so tired. How were you able to tolerate the cleansing prep if you were working? How were you able to do all that?

THE WITNESS: It wasn't -- I -- if that came off as I was working the night before, I did not. I work nights and so I'm used to sleeping in. So I was very tired.

THE COURT: Okay. So you didn't work --

THE WITNESS: No.

THE COURT: -- that prior night?

THE WITNESS: There's no way. I --

THE COURT: Okay.

THE WITNESS: This is my second time getting a colonoscopy. There is no way.

THE COURT: All right. Any follow up question? That was the impression because that's what I --

THE WITNESS: I'm sorry.

THE COURT: I had that thought myself.

Any follow up from the defense?

MR. SANTACROCE: No, Your Honor.

MS. STANISH: No, Your Honor.

THE COURT: Any follow up from the State?

MS. WECKERLY: No, Your Honor. Thank you.

THE COURT: Any additional juror questions?

All right. Sir, thank you for your testimony. Please don't --

THE WITNESS: Thank you.

THE COURT: -- discuss your testimony with anyone else who may be a witness in this matter. All right. Thank you, sir, and you are excused.

And the State can call its next witness.

MR. STAUDAHER: The State calls Lawrence Preston to

the stand.

THE COURT: Sir, just right up here, please, next to me.

LAWRENCE PRESTON, STATE'S WITNESS, SWORN

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

THE WITNESS: Lawrence Preston; L-A-W-R-E-N-C-E P-R-E-S-T-O-N.

THE COURT: All right. Thank you.

Mr. Staudaher.

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Mr. Preston, what do you do for a living?

A Healthcare consultant.

Q Now, is that your business or is that what you do?

A That's my business.

Q The business name is what I was saying.

A Professional Medical Consultants, Inc.

Q Have you always had that business or have you changed businesses over time?

A I've had that business since 1991.

Q Okay. So you know an individual by the name

of Dipak Desai?

A Yes, sir.

Q Do you see him in court today?

A Yes, sir.

Q Could you point to him and describe something he's wearing for the record, please?

A He's sitting to my left with his glasses on.

MR. STAUDAHER: Record reflect the identity, Your Honor?

THE COURT: It will.

BY MR. STAUDAHER:

Q With regard to Mr. Desai or Dr. Desai, have you ever had dealings with him in the past?

A Yes.

Q When did you first have your first dealings with him?

A I'd say probably in the mid to late '80s when I was at North Las Vegas Hospital.

Q So you've had your business since 1991, but you were at another place before that?

A Correct.

Q You said North Las Vegas Hospital. In what capacity?

A I was a chief financial officer.

Q How long did you have that job?

A From '83 to '85.

Q And then after '85?

A Then went from there to Women's Hospital, Women's Hospital to University Medical Center, University Medical Center to ACI. Then in 1991 I opened my own business.

Q Okay. So as -- as far as your relationship with Dr. Desai, how did it start? I mean, how did you meet him, what were the circumstances?

A He was a physician at the hospital doing procedures, covering ER calls for any gastro needs or any procedures that would have been called on by another specialist or primary care.

Q Did you work with him at all?

A Not really. I mean, at the hospital level just as, you know, in administration to physician. That would be it.

Q So in your transmission to these other facilities, UMC and the like that you mentioned, did you have interaction with him in those instances as well?

A Not at Women's. At UMC probably, not that I really remember since I was off campus at the hospital, so I wasn't in the hospital that often.

Q So when you started your business, and you said it was professional medical consultants --

A Uh-huh.

Q -- is that right? Was it just you? Did you have employees? I mean, what kind of things did you do?

A Well, it was initially just me, and then eventually I had more employees.

Q So as a consultant, what kinds of things did you consult on at that time?

A Well, anything in medicine regarding financial, whether it was staffing, requirement staffing levels, hiring and firing people, training people for administrative functions. Basically anything non-medical, you know, from a -- from a nurse or doctor, I don't do anything as far as that goes. But there's a lot of the business aspects of it and that's what we specialize in, the business aspects of the healthcare field.

Q Would that include billing?

A Billing, yeah.ee

Q Anesthesia billing at all?

A We did, yeah.

Q Now, as far as, let's say, the financial aspect that's not related to billing. Have you ever done anything like evaluating businesses for sale, valuing businesses, anything like that?

A Yeah, we do that to this day.

Q So that's -- is all of the -- are all of those things you mentioned, are they still part of the mix of what

you do?

A We don't do billing any longer. I sold that, I think, in 2001, 2002, somewhere in that range. It's been about 10 or 11 years ago.

Q Who did you sell it to?

A To what's now HealthCare Partners, Dr. Abdou and his companies.

Q So at the time you sold it, what was the reason?

A I didn't want to deal with all of the federal legislation that was going down.

Q What do you mean by that?

A Well, in other words, they were making billing companies responsible or potentially responsible for the actions of their clients. And if you're doing a batch billing you have no clue what's going on within the structure. The patient comes out of the room, they bring a superbill to the front desk, the superbill gets marked on up, the diagnosis gets put on it, they send it over to us, we do the billing.

We're offsite, so we can only presume that whatever they're putting on the bill is what they -- they physically did. We wouldn't really know if that was true or not. But the way a lot of the cause of actions were going through with the federal guidelines, I just felt that they were trying to make the billing company, the billing personnel, more

responsible for the actions of what was on that bill. And if we didn't know, we could be culpable. And I just didn't feel that was an area I wanted to stay involved in any longer.

Q So, I mean, accuracy was important in the billing, obviously.

A Well, accuracy is critical in the billing, yeah.

Q So is it fair to say that you were concerned about somebody not being accurate and putting something down that wasn't the case and then you being held liable for that if that went through and was discovered?

A No, just I didn't trust the federal government. I mean, they can basically make any case they wanted to make and I don't know which -- which direction I would be going into. So I didn't have any real reason to doubt that the doctors were putting down the right times, the right CPT codes and stuff like that. I just didn't know how somebody outside of that would interpret that. And I wanted to stay in the healthcare consulting business. I never really wanted to be in the billing business, we were just very good at it.

Q Okay. But you said that the reason you got out was because of the liability potential; correct?

A Potential, yeah.

Q And the liability, would that have been

because you might be held liable for somebody's billing issue that they might have that you had nothing to do with?

A Correct. Well, I didn't have anything to do with it, but it was an interpretation of what I felt where the government was going.

Q Okay. I just want to be clear on this. Let's just say that --

A If you can be, it'd be the first time in 12 years I've been able to be clear on it.

Q All right. You've got a bill that comes in that you're going to -- your billing company is going to use to then bill an insurance company.

A Right.

Q So you're kind of the person that does that for the doctor, the clinic, or whatever; correct?

A Correct.

Q So that bill comes in. Do you have to assume that everything in that is accurate and done properly, from the coding to whatever is represented on that particular information that you're going to use?

A Correct. At that time that's all we had. You know, they'd generally give us the phase sheet, they would give us potentially the medical record or the doctor's notes or the nurse's notes. Then we'd have our coders kind of look at that to make sure that what was in there seemed reasonable.

If we didn't think it was reasonable, we would return it to the office.

Q And you were concerned that if there was some problem with that that you're then now going to use that information to bill with that you personally could be held liable for whatever actions took place in a doctor's office where you weren't present. Is that fair?

A Yeah, that's a simple paraphrasing of that, yeah.

Q I mean, is that fair, though?

A Well, again, you know, the laws have changed so dramatically. At the time they didn't know what they wanted. All they knew is they wanted to be able to have somebody held responsible. And in our contract it says we were not responsible for what was checked. All we were doing is just moving it from point A to point B, billing the insurance companies, billing the government whenever we do.

The government was changing at that time, and it didn't go through to full fruition, but what they were trying to do is say that we're going to hold you responsible as the person who actually hit the send button to the insurance company to the government. And the law was so vague that it could basically leave me open for anything. And I just, as an accountant by training and nature, vagueness doesn't work really well with me.

Q Related to the -- to the billing just one more -- for one more minute, related to the records that came in --

A Uh-huh.

Q -- I mean, if you had -- if you were doing the billing -- and this was before you decided to get out of it because of liability or whatever, okay.

A Right.

Q Billing comes in. Did you have various clients that you used?

A Yeah, we had 32, 33 clients at the time.

Q Okay. Was Desai or Desai's clinic one of those clients at any time?

A Yeah, way back at some point it was. I couldn't tell you when. But we had -- we had the -- we had the anesthesia billing for a couple years. Maybe shorter, maybe longer, but, you know, then they took that on in-house after that. Or maybe they gave it to another billing company. I can't really remember.

Q Would -- I mean, do you feel that it's important when you're getting those records that they actually reflect what happened, I mean, that they're accurate?

A Well, I would hope they would be accurate, yeah, because that's what you're --

Q Because you're going --

A -- trying to get reimbursed.

Q -- to use that to bill an insurance company --

A Correct.

Q -- correct, and get reimbursement?

A Right.

Q If -- if you -- I mean, have you ever been in a situation when you were doing the billing where you could just send something to the insurance company and say, you know, this is -- we think this is kind of right. There may be some problems here, but go ahead and pay us anyway. Would you ever do that?

A No.

Q I mean, if you knew something was wrong with the bill, that something was false or inaccurate, would you ever send it on to the insurance company?

A No, because that would be a false claims act and you'd be subject to that. If you -- if you knew it was false, why would you send it?

Q And that could potentially cause you some real problem if you knew it; correct?

A Yeah, I'd probably be up here myself. Yeah.

Q Well, in a different capacity; right?

A Yeah.

Q Now, let's -- let's kind of go back, and we may revisit that in a moment. But you said that Dr. Desai you knew kind of initially in some of the businesses you had --

well, business arrangements you had with like North Las Vegas and some of the hospitals and so forth.

A Uh-huh.

Q But after you became Professional Medical Consultants, what relationship, if any, did you have with Dr. Desai?

A Well, initially it was -- I think how we first got started is that one of our groups was doing a lot of referrals to his physicians and they were on the same basic campus of Valley Hospital at the time, and so it was very easy for us to send patients on over there.

And if we had problems getting patients on it, we could call up Dr. Desai or we could call up one of the other doctors and say, look, you know, we've got a patient that needs to be there stat, you know, and can you get them in today, can you get them in tomorrow, when can you get them on in? And so any -- if there was issues with patient related issues between our doctors and our patients getting into one of their offices, that's kind of how it got started.

So I was working for another client and he was the specialist. I mean, we did that with all the doctors in town for that -- for that group. Then I think the first actual encounter that they engaged and paid us for was they were having a problem with one of their administrators and wasn't sure whether she was doing a good job or bad job and asked us

to come in and do an assessment. And after the assessment they decided to let the person go.

And then it was probably two years later before he called us back and said we've got another issue. We'd like you to come in and I think we've got a problem and can you look at it and we took a look at it. And there was nothing wrong with what she was doing. It was just the protocol was -- wasn't -- you know, there was gaps. And we just closed those gaps out and she continued doing what she was doing after that.

And eventually we had the consulting agreement, then we got some billing out of it, and then we just -- they took the billing over and we left the consulting agreement in until I sold the billing company. And I think just the healthcare consulting went on for about another three to five years, something like that.

Q When did you get out of the -- out of the billing for -- for that?

A What did I get out of it?

Q When did you get out? When did you get out, meaning when did you --

A When I sold it somewhere in the 2000 to 2001, '02 range. I sold two of my companies to Dr. Abdou's companies.

Q Okay. Did you -- have -- were you still doing

this when Dr. Desai used CRNAs in the practice?

A Well, we had anesthesiologists in there originally. And I can't remember that doctor's name. Dr. -- I don't remember what his name was. But I think they had just started hiring the CRNAs, but I couldn't -- I -- I think so. I think they had just started hiring the CRNAs.

Q Because that's what the anesthesia billing you were doing for them was was for the CRNAs.

A Correct. Yeah.

Q Okay. Because you wouldn't do it for the -- an anesthesiologist per se.

A No, we could. Yeah.

Q You could.

A Yeah.

Q But for him did you?

A You know, I just don't remember that.

Q But you do remember the CRNA billing. That's at least part of it?

A Well, that must have been when it got started because I think the other doctor -- you know, actually, I don't know. I really don't remember that time frame.

Q Well, let's talk about the anesthesia billing issue. Do you recall ever having meetings with Dr. Desai about specifically anesthesia billing and CRNAs, use of CRNAs?

A Yeah. Yeah, that the CRNAs would be better

bring -- bring in the CRNAs and have full time coverage in his clinics than -- than have an anesthesiologist who is going to get there and then had his own full time practice or a practice outside of it. So if he were going to bring it in, it would make more sense to hire the CRNAs himself.

Q Do you remember a specific meeting where there were -- Dr. Desai was present, you were present, maybe anesthesia people were present regarding billing and how you would bill anesthesia services, things like that?

A Well, anesthesia services, I'm sure there was meetings on that. But anesthesia services were billed under a whole other set of guidelines. You know, most everyone bills under the CPT books, which are the books that are approved by the MA. CRNAs and anesthesiologists have their own billing set of rules, and so some of it is based on time, some of it is based on units. Contracts can -- can vary from that. That could be a combined fee, it could be a separated fee. So back then it was very, very difficult to dilute, you know, who you were billing it to. And if you had a cap rate that -- and it already included that, it really didn't matter what the time was when you were billing.

Q Well, do you remember there ever being an issue of the -- just anesthesia coverage as you're talking about with Dr. Desai and having a meeting about, you know, who could -- I mean, essentially who could get the money for the

anesthesia, meaning the anesthesiologist if they brought in an anesthesiologist, or if it was a CRNA that he could retain the money?

A Well, it's six of one, half a dozen of the other. You're going to bill it out the same way no matter which. So as far as whether or not the CRNA -- the CRNA would have to be under the physician, so the CRNA billing would be an employee of the group, and the group would then do the billing. But you can employ the anesthesiologist either as a W-2 or a 1099 and you can do the same impact. I think the initial doctor billed it on his own, but, again, I couldn't be certain that that's how it went down initially.

Q In your experience with anesthesiologists do they typically bill their own work? Meaning -- and not necessarily --

A Well --

Q -- they do the billing.

A -- there's nothing typical. I mean, you've got ten people that do and you've got three people that don't. So is that typical?

Q Well, what would the three people do that don't?

A They would bill it under the group that they were contracted to.

Q So --

A That group would bill it.

Q But it would still be them who would receive the anesthesia payments; correct?

A No, it would be the group. Either I didn't state it right or you didn't hear it right. If you have ten people who are independent and they bill it out on their own, they're billing that professional fee out and the facility is billing the facility fee out. You could have three people other -- three people who are contracting to the group and they are going to bill that as part of their fee, including their technical fee, and then they'll pay them as either a W-9 or -- or a W-2 or a 1099. So the group can bill it out or the individual can bill it out. It was legal either way. It still is to this day.

Q Well, what was the discussion about with Dr. Desai?

A I don't know. It was 15 years ago. I don't have a clue.

Q Have you had a chance to review your -- your statement?

A No.

Q Okay. Would it --

A I mean, that was --

Q -- possibly refresh --

A -- like three years ago.

Q -- your memory to review a copy of the transcript of the statement --

A If you want.

Q -- you gave to the police?

A Yeah.

Q I'm asking you.

A Well, you're asking me something that happened a long time ago about a meeting that you're not sure occurred, and I'm not sure which one we're talking about.

Q Would it refresh your memory to maybe see a copy of the transcript of an interview you did with the police where that -- that discussion was had?

A If you wish, yeah.

THE COURT: Why don't you show him the transcript.

Mr. Staudaher is going to show you a transcript. He's going to direct you to part of the transcript.

THE WITNESS: All right.

THE COURT: Read it quietly to yourself and then he'll ask you whether or not that refreshes your memory.

MR. STAUDAHER: And for counsel, it's page -- it's starting at the bottom of page 9, mostly page 10.

BY MR. STAUDAHER:

Q You can read as much before and after as you wish and take as much time as you need for context.

A Okay. So I assume you're talking specifically

about this paragraph.

Q And if you need to read some more, go ahead and do so.

A No, I --

Q Okay.

A I don't know what I cleared up. I mean, it sounds like I said that there was a meeting and at some point in time Dr. Desai asked whether or not it would be easier to bring it in or we'd keep continuing billing the anesthesiologist. It seems like we made the decision to -- our recommendation to bring the CRNAs in.

Q Okay. Did -- did that refresh your memory about the meeting that I'm talking about?

A No.

Q It doesn't?

A No.

Q Okay. So in this were you not asked a question about anesthesia billing?

A Yes.

Q That's how it started out --

A Yeah.

Q -- correct? Are you familiar with anesthesia billing times? Do you recall that?

A Correct. Yeah.

Q Okay. And I was -- and I'm just going to read

it since that --

A Yeah.

Q -- didn't refresh --

A Go ahead.

Q -- your memory. I was -- I don't know if --

MR. SANTACROCE: I'm going to object as to improper refreshing.

MR. STAUDAHER: Actually, I've asked him if --

THE COURT: Well, he's asked him --

MR. STAUDAHER: -- it refreshed. It didn't.

THE COURT: -- and now he can --

BY MR. STAUDAHER:

Q I don't know if I'm now -- but I know --

MR. STAUDAHER: Maybe I should just display it, Your Honor. Would that be easier?

THE COURT: Well --

MR. STAUDAHER: I can read it. That's fine.

THE COURT: I think you need to read it because it's not an exhibit, so technically you can't display it.

BY MR. STAUDAHER:

Q I was there when Dr. Mashood-- and it's spelled -- I don't know if that was the --

A I don't know. I think it's Mashood, but, yeah.

Q Mashood. Okay. Was the first anesthesiologist that he brought in. And you're talking about

Dr. Desai at this time --

A Correct.

Q -- correct? And there were two other anesthesiologists. I couldn't tell you their names, but I think that he used a total of three anesthesiologists. And when I was there he decided that when the anesthesiologist wanted to bill for 100 percent of -- instead of, you know, working under him, then he said, well, you know, well, then I'll just bring in CRNAs, you know, registered nurse anesthetists.

A Uh-huh.

Q Okay. So there is a discussion during a meeting with you present, correct, because you're talking about this?

A Yeah.

Q And Dr. Desai is talking about the anesthesiologist that he's working with.

A Okay.

Q That they want to bill 100 percent of their service; is that fair? I mean, that's what it says.

A It sounds reasonable.

Q Okay. And those are you words; correct?

A Sir, I do not remember the meeting.

Q I know you don't remember it.

A So, I mean, we can't -- we can't --

Q Do you have any dispute that this is --

MR. SANTACROCE: I'm going to objection, Your Honor. Counsel is arguing with the witness and not letting him finish the answer.

THE COURT: Well, he -- I thought --

Were you finished with your answer? As you --

THE WITNESS: Well, I --

THE COURT: -- sit here today --

THE WITNESS: I'm kind of --

THE COURT: -- you don't remember --

THE WITNESS: -- confused.

THE COURT: -- the meeting.

THE WITNESS: Yeah.

THE COURT: Okay.

THE WITNESS: There's -- I mean, we were meeting once or twice a week. So this could have happened over a series of months and discussions with the anesthesiologist and what he wanted to do.

THE COURT: So you don't --

THE WITNESS: I couldn't put it in a time context.

THE COURT: And that's fine. You don't remember the specific meeting. Do you recall making the statement that Mr. Staudaher --

THE WITNESS: Yeah.

THE COURT: -- has asked you about?

THE WITNESS: Correct. I think --

THE COURT: Okay.

THE WITNESS: -- it's a reasonable statement.

THE COURT: Okay.

BY MR. STAUDAHER:

Q So, again, Dr. Desai had people that he was working with that wanted to bill their own time, their own -- 100 percent of it; correct? I mean, that's what we're talking about here; right?

A Well, I think they were billing it at that time.

Q Okay. They were billing it.

A All right.

Q Does that mean if they're billing 100 percent that Dr. Desai wouldn't get any portion of that?

A That would make sense, yes.

Q Okay. And is that why you said that he, Dr. Desai said, well, I'll just bring in CRNAs?

A Yeah, that would be an option. But I don't think that's how the discussion started. The discussion started was if the CRNAs -- if the anesthesiologists, I think is what we were having a problem with, they have private practices. And if he -- they couldn't make it over the time, then they weren't going to be able to do either the procedure, or they were going to be able to do the procedure the old way

without anesthesia.

Q I get that. But I'm asking specifically about this portion of this where it's talking about who's getting paid. See, the doctors that would come in got 100 percent, correct, because they're billing their own work?

A I don't know if they were billing it or we were billing it. I mean, I don't remember that.

Q But regardless of who was billing it, who was going to get the money in that situation?

A Oh, the doctors, it was whatever their contract stated they were going to get, if they were going to get a flat fee or they were going to get the actual dollars. If you had the contracts it would be a lot easier to tell you the specifics. I don't remember the specifics that far back.

Q When you said here that the anesthesiologists wanted to bill for 100 percent --

A Right.

Q -- does that mean --

A So wanted to.

Q -- that they're going to get --

A So that means --

Q -- their money?

A -- I don't remember whether they were at the time or they were going to change it from him billing it and then they were going to bill it.

Q That's not what I'm asking you. The anesthesiologist wanted to bill 100 percent --

A Okay.

Q -- correct? I mean, that's what you said.

A I don't know.

Q I'm asking you --

MR. SANTACROCE: I'm going to object.

BY MR. STAUDAHER:

Q -- what you're --

MR. SANTACROCE: It's asked and answered.

THE WITNESS: I don't know the answer to that question because the way I phrased it in that statement that you showed me and I read in my transcript, it says they wanted to. That doesn't mean that was their ultimatum or that they did or they weren't.

BY MR. STAUDAHER:

Q Did you make this statement?

A I made the statement but it's vague at the time, and it's even more vague when you're asking a direct question.

Q So I'm going to -- I'm going to read this one more time to you and ask you if you think that that's accurate.

A You can do that again.

Q Okay. I was there --

MR. SANTACROCE: I'm going to objection, Your Honor.

BY MR. STAUDAHER:

Q -- when he decided that when the --

THE COURT: All right. Let it --

MR. SANTACROCE: It's asked and answered.

THE COURT: Okay. And then, Mr. Staudaher, you need to --

MR. STAUDAHER: I'll move on.

THE COURT: -- move on. You've tried to --

MR. STAUDAHER: But I want to make sure.

THE COURT: -- to refresh his recollection. You've read the statement. He says he doesn't remember. You can ask one more question about the statement --

MR. STAUDAHER: Can I read that portion?

THE COURT: -- and then you need to move on.

MR. STAUDAHER: Thank you.

BY MR. STAUDAHER:

Q I was there when he decided that the anesthesiologist wanted to bill for 100 percent of it instead of, you know, working under him. And then he said, well, you know, well, I'll just bring in CRNAs, you know, certified registered nurse anesthetists.

A Uh-huh.

Q Did you make that statement?

A Uh-huh. I did.

Q Now, in the context of that, the very next question --

MR. WRIGHT: We're going to move on.

BY MR. STAUDAHER:

Q -- was there any discussion about you telling him that he would have to deal with some sort of supervisory issue if he used nurse anesthetists?

A Right. Yes. I told him we'd have to call the State Board of Nursing or they'd have to call the State Board of Nursing because that's who regulates them or the State Board of Medical Examiners and get an opinion for both of them as to how we'd have to make sure that we're supervising, you know, mid-levels. That's what they're called, mid-levels.

Q In fact, the licensing was done?

A Uh-huh.

Q That he would have to be sure -- you'd have to make sure that he could supervise nurse anesthetists; correct?

A Well, with the State Board of Nursing it's actually not a supervision. I think you have to have a -- they have to approve a job responsibilities. Under a physician assistant it's absolutely a direct supervision. They can't work without being a supervising physician. Under the CRNAs it's under the State Board of Nursing, so they work in a similar capacity, but they actually don't have to be a direct supervising physician. But you have to have a contract

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saying responsibilities.

Q Did you not say in here that you have to make sure that you can supervise a nurse anesthetist?

A I said that, but, again, I'm just clarifying it for you what -- what I knew then and what I know is that it's different.

Q I'm not talking about what you know now. I'm talking about --

A Okay.

Q -- back then.

A Then I'm clarifying what I knew then, is that they will supervise them as an employee/employer relationship. But the State Board of Nursing has different criteria than the State Board of Medical Examiners.

THE COURT: Are you saying a physician's assistant is under the Medical Examiners, and the nurse anesthetists are under the State Board of Nursing --

THE WITNESS: Right.

THE COURT: -- as you understand it?

THE WITNESS: Two separate governing bodies. Yeah.

BY MR. STAUDAHER:

Q Do you say that in here at all?

A No, I don't think they asked it that way at the time.

Q Okay. Again, your statement, They have to be

registered under you and that type of thing. You either call the Board of Health, make sure that you can supervise a nurse anesthetist, and, you know, the normal things you guys would do. And you said that; correct?

A Yeah.

Q Okay. Now, with regard to billing, I mean, you did -- you did anesthesia billing at times.

A Right.

Q Back then --

A Uh-huh.

Q -- did you do anesthesia billing for Dr. Desai?

A Yes, I think we did for a few years.

Q Okay. And during the time that you were doing the anesthesia billing it was for a nurse anesthetist, correct, at least part of it.?

A I think so, yes, sir.

Q When the nurse anesthetist billed, was there any difference, meaning you got a procedure -- you know what coding is; right?

A Yes.

Q And do you know what upcoding is?

A Yes.

Q What is upcoding?

A Upcoding is where you charge a higher level of

service.

Q Upcoding -- do you know the difference between, let's say, you do a procedure that's a 1050 procedure which pays a certain amount of money. And you --

A What?

Q Let's say that there is a certain procedure that pays a certain amount of money.

A Okay.

Q And the doctor -- have you ever heard of a doctor or anybody say, you know what, but if we -- if we code it a different way we'll get more money.

A Yeah.

Q Okay. Is that considered upcoding at all?

A No.

Q So would that be okay to do?

A As long as you documented it, yeah.

Q What if it was asking to do like the use of one device when you used ancther device and they --

A No, that wouldn't --

Q -- were different?

A That wouldn't be -- that wouldn't be upcoding. That would be fraudulent billing.

Q So that wouldn't be okay.

A No.

Q Now, with regard to anesthesia billing.

A Uh-huh.

Q When you were doing -- dealing with the CRNAs, you had dealt with other people that you did anesthesia billing for, as well, doctors.

A Well, one other group, yeah.

Q So -- but you had an experience with doctors being anesthesiologists, billing for them?

A Inpatient only, yes.

Q Did you have anesthesiologists that you billed for?

A Inpatient only.

THE COURT: What does that mean, inpatient?

THE WITNESS: Hospital-based physicians, not outpatient like the clinic was outpatient.

THE COURT: All right.

BY MR. STAUDAHER:

Q Okay. Is there a difference how billing, whether it's in a facility or out of a facility for anesthesiologist, is done?

A Yeah, I think there could be, mainly the intensity of the care.

Q But the time or however you bill it, would it be different? 15 in a hospital setting versus an ambulatory care setting, would you bill it the same way?

A In general, yes, but there is, unfortunately,

where goes most -- at the problem in anesthesia billing. When does anesthesia start and when does your time eliminate? And that's one of the problems that was easy in a hospital, but was hard in an outpatient setting. In a hospital the physician had to physically stay there and couldn't leave the OR or the recovery area. And so he may have five patients or ten patients sitting in recovery that he did anesthesia with or he's covering for one of his other doctors in a group. And until that patient was discharged up to the floor, he was -- he was billing for that time.

Q So you think it would be reasonable for an anesthesiologist to have five patients lined up and to be billing anesthesia for each one of them at the same time?

A Well, if he had a good attorney, all five of those people would be suing his butt if he didn't, so yes.

Q That's not what I'm asking.

A Well, no, but that's what you are asking because he has liability until that liability is discharged to the floor, they're discharged ambulatory. So from my personal opinion, the way I always used to read the guidelines is the -- when the liability stopped is when the billing time stopped. Now, whether ASA agreed with that, American Society of Anesthesiologist, or not and they kept re, you know, adjusting their -- their interpretations of that. But, to me, when the attorney has liability or the physician has

liability, then he's got reasonable grounds to be billing for that time.

Q So let's get this straight. We've got --

A And that's my opinion, by the way.

Q -- a situation --

A Not -- I don't know if that's actually fact.

Q We've got a situation where there is a doctor who has given care to various patients in the hospital.

A Right.

Q Because you've dealt with hospital settings in the anesthesia personally; correct?

A Right.

Q And as long as that person is still in the hospital and this person has liability in some way for them --

A No, as long as he's in the recovery room, in other words, the operating theatre. Once he leaves the operating room and goes to recovery, then once he leaves the recovery room, the anesthesiologist doesn't have any more liability to him. Now it's back to the primary care doctor, the hospitalist.

Q Okay. Have you ever --

A So you have a delineation in an inpatient setting that's so clear that's not as clear in an outpatient setting.

Q Well, you just said that there would be five

patients in -- that he might have liability for.

A Right, all in the recovery area.

Q Let's -- let's talk about that for a minute. In order for there to be five patients, does that mean that he is somehow administering anesthesia at some point to all five patients at once?

A Well, anesthesia is generally over at that time. What they're doing is they're coming out of the anesthesia and they can still have side effects, they can still have, you know, conditions that require his attention. He's still monitoring vitals with the nurses. So he has -- he has reasonable assumption of care at that time until that patient is moved out of that recovery area and onto the floor.

Q Well, let's talk about that. We've got five patients lined up here.

A Uh-huh.

Q He's brought -- well, before they have five patients there had to be one to start off with, right, because he did a procedure with that person?

A Okay. Yeah.

Q Okay. So he does a procedure with this person and then he walks away to do the procedure with the next person.

A Uh-huh.

Q And during the time that he's in a room doing

a procedure with the next person, person 1 is still out in recovery.

A Right.

Q Person 2 now he walks out to recovery with, and that goes into this slot here.

A Yeah.

Q Okay. He's -- he's there. His first patient is still there, but --

A Right.

Q -- he's actually done a procedure on a second patient.

A Right.

Q Are you saying it's okay to continuously bill for that patient, that first patient --

A I would.

Q -- even though he was with another patient exclusively in an operating room?

A Yeah, because if that patient started to crash they'd pull him out of the operating room to come revive or work on that patient.

Q So you're telling me --

A So he still has liability.

Q You're saying that --

MR. SANTACROCE: Your Honor, there's too much --

BY MR. STAUDAHER:

Q -- if he was in --

MR. SANTACROCE: I'm going to object. Mr. Staudaher is interrupting every end of his answer and I can't hear his answer.

MR. STAUDAHER: I'll try to -- I'll try to refrain.

THE COURT: Okay. Just try to make sure that the witness is finished with his answer --

MR. STAUDAHER: I'm going to try --

THE COURT: -- before you --

MR. STAUDAHER: -- my best --

THE COURT: -- move -- move --

MR. STAUDAHER: I'm sorry. I did it to you.

THE COURT: Make sure the Judge is finished with her instruction before you move on to your next question. Just -- I know we all -- as lawyers we all interrupt people constantly. It's a bad lawyer habit. But let's just be mindful of the record and --

MR. SANTACROCE: I didn't hear his last answer with regard to whether it was proper.

THE WITNESS: I would say yes it was proper.

MR. STAUDAHER: Okay.

THE COURT: All right.

BY MR. STAUDAHER:

Q Let's ratchet that up. He -- we've got the two patients there --

A Right.

Q -- now. Now, he actually leaves both of those patients and he goes and takes Patient Number 3 and he does a procedure on him. That's a longer procedure.

A Uh-huh.

Q He's with that -- that person for a long time in the room. Patient 1 starts to crash. He's in the middle of a procedure with Patient 3. You're telling me that that doctor would leave the patient in the middle of an anesthetic, come out and deal with this patient over here, would abandon his patient in the room, and that would be okay?

A I would --

MR. SANTACROCE: Objection to speculation.

THE WITNESS: He's not abandoning the patient at all.

THE COURT: Yeah, don't speculate. Only if --

MR. STAUDAHER: Well, that's --

THE WITNESS: All right.

THE COURT: I mean, that's what -- what --

THE WITNESS: My interpretation would be that patient who is crashing would take priority over the patient that's under sedation in -- in that particular case in the OR.

BY MR. STAUDAHER:

Q So you think it's okay to leave a patient under anesthesia --

A I'm not a doctor. I couldn't tell you whether it's okay or not.

Q I'm asking you -- you billed for these things.

A You're asking about billing, but you're not asking about medical decision making.

Q Billing wise, that's what I would do. Whether that's an ethical decision on his part of not, it's his -- his responsibility as a physician, not mine. But does he still have time? Yes, he's still responsible. If that patient dies, your office is going to -- going to try him. So if he doesn't go out there he's in trouble. So he's got double jeopardy no matter what he does. But if -- if they were big enough, the anesthesiologist, maybe they would -- if there was five people out there, maybe they'd bring one of his partners in and they would sit in the recovery room. I don't know. I don't sit in recovery room and couldn't tell him that. But he still has liability. Under my interpretation, the liability follows the billing.

Q So patients in recovery room -- let's talk about just one patient.

A Okay. It would be easier.

Q Okay. So he's done his procedure. He's rolled the patient out. The patient is sitting in bed. Okay?

A Uh-huh.

Q He does his thing, he talks to the nurse, the

patient is in whatever condition or starts to wake up. That person then leaves. Is that when the --

A Leaves -- leaves the recovery area?

Q Leaves that recovery area for --

A Yeah.

Q -- whatever reason.

A Time ends.

Q Time ends, primary care doctor's coverage now covers him.

A Correct.

Q Okay. So he doesn't necessarily leave the facility. Maybe he goes out and has a cup of coffee down at the cafeteria.

A Right.

Q Maybe he goes up and sees patients up on the floor. But he's walked away from that patient. Time ends.

A I would agree with you there, yes.

Q Okay. That's what I'm having reconciling some trouble with. Now we talk about two patients. He's going to do a procedure on another patient. He's been with this patient.

A Uh-huh.

Q The nurse comes out. He's signed off on that patient. Now he's going to do a different patient. He's walked away. Time ends for that first patient.

A No, because he still has liability to that patient and he's still in the operating theatre. So if something happens, he's still available to help the nurses or anybody else assist with that.

Q But you just said that --

A No, you gave me a different scenario. He left the operating theatre.

Q Oh, he's got to actually leave the operating theatre?

A That's my opinion.

Q Okay. So as long as he for some reason is down in the operating theatre somewhere, he can have 100 patients that he's operated and he would be responsible --

A Well, remember, he's not the operating. He's -- he's giving the anesthesia.

Q Yes, my mistake. There could be 100 patients there that he had given an anesthetic to. He could continue to bill time for each one of those patients as long as he stayed down there?

A I would --

Q Is that what --

A -- think that's --

Q -- you say?

A -- reasonable, yes.

Q And you --

A Because he's got --

Q -- actually ran --

A -- liability.

Q -- a billing company?

A Yes, sir, I did. Very successful, too.

MR. SANTACROCE: Objection. Move to struck. The last statement is argumentative.

THE COURT: Yeah, that's getting argumentative.

Let me ask you -- let's look at this from a billing perspective. Are you aware of times -- I mean, you're billing for anesthesia groups, so you would know -- or would you know which physician it is that's doing the work?

THE WITNESS: Only based on the superbill that they gave us.

THE COURT: Okay. And then --

THE WITNESS: So it checks off the doctor, checks off the start time and the end time.

THE COURT: All right. Let's just --

THE WITNESS: Whether he started on time or ended on time, I wouldn't know.

THE COURT: Okay. So do you -- are you aware of situations where you would have billing time overlapping for a single physician?

THE WITNESS: Yes.

THE COURT: Meaning you've got Patient 1 -- I'm

hypothetically ending at 10:30, and Patient 2 beginning at 10:15 so that you would have a 15 minute overlap in the billing?

THE WITNESS: Yeah, I am aware of that.

THE COURT: But that only happened in an inpatient hospital setting because that's all you billed for for anesthesiologists who are medical doctors?

THE WITNESS: Prior to working with his -- his endoscopy center.

THE COURT: Okay.

THE WITNESS: Yeah.

THE COURT: All right. So that's clear.

THE WITNESS: Yeah.

THE COURT: All right.

BY MR. STAUDAHER:

Q So let's talk about the endoscopy center. Obviously those are procedures that get done; correct? The CRNA that you're billing for remains in the facility for the entire day.

A Uh-huh.

Q Patients come, patients go, patients have procedures, all of that.

A Right.

Q Okay. Did you see -- when the bills came in, did you see them all billed at the same rate, 31 minutes or

thereabouts?

A No, I -- I -- I couldn't tell you the percentage, but I would say there was 0 to 30 and 31 to 60 and 61 to 90. I think those were the three major times because most of those procedures were, you know, 15 to 20 minute procedures, 5 minute procedures, whatever the number was going to be, but the amount of time that they went into anesthesia then they came out of it and left it.

And at the time we were doing the billing the room was about as big as that jury box over there. I mean, there was the procedure room, there was the recovery room, and there was the ambulatory door of the patient's spouse or loved one or friend or someone that came and picked the person on up.

So the anesthesiologist, realistically, he -- he starts his procedure and he can walk on out and he can see the whole theatre right there. Now, once he grew, that changed. I mean, then he had rooms that -- I think they had to be 360 square feet and he had a clean room -- I mean, it -- it multiplied and changed more like a hospital setting because he was going for accreditation at that point in time.

But when it started off it was like an eight by ten room, an eight by twenty room, and then a door. That was it. So you could literally hear what was going on and see what was going on if you step back as the anesthesiologist. You could see everything. And, you know -- you know, if you had your

crossed eyes you could see them both at the same time.

Q Okay. So I guess it's okay to bill whatever you want as long as your cross-eyed and can see everything, is that --

MR. SANTACROCE: Objection, Your Honor.

MR. STAUDAHER: Withdrawn.

THE COURT: Well, I appreciate the humor. That's sustained.

MR. STAUDAHER: Okay.

BY MR. STAUDAHER:

Q In regard to the billing, though, when you saw those bills come in that said -- I mean, did you see them come in? They all were the same; right? They were 31, 30 minutes, 32 minutes, 33 minutes. Those were the types of bills that came in?

A Well, I think if I'm not mistaken they had a box they checked in, 0 to 30, 31 to 60, 61 to 90. I think we had two or three boxes on the bottom to bill for the CRNA. And whatever they put on there, we didn't know if it was 29 minutes or if it was 37 minutes. I think we eventually started putting a start time and an end time, but they still checked the box that it was related to. But I couldn't tell you that for a fact.

Q So when you did your billing for CRNAs and you did your billing for anesthetists -- or, excuse me,

anesthesiologists, did procedures typically have a base amount that you started with?

A 0 to 30 minutes.

Q I'm not talking about time. I'm talking about did you get a certain number of units? Do you know what units were?

A Yeah.

Q Okay. Did you get a certain number of units to start off with, meaning five units --

A It was --

Q -- ten units, whatever depending on the procedure?

A Specifically for anesthesia billing?

Q Yes.

A It was based on time and those time equated to units, and those units changed over time. I mean, in 2000 it probably was less units than it was in 1990.

Q I'm not talking --

A I don't remember that.

Q -- about the time at this point.

A But the units equated to time.

Q Okay. Did you start off with, whether you spent minute one on a patient or an hour on a patient, depending on the procedure did you get a certain number of base units to start off with just for walking in and setting

up, doing whatever?

A Yes, but I think that was based on time.

Q Yes, based on units. I'm not disputing that with you. I'm just asking you when you started a procedure was there a base number of units that you started with and then added time to that for how long you spent with a patient?

A I guess I don't understand what -- you're not understanding what I'm saying. If it --

Q Sir --

A -- may have been --

Q Sir, I'm just asking --

A 0 to 30 --

Q -- you is that --

A -- was two units.

Q -- is that accurate or not?

MR. SANTACROCE: Your Honor, objection.

THE COURT: All right. Try not to speak over.

THE WITNESS: I think 0 to 30 units was worth two -- or 0 to 30 minutes was worth a couple units. And 31 to 60 was worth four units and so forth, but it was based on your time that you got your units. That's how I remember it.

BY MR. STAUDAHER:

Q Okay. I'm going to ask this just one more time, so I hope we can get it.

A Okay.

Q You start a procedure. Whether you spend a minute or an hour with the patient, that's not what I'm concerned about. You start a procedure. Before the procedure actually begins because you're doing a specific procedure, do you get a certain number of units out of the box before you start recording time?

A I don't know.

THE COURT: Well, I think that, you know, if a -- is there a base number of units like even if the, say, procedure takes -- I don't know that there's any such procedure, but eight minutes. Would there be a minimum amount that you would --

Is that your question, that you would get or just a minimum number of units just for starting the procedure, I guess, or starting --

MR. STAUDAHER: Kind of.

THE COURT: Is that what you're asking?

MR. STAUDAHER: Let me ask it a different way.

THE COURT: Okay.

THE WITNESS: Okay.

THE COURT: Because I'm confused --

BY MR. STAUDAHER:

Q And let me give you --

THE COURT: -- about the question, obviously.

BY MR. STAUDAHER:

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Q -- a specific example.

A Okay. Thank you.

Q Let me give you a specific example related to what you did with Dr. Desai. Because the two types of procedures you mainly billed for were colonoscopies and upper endoscopies. Is that fair? That's what he did.

A Okay.

Q I mean, do you recall that at all or not?

A No.

Q Okay. On a colonoscopy or an upper endoscopy, were you aware or do you remember that there were five base units that you started with, and then every time period increment you got an additional unit for. Do you remember that?

A Again, I'm -- I'm confused. So you're agreeing that there's a start and the start is based on zero minutes?

Q Yes.

A Okay.

Q What I said was, used colonoscopy as an example, that before you actually start the procedure because you're doing a colonoscopy that you get five units to start off with.

A I don't know that.

Q But your --

that it was, you know, a road nurse or it was one of the -- it was Lynette Campbell or somebody like that that was out there who did the pre-op injections of the saline. That's been out there over and over and over again. She didn't work at the clinic in all these other times when these people got infected.

So that -- so to leave that impression that it was just this one nurse who was working during a limited window of time predating -- or during -- during a period where that person could have potentially done this when, in fact, we've got, at least from the Health District's perspective, a larger number of patients over a larger window from the practices at the clinic that they investigated and took that kind of thing into account are the -- are part and parcel to not only the statements made and the questions asked by counsel, but it goes to the impression left by this jury -- or left with this jury that, hey, we're just talking about a single nurse or a single rogue employee or something like that that was operating on those two days. And she's not even there on those two days, so --

MR. SANTACROCE: This is how you charged it. This is the evidence you've given us to defend against. You want to bring in the other 100 people, give us the evidence.

(In the presence of the jury.)

THE COURT: All right. Court is now back in

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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.

And the State may call its next witness.

MS. WECKERLY: The next witness is Lakota Quanah.

THE COURT: Now, ladies and gentlemen, I was thinking about this as I was driving to work this morning. I know these chairs are really uncomfortable and it's difficult to sit for these long periods of time. I don't know if I told you already, but if I didn't, let me tell you know. When we have the conferences at the bench or when they're getting other witnesses, if you just want to stand in place and stretch or anything like that, feel free to do that.

And, sir, come on up here, please, next to me.

LAKOTA QUANAH, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: My name is Lakota Quanah. It's L-A-K-O-T-A Q-U-A-N-A-H.

THE COURT: And, sir, you have kind of a low --

THE WITNESS: Sorry.

THE COURT: -- soft voice. That black box is the microphone.

THE WITNESS: Okay.

THE COURT: So just we can make sure all the jurors --

THE WITNESS: Sure.

THE COURT: -- can hear you.

Ms. Weckerly, go ahead.

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Good morning, sir.

A Good morning.

Q In 2007 were you living in Las Vegas?

A Yes.

Q And during like August and September of 2007 did you have a primary care doctor that you were seeing?

A I first began going to Dr. Angela Miller in 2007 in August.

Q In August of --

A Yes.

Q -- 2007?

A Uh-huh.

Q And when you were seeing Dr. Miller, did there come a point in time where the doctor suggested that you have sort of a full battery of blood tests done on yourself?

A Yes. When I first became a patient she wanted me to go in and get all the tests taken so she'd have a basis for my care.

Q And was that -- I guess was that just there was nothing wrong, it was just the result of I'm going to see a new doctor and wanted to run a battery of tests?

A Yes, and that's what she always did, she said.

Q Okay. And did your blood test -- I think you said you did them in August or was it September?

A I believe it was August.

Q Of 2007?

A Yes.

Q And did you learn the results of those blood tests?

A Yeah, I didn't have anything wrong with me. All the blood tests were negative.

Q And did those blood tests include a test for hepatitis C?

A Yes.

Q And you were negative?

A Yes.

Q Sometime after that did you go for a procedure at the Endoscopy Center of Southern Nevada?

A Yes, I did.

Q And was that on September 21, 2007?

A Yes.

Q And just without prying too much, can you just tell us why it was that you went for that procedure?

A My father had colon cancer when he was 25, and my aunt, my uncle, and my grandfather all died from colon cancer. So it was recommended that from 25 on I get tested for it.

Q And in 2007 you were how old?

A I would be 36.

Q Okay. So you would --

A 35, actually.

Q You would be younger than the risk group, but because of your family history --

A Yes.

Q -- you were sent for the -- the procedure?

A Yes.

Q And did you go for the procedure on the 21st?

A Yes, I did.

Q Do you recall if you had an appointment with the medical offices associated -- associated with the clinic before going for the procedure?

A I went to my primary care physician and met with a Dr. Baker who suggested that I go over to the clinic.

Q Okay. And you go on the 21st?

A Yes.

Q Did you have to do kind of a prep and drink stuff to --

A Yeah, I took -- I did all that stuff --

Q Okay.

A -- the night before, yes.

Q I'm sure that was a lot of fun.

A Yes.

THE COURT: Fun memories there.

BY MS. WECKERLY:

Q Yeah. When you get there on the 21st, do you recall if your appointment was in the morning or the afternoon?

A It was in the morning. I wanted to get it done as quick as possible.

Q Okay. And when you got there in the morning, do you have any recollection of what the waiting room looked like at all?

A It was very crowded, hard to find a seat. I figured there must be many doctors if there were that many people.

Q Did you go up to the -- the sort of check-in area and give your name and your insurance and all of that?

A Yes.

Q What was your -- did you have insurance at that time?

A Yes, I did.

Q And was that through your work?

A That was through my work, yes.

Q So did you have to do -- give a co-pay or anything like that? Do you remember?

A I'm sure I did, I always had to, but I don't remember.

Q Okay. So then I assume you take a seat somewhere in that waiting room?

A Yes.

Q Do you recall how long you had to wait before they called your name?

A No, I don't.

Q At some point they do, obviously.

A Yes.

Q And explain what happens after they call your name.

A I went in, got in my gown, and went to the waiting area.

Q And so you change out of your regular clothes --

A Yes.

Q -- and into a gown?

A Yes.

Q Do you remember what you did with your clothing?

A No. I'm sure I put it in a locker. I've been to many doctors and had to put on many gowns.

Q Okay. So you go to the waiting area. And describe what that looked like.

A My main thing that I remember about the waiting area is that I was waiting next to a woman in a gown, and I thought that it was very strange that we were all in there together.

Q Okay. So everybody, all the patients --

A Yes.

Q -- were sort of in their gowns. Were you sitting -- sitting in chairs?

A Yes.

Q And did a nurse do anything with you that you recall at that time?

A I recall meeting the nurse and she came over to prep me, but I don't recall if I got an IV or -- or, you know, whatever she put in my arm.

Q Okay.

A I don't recall.

Q Okay. But you recall meeting a nurse.

A Yes.

Q And do you recall if the nurse was male or female?

A Female.

Q And at some point after you had the contact with the nurse I assume you're brought back for your

procedure?

A Yes.

Q And how did -- how did that work logistically? Did they just have you walk to the procedure room or do you remember?

A I don't remember.

Q Okay. So you get to the procedure room.

A Uh-huh.

Q And describe what happens there.

A I briefly met the doctor and just was given the anesthetic and went to sleep.

Q Do you recall who the doctor was?

A Dr. Desai.

Q Okay. And do you recognize Dr. Desai here today?

A Yes.

Q And can you point to him and describe --

A Yes, he's --

Q -- what he's wearing?

A -- right over there.

MS. WECKERLY: May the record reflect identification of Defendant Desai?

THE COURT: It will.

BY MS. WECKERLY:

Q Did the person giving you anesthesia introduce

themselves or talk to you at all?

A I don't remember.

Q You don't recall?

A Yeah.

Q Okay. So you get into the procedure room and is it fair that you don't remember too much after meeting Dr. Desai?

A Right. I just -- for me, I worked nights so I was very tired, so I just relaxed and went to sleep.

Q Okay. You know you got anesthesia --

A Yes.

Q -- though?

A Yes.

Q Okay. What was the next thing you were aware of? Could you tell where you were?

A I was in the recovery room and I was pretty awake pretty fast and got up.

Q What did the recovery room look like? What were --

A Just white walls. That's all I remember.

Q Okay. And did you kind of wake up and feel like you were pretty alert?

A Yes.

Q Was any nurse around you? Did anyone come up --

A I remember talking to somebody and they asked me if I was already ready to go. They said I could rest longer, but I was fine to go.

Q Do you remember if that person that you talked to was the same one who gave you your anesthesia or anything?

A I don't think so, but I don't remember clearly.

Q Okay. You don't think it's the same person, but --

A I don't think so.

Q -- you're not sure?

A Yeah.

Q How about Dr. Desai? Did you see him at all --

A No.

Q -- after you woke up?

A I didn't see anyone else.

Q Whoever it was asked you if you were ready to go?

A Uh-huh.

Q Is that yes?

A Yes.

Q Sorry. We just --

A Sorry.

Q -- have to say --

A Yes.

Q -- yes or no for the record. So you got up and I assume you got dressed or --

A Yes.

Q And what happened after you got dressed?

A I went down to the waiting room. My friend picked me up and took me home.

Q Okay. Did anyone ever go over your results with you?

A Not that I remember on that day.

Q Okay so you -- you had someone to drive you home?

A Yes.

Q And sometime -- sometime after that did you ever start not feeling well?

A Later in that year I was at my mother's house on vacation and I suddenly got sick to my stomach and felt like I had a fever and it was very unexpected.

Q Okay. Do you recall just approximately how long after your procedure it was that you -- that you felt sick?

A I don't remember.

Q Okay.

A Yes.

Q Was it within the same year, though?

A Yes, I believe so.

Q And your procedure was in September?

A Right.

Q So it was sometime before the new year?

A Uh-huh.

Q Is that yes?

A Yes.

Q Okay.

A Sorry.

THE COURT: It's all taped. That's why you have to say yes or no.

THE WITNESS: I know. I'm sorry.

BY MS. WECKERLY:

Q Yeah, I'm not picking on you.

A No, I know.

Q So describe what the symptoms were that you felt the day you got sick.

A Just fever, sick to my stomach, just needed to lay down desperately.

Q Did you feel nauseated?

A Yes, I did.

Q So was it kind of like a stomach flu feeling?

A I thought maybe I had eaten something that wasn't good or that I had the stomach flu, but I didn't -- didn't vomit. I had not other problems. I just needed to lay

down the whole day.

Q How long did that -- those symptoms last for you?

A I felt horrible for one full day and then I was better the next day. So it was kind of sudden. I've never had a stomach flu or a food poisoning that only lasted a day like that.

Q Did you go to the doctor at all?

A No.

Q Sometime after that did you get a notification letter from the -- from the Health District?

A In the spring I did, yes.

Q And so this is now the spring of 2008?

A 2008, yes.

Q Based on that letter did you go into the Health District?

A I did. I had an appointment.

Q And did they ask for a blood sample?

A Yes, they did.

Q And this was related to a possible hepatitis C outbreak?

A Yes.

Q After you gave your blood sample to the Health District did you ever learn those results?

A Yes, I did. I learned the results. Actually,

I remember I was in my Chinese class and I got called out of class and found out my results.

Q By phone?

A By phone.

Q So were you at a class at like UNLV or something?

A Yes, I had just gone back to school in the spring.

Q And did you -- you had like a cell phone, I assume, and --

A Yes.

Q -- you got a call?

A Yes.

Q And so you were told the results.

A Uh-huh.

Q Is that yes?

A Yes, I did.

Q And when you heard the results, what did you do?

A Well, I actually had an appointment already to go to the Health District that day to get my health card renewed and make an appointment to talk to somebody.

Q Okay. And your health card, that would have been like through work or something like that?

A Yes.

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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 14

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A Yeah, I noticed other issues, yes.

Q So of all of the times we're talking about -- and you know there's some -- there's also two different computer-generated strip times, one for the room and one for the recovery area?

A Okay.

Q Is that right?

A Yes.

Q Did those match up with the other times that were on the charts?

A That I didn't assess.

Q Okay. So you didn't assess everything, then?

A No, not -- that -- that particular point I -- I don't mean -- excuse me, recall assessing that.

Q So if we look back up here with you, you had Mr. Rubino, who has been delineated as the source patient, and then a patient immediately after that who is hepatitis C positive, and then the one after that is Rodolfo Meana?

A So this is that same room, one next and one after, right after it, right?

Q Well, let's look at it. If we slide across to, and I think you said that the -- which one was the -- the physician time -- well, if we look at -- let's just look at all the times. If we start off over here, we'll look at the anesthesia records and it says time starts between 9:45 and

goes to 11:03; do you see that?

A Yes.

Q 9:45 to 10:17, 10:00 to 10:33, 10:30 to 11 -- it looks like 11:03, and that's the anesthesia record, okay?

A Okay.

Q Unbroken between those, correct? As a matter of fact, there's overlap.

A Is there -- those are the anesthesia times?

Q Anesthesia records. Okay. Now let's move across to this one, which is the nursing log time; do you see that?

A Yes.

Q 9:49 to 10:00, 10:05 to 10:16, 10:24 to 10:35; do you see that?

A Okay.

Q Also appears to be sequential, correct?

A Yes.

Q Move across to the next one -- oh, and by the way, those times calculated are each 11 minutes for those three times; do you see that?

A Yes.

Q If we come across here and the physician at bedside time and discharge time, let's -- we don't -- that's not really that important for the procedure, so let's go across here to the tape times that are in the rooms on those

days. So this is the one that's actually recorded on the machine, and this one, I think, is the -- where it's talking about the procedure start time, procedure end time. So there's two different tape times we're looking at. A monitor read tape and a tape time. So we've got two separate time -- time frames, okay?

10:01 to 10:15 -- or 10:16, 10:18 to 10:33, 10:36 to 10:51; do you see that?

A Yes.

Q Move across here and this one is the monitor read tape. 9:49 -- this is the one that's in the procedure room. The other one was in the recovery room.

A Okay.

Q In the procedure room, 9:49 to 10:00, 10:05 to 10:16, 10:24 to 10:35; do you see that? Do you see that?

A Okay.

Q Okay? So now, the report time which is the one that you said that you went off of. Let's go over here to this one. 9:50 to 10:00; do you see that?

A Yes.

Q 10:54 to 10:16; do you see that?

A 10:04 to 10:16.

Q 10:04 -- I'm sorry. 10:04 to 10:16?

A Yes.

Q 10:22 to 10:36.

A Okay. So which -- what are these times -- these particular times?

Q These are the ones that you used which came off the physician's report.

A Is the -- the one I'm -- right above your finger now, is that the stamped time that the doctor finished their procedure right there?

Q The start time is in -- is in this column here, and the end time is over here. So if you look at the start times, 10:50, 10:04, 10:22 for the procedures in that room.

A Okay.

Q Okay? And if we look at the amount of time according to the procedure record in those rooms, it was 10 minutes, 12 minutes, 14 minutes, correct?

A Okay.

Q And that indicate -- that was what you indicated would be normal times, roughly, for some of these procedures; is that right?

A Right.

Q And if we look back and see what kind of procedures, they were they're all colonoscopies, fair?

A Fair.

Q So would a 10-minute, a 12-minute, and a 14-minute window for colonoscopies be reasonable?

A Yes.

Q And that includes, like you said, 30 seconds to a minute turnover between the rooms?

A Right.

Q Within that window of time, we've got that anesthesia record where Keith Mathahs is in the other room. So can you explain that based on your perception, your knowledge of what happened on that day?

A No. I -- my best assessment of what you just showed me is that one of them is wrong. They had to -- one of them was there and one wasn't, and I don't know if when the report was made that someone didn't change Mr. Lakeman's name, or if Mr. Lakeman was truly there.

Q Well, clearly he couldn't have been physically in two rooms at the same time.

A Absolutely true.

Q Unless he was doing two patients at the same time.

A Right.

Q So that's a possibility. The other -- is the other possibility that none of these times are even remotely accurate? You can't rely upon them in that way?

A It's -- that's possible.

Q Now, we know that they're ordered in different rooms because you found the date glitch, right?

A Right.

Q So we know that one person is in one room and one's in another room during --

A Yes.

Q -- that time. So clearly, if we have Ronald Lake -- or, excuse me, Keith Mathahs -- I'll go to it, Keith Mathahs, right here, in the second room in that time frame between 10 -- well, however you put it, it's 10 -- between 10 -- around 10:30, 10:15 --

A Right.

Q -- somewhere in there, correct?

A I see it.

Q Regardless of what time you look at it, it's within that window. And you even said that the times between rooms were not necessarily in synch, correct?

A Right. Sometimes the times between the rooms -- the two computers in each room may not have been perfectly synched. They weren't synched.

Q So we add that layer of inconsistency between rooms.

A Okay.

Q So is it fair to say that based on the records -- and I -- and I can show you the -- I showed you the one that was redacted, but I'll -- I've got the one that's not. I can walk up there and show you the actual record itself. Is there any indication to you -- or any explanation that you can

have that during that window of time that Keith Mathahs didn't travel from the -- your room, the one you were in, to a -- the other room?

Do you have any way of -- of showing that he didn't do that --

A Oh, do I --

Q -- based on the record?

A -- do I have any way of proving to you that he didn't --

Q No, you don't have to prove it. I'm just saying do you have --

A -- showing?

Q -- an explanation for it or showing it based on your review of the records?

A I -- if I can -- if I can understand your question, you can show me the record. Just reiterate the question again.

Q Does it appear during the window of time that you are exclusively with Keith Mathahs --

A Okay.

Q -- that in fact, he was in another room doing a procedure?

A While I'm doing --

Q On that patient?

A While I'm doing the procedure with Keith, is

there any evidence -- anything -- any evidence that he's in a different room?

Q No. I said, does this record that we're looking at and we're relying on for your opinion, does that not show that while he's in the room with you -- the records you're relying on -- during that three-patient window --

A Yes.

Q -- that he was, in fact, in another room during that time period, doing a procedure on another patient? That's what the record shows, does it not?

MR. SANTACROCE: I'm going to object. That misstates what the record shows. That's an --

THE COURT: Well, he can --

MR. SANTACROCE: -- that's an opinion Mr. Staudaher is proffering.

MR. STAUDAHER: Well, I'm going to show him the record right here again.

THE COURT: All right. And obviously if he disagrees with that characterization of the record, the witness can say that's --

BY MR. STAUDAHER:

Q Then let's look at the original.

A Okay.

Q So you've got a good -- good view of this.

MR. SANTACROCE: What are you referring to?

MR. STAUDAHER: The file number --

THE COURT: We're still on Patient 18?

MR. STAUDAHER: Yes, it's 47R is the actual, real patient file.

MR. SANTACROCE: Can you give me the Bates stamp?

MR. STAUDAHER: There is no Bates stamp --

MR. SANTACROCE: Okay.

MR. STAUDAHER: -- on the real.

THE COURT: Hey. Hey, it's K. What's -- Bates stamp number --

MR. WRIGHT: I can't hear.

THE COURT: -- are you looking at?

MR. STAUDAHER: We're looking at Bates Stamp No. 3259, Your Honor.

BY MR. STAUDAHER:

Q So before -- we've got the original document here --

A Yes.

Q -- correct? So look at the people that are in that room at that time.

A Okay. I'm looking at the providers in the room --

Q Okay.

A -- with you, right now?

Q Yes.

A Okay.

Q Read them off.

A Dipak Desai, Linda McGreevy, Ronald Lakeman.

Q Ronald Lakeman, according to that record, right?

A Right.

Q Okay. Now, go to the time stamp the next page, which is the following Bates No. 3260, and tell me what the time range is from when the time was first off, logged in, and now this is a different room than you're in, correct? This is -- and look at the date stamp so you can tell that it's a different room.

A So there's a -- there's a date stamp of August 21, 2007.

Q Okay.

A At 10:24 in the morning.

Q And that would have been the different --

A And the --

Q -- room --

A -- that would have been the --

Q -- than you were?

A -- right.

MR. SANTACROCE: I'm going to object.

MR. WRIGHT: I can't --

MR. SANTACROCE: He's saying August 21st?

MR. STAUDAHER: Yes, because the data glitch.

MR. WRIGHT: That's the glitch.

BY MR. STAUDAHER:

Q That's how we know that it was in a different room, correct?

A Yeah, that's so we can separate the rooms out.

Q Okay. So what is the time range again?

A Well, it's -- the dates that this report is initiated at 10:13 in the morning.

Q Okay.

A Whatever that means. That means the note gets ready to be operated.

Q But the doctor does that or does the nurse?

A No, somebody else does that.

Q Okay.

A The nurse does -- the doctor doesn't do that. So the -- the note gets ready at this time --

Q Okay.

A -- by someone. And it -- that means that information is being put in and the computer records that at 10:13.

Q Okay.

A And the computer records, again, the mistake, August 21st --

Q Okay.

A -- and records that it's signed on -- at

10:24:01.

Q So we know the procedure is done because the doctors over there have signed --

A Would be clicking it and that's it.

Q Okay. So the doctor was in the room and he finished with the procedure at 10:24?

A And he's doing -- and so the notice -- the note is done and clicked by 10:24.

Q Okay. So we know that whoever -- according to the record that you're talking about, it looks as though Ronald Lakeman is in that room, right?

A Right. But if you look at this record, then you say Ronald Lakeman did this procedure.

Q Correct. Okay. If we go to the anesthesia record though, for the same day, same time period -- well, we know the time is fabricated, but it -- but 10:15 to 10:47, at least according to the time period, so same general window, in the ballpark.

MR. SANTACROCE: I'm going to object. Misstates the --

THE COURT: Yeah.

MR. SANTACROCE: -- testimony.

THE COURT: That's --

MR. SANTACROCE: Or the evidence.

THE COURT: -- that's sustained as to the term. You

could -- I think the time is incorrect.

MR. STAUDAHER: The time is incorrect.

THE COURT: Is that -- was that the basis of your objection?

MR. SANTACROCE: I believe the testimony is that the start time was correct; the end time was incorrect.

MR. STAUDAHER: I don't think he -- well, let him say that.

MR. SANTACROCE: Well, he has said it. Over the last three days.

THE COURT: Okay.

MR. STAUDAHER: Well, I'm asking and he's got a --

THE COURT: Okay. Enough. Enough. Again, he's -- the witness, if he disagrees with the question or the premise he can say --

THE WITNESS: Would you like me to explain this again to everybody?

BY MR. STAUDAHER:

Q Go ahead.

A So when it says note initiated, right here, that means that on this date and at this time someone -- not the doctor -- someone is getting the note ready to be populated.

Q Would that be a nurse?

A Yes, it would be a nurse or a -- I -- my recollection it was a nurse who did that, not the technician.

Q Okay. So the nurse would put in the information about --

A Patient's name --

Q -- people and --

A -- who is there. And as soon as that process starts, as soon as that first click starts, the computer is recording that it -- that's occurring.

Q So whoever is putting that in on that day records that Ronald Lakeman is the CRNA?

A That's right.

Q But when we look at the actual anesthesia record for that day, who was the anesthesia person?

A It seems to be Keith Mathahs because of that signature.

Q And during this window of time, however you dice it, going through the three patients successively that were in your room with Keith Mathahs at that time, it appears as though he's in two places at once?

A Right. So now I understand what you're saying. Yeah, it appears that this separate room has Keith in it when he's really supposed to be with me on the other side.

Q Correct, that's what the records show.

A How -- are you saying can you explain that? No.

Q But do we at least have him -- you know he was with you?

A Right now it would be -- it would be helpful because I left after Mr. Rubino, where this guy is -- where this patient is.

Q That patient is right here.

A No. 43?

Q No, number -- well, 43 is the number in sequence, but 18 is the patient's number that's been designated Keith Mathahs; do you see that?

A Right.

Q And the ones we were going over were these three up here within the same time window.

A So in the same time window as these three, this one appears to have Keith there, suggesting he was in two places at once.

Q If these times are accurate.

A If that is accurate.

Q So since you have independent memory of that day, do you recall a delay or something happening which would have allowed him to leave if he left at the end of a procedure and before beginning the next procedure?

A I don't recall any delays. Everything went very smoothly. I left and things were still continuing.

Q But if we look at the records --

A Yes.

Q -- and these times obviously come right off

these records, correct? So if we look at the records, it appears as though Keith Mathahs remained in your room for that entire window between about 10:17 --

A Right.

Q -- and --

A Because he had --

Q -- or 9:45 --

A -- one, two --

Q -- to about 11:00.

A -- three, Mathahs, Mathahs, Mathahs.

Q Right.

A Right there.

Q Right.

A And -- and then there's a problem because he's here --

Q Correct.

A -- at the same time. Do I have an explanation? No.

Q So at least --

THE COURT: Does the -- I'm sorry.

BY MR. STAUDAHER:

Q -- according to the records he had to have gone from one place to another with you, and then he shows up in the second room.

A Where you at? If -- according to the records

that -- he did -- he did the procedure because he signed the anesthesia, but I don't know.

Q Does that alter the premise of your belief in any of what you've said before? Basing your analysis on everything you looked at?

A Well, you know, I still don't know how -- it doesn't alter it very much because I don't -- still don't know how it skipped so many people.

Q Did you not say that at one point you even actually yourself, with Linda Hubbard, witnessed her pooling propofol?

A She -- like I told you, I witnessed her not finish the bottle, suction out the remainder of that bottle and throw it away, and then suction out -- start to suction a new bottle in a sort of sequence.

Q So she mixed bottles --

A Yes.

Q -- essentially? Okay. Did you ever see any of the anesthetists ever take a bottle that was partially open and set it on the counter and not use that one right away, and possibly use it for another patient later on?

A That I've never seen.

Q Okay. Did you even look and notice that?

A No.

Q If that had happened, would that be a way -- a

bottle that's contaminated, doesn't get used necessarily for the next patient --

MR. SANTACROCE: Your Honor, I'm going to object.

BY MR. STAUDAHER:

Q -- it's used for the next one after that.

MR. SANTACROCE: It's an improper hypothetical. He said he's never seen that happen.

THE COURT: Well, overruled.

BY MR. STAUDAHER:

Q Would that be a way?

A So -- so what you're saying is that, is it possible that if someone was storing unused bottles of propofol and could then, some other time in the future, coming back to these and putting them together to give to a patient, could that be a problem? Yes, that could be a problem.

Q I mean, because it's -- I'm talking about, like, the pooling that you saw. Partial remnant bottle gets set aside. New patient with a new bottle, later on there's a couple of bottles, they pool it up, give it to a patient, reinoculate the next patient?

A So that -- that, you know, that statement right there, collecting up some bottles and then pooling them all together to give to a patient, that I've never observed.

Q Well, did you ever see at the end of the day when -- at -- during the time that you were in the clinic --

all the times you were in the clinic, did you ever see any of your staff gathering up remnant bottles of propofol and walking around and trying to get the CRNAs to use them?

A I never saw that.

Q Would that surprise you if that occurred?

A Yes.

Q Now, with regard to -- well, one second. You were asked some questions about exit surveys; do you remember that?

A Yes.

Q Do you recall giving a deposition in January of -- I think it was January of '12 where you went in and were asked -- or you were asked questions about that very thing, about patient satisfaction surveys, things along those lines?

A Oh, I -- very vaguely, so you have to remind me.

Q January 26th of 2012?

A Okay.

Q Do you remember having some -- telling -- in a deposition talking about sitting down with somebody from an insurance company about how well you guys were doing?

A Oh, yes, but that was --

Q Now, beforehand, you had said that there was -- I think when AAAHC and this other organization, what was it, the Quality --

A Quality Consultants?

Q -- they came by, there were two people, they were there for a couple of days looking at the clinic and then they left and generated a report; is that right?

MR. WRIGHT: Object to this testimony --

THE COURT: Overruled.

MR. WRIGHT: -- of the prosecutor.

BY MR. STAUDAHER:

Q Is that what you said happened?

A Can you repeat that?

THE COURT: Is that your testimony?

THE WITNESS: If you could just repeat it.

BY MR. STAUDAHER:

Q That those two different organizations each had a -- two people that came on those -- but different -- separated at different times --

MR. WRIGHT: What pages in the deposition?

MR. STAUDAHER: The page is in the deposition, but I haven't referred to yet, are pages --

MR. WRIGHT: Well, that's what I thought you were talking about.

MR. STAUDAHER: No, I'm ask -- I'm setting it up to ask him the question.

THE COURT: So are you talking about his testimony here in trial?

MR. STAUDAHER: Here in court, yes.

THE COURT: Okay. So you're talking about his testimony the other day about the two reviewing agencies that sent people on different days to over -- or look -- observe is the word --

THE WITNESS: Right.

MR. STAUDAHER: And just for --

THE COURT: -- the practices in the clinic. Is that what you're talking about --

MR. STAUDAHER: Yes.

THE COURT: -- Mr. Staudaher?

MR. STAUDAHER: Correct.

THE COURT: Right. Doctor, do you understand that's what he's talking about now?

THE WITNESS: Yes.

THE COURT: Okay. Ask your question.

MR. STAUDAHER: And for counsel the -- the deposition pages are 459 to 474 of the videotaped deposition of Dr. Carrol on January 26th of 2012.

BY MR. STAUDAHER:

Q When you said those individuals came in from the two different agencies to look, you said there were two people that came in for -- from each one?

A That's -- yes.

MR. WRIGHT: Objection.

THE COURT: Basis?

MR. WRIGHT: He's repeating again --

MR. STAUDAHER: I'm trying to make sure --

MR. WRIGHT: -- the same thing you already --

MR. STAUDAHER: -- we're at the same place.

MR. WRIGHT: -- straightened out.

THE COURT: All right. I think we know where we are. So ask the question.

BY MR. STAUDAHER:

Q How many days were they there?

A Which ones?

Q Well, let's talk about the -- the very first one that I think you mentioned was the AAAHC.

A Again, to the best of my recollection, they were there, I think, for three or four days.

Q Okay. And then -- and you knew they were coming, right?

A Yes.

Q Long in advance?

A Yes.

Q And as far as the other entity, the Quality Care Consultants?

A Yes.

Q How long were they there?

A I believe they were there for about two days.

Q And you guys also knew they were coming,

correct?

A I didn't know.

Q You didn't know but --

A I personally had --

Q -- the practice did, right?

A I don't know if the practice knew. I certainly didn't know.

Q They just don't -- this isn't an organization that just drops in on doctor's offices and inspects them --

A No.

Q -- does it?

A No.

Q It had to be arranged in some way?

A Yes.

Q So when we look at the patient satisfaction surveys that you were asked about, those are basically from patients who have gone to your clinic?

A Well, you just mentioned very briefly the -- the patient surveys that I was asked about on the deposition. I want to be clear.

Q Okay.

A Because you just mentioned something about going to a meeting and talking about how everyone was doing. That was different. If I have -- if I have you right.

Q Sure.

A That was totally and completely and utterly different. What we're talking about are two things. One is a survey that the patients who have endoscopy fill out at the end of the procedure or take home and mail back to us, but I think what you just talked about was a quality measurement by Health Plan of Nevada with whom I met to talk about every -- how everyone was doing.

Q Yes, that's true.

A That's different.

Q I know they're different.

A Okay.

Q So don't let -- I'm glad you mentioned that. So the one is the patient's assessment, not necessarily them coming in and doing a quality assessment of your practice, correct?

A Yes, they're both quality assessment -- they're both patient assessments.

Q So the one is by people just observing. The patients are the ones that are sending in these questionnaires, basically about their experience with you?

A So both of them that you -- we just talked about. Both of them are patient-generated. One is generated by our own patients who are filling out a survey. Here you go. Fill this out. Tell us how we're doing. It has all sorts of assessments. How did you -- how were you treated, et

cetera.

The other one is -- is a review of patient-generated reviews for Health Plan of Nevada patients who had been seen in the clinic, and I'm being asked to take a meeting about those results.

Q So one --

THE COURT: So one survey is something that your office generates to the patients as they're leaving and then they fill it out --

THE WITNESS: Yes.

THE COURT: -- there or mail it in. The other one is Health Plan of Nevada generates the surveys to their own patients of -- patients of theirs that they referred to your clinic?

THE WITNESS: That's correct.

THE COURT: Okay.

BY MR. STAUDAHER:

Q So when you have a patient who -- or when you got the reports from the AAAHC and Quality Care Consultants, they were basing that in part off looking at satisfaction surveys and so forth that you had in your records?

A Well, honestly I don't know if that was part of the assessment.

Q Well, is that --

A I don't know.

Q -- isn't that what you just said, it was based on those that were generated --

A No. No. No.

Q -- by you?

A No. So when you say -- where AAAHC assessments, did they include looking at our own generated survey results, I don't know. I don't think so, but I don't know.

Q Okay. The ones that -- where you sat down and had the meeting with --

A That's Health Plan of Nevada.

Q Okay. Which ones were they looking at?

A They were looking at their own that they send out to all their participants. They may do it for orthopedics, neurology, et cetera. They did it for our group too, over time. Those are sent back to Health Plan of Nevada. We never generated those.

Q Okay.

A And on that -- I was asked by Dr. Coffman to come in to talk about those results.

Q And why were you asked to come in and talk about this?

A Why did he ask me? Or generally?

Q In general.

A In general, to go over results and to -- and to assess -- and to critique our performance and to make

improvements.

Q When you looked at your results, were you surprised? Your results, were you surprised?

A I was surprised because --

MR. WRIGHT: Objection. Can we approach the bench?

THE COURT: Yeah.

(Off-record bench conference.)

THE COURT: Doctor, I just am going to interject a juror question based on what Mr. Staudaher had just previously covered about the, you know, these ranking agencies, or these reporting companies that came in and gave high marks. And you already said you -- the clinic got advance notice, correct?

THE WITNESS: Yes.

THE COURT: And that was -- two jurors had asked about that. And a follow-up to that was, at the time of the inspection do you know if the patient load was less, or if the patient load on those days was the same that it was on, you know, the prior day, 60-plus, you know, 70-plus patients?

THE WITNESS: I don't remember --

THE COURT: Okay.

THE WITNESS: -- if they were reduced.

THE COURT: All right. Go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q Related to those exit surveys that you went over and were questioned about --

A At Health --

Q -- do you recall that?

A -- Plan Nevada. Okay.

Q Did any of those have to do with wait times for patients; for example, how long they had to wait in the facility?

A Yes.

Q Did any of them have to do with anything related to how fast the procedures were or how abrupt the staff was or anything like that?

A No. To my recollection they were about how long did you have to wait? Was the professional nice to you? Did the professional explain things to you? Again, I can't recall every question, but those are the tenor of the questions.

Q You said that you -- and I'm almost done. You said that you had no concerns for patient safety; is that correct? Regarding what was happening in the clinic.

A Right. What I said was I never saw anything that was a concern for a patient -- individual patient's safety.

Q Counsel asked you the -- the decrease that you were instituting was done purely for the comfort of the patients and the staff?

A Yes.

Q Is that correct?

A Yes.

Q I just want to be clear, are you saying that rushing patients through at the level that you were going that you felt was unsustainable, that that didn't compromise, potentially, patient care at all?

A Well, my issues and why I did it and why I reduced the number of cases, was I believed that the -- there's too much stress on the patients, especially the patients toward the end of -- the end of the day, and toward the later afternoon. Waiting too long, and the preparations not being as good. Patients with diabetes not eating. Staff working hard and then into 4:00, 5:00, 6:00.

I thought that that was too much, and I wanted to make it more spread out so patients felt that they weren't waiting so long, and to have fewer patients so it didn't extend so late into the day.

Q Okay. On the issue of extension of time or patients waiting in the waiting room and being unhappy, I'm talking about the sheer volume of patients rolling through room after room after room, day in, day out. Do you -- did you -- you didn't have any problem with the level that you guys were at with regard to that?

A Well, I had a problem with the level. That's why I reduced it.

Q Okay. But you said the reason, just a moment

ago, that you reduced it was because you wanted to eliminate wait times for patients in the waiting room?

A Yes, it was uncomfortable for them.

Q That's not what I -- I'm going to put it -- put that aside. What I'm focused on is the patients in the room.

A Okay. In the room? Okay.

Q Okay. So we're doing 35 -- 30-35 patients a day each room, correct?

A Sometimes. 30 to -- remember the average is around 53, I think, that I said.

Q That's what you said.

A Right. So --

Q Okay.

A -- so about -- let's say 30 to -- 30 patients a day in each room, okay?

Q Okay.

A That's fair.

Q And you thought that was a completely safe number of patients to do?

A I thought it was safe. I just -- I didn't think it was comfortable. I never rushed to go through a patient just because there were patients waiting, ever.

Q When you were doing patients that quickly, that many, are -- did you -- do you at least agree that it would cause stress on your staff?

A Yes.

Q Was it difficult for your staff to keep up?

A Well, the staff -- yes, it was difficult for the staff to keep up, they -- so they -- we -- sometimes we had delays and we had to wait. Things happened that we'd have to wait for patients to get ready. So it was hard to keep up, yes.

Q If the staff is having a hard time keeping up with the volume and the load day in and day out, is that not a recipe for disaster? I mean, mistakes to be made by the staff?

A No, I -- so it's hard to say it's a recipe for disaster. It's stressful. And that's why I wanted to reduce it. To say -- I can't say to you it's a recipe for disaster.

Q But to this day you don't think that anything was wrong with the levels you were at?

A In terms of -- like we -- like you asked me --

Q For patients --

A -- for the patient in the room, right then and there in front of me, the patient about to have a procedure by me, is there -- is that patient in danger, no?

Q With regard to the level, then -- at what level -- I mean, because you know that there's a fixed amount of time in the day --

A Yes.

Q -- fair? And there's a fixed amount of physical time that it takes to deal with these patients, even as efficient as you possibly could be?

A Yes.

Q What is a level that you would deem just going too fast, it's unsafe?

A I don't think I have --

Q Because you were there, you dealt with the whole range, right?

A Now, I'm going to answer that by telling you my comfort level. My level of what I do, and I'm comfortable doing so that I would never be pressed above that. And that, like I said before, was about four to six cases per hour, was my level of comfort.

Q So in a -- in a 10-hour day, is that what you -- 7:00 to --

A 5:00ish, sure.

Q Okay. You're talking about that level, six patients at -- per hour throughout the entire day nonstop?

A All right. Now, am I saying to you and everybody here that I, every day, could do 60 patients? Absolutely not. But I'm talking about, you know, doctors coming in, replacing others. Staff getting their breaks. That's the level that I'm comfortable with. But that extends to 5:0,0, and I wasn't comfortable going every day to 5:00.

That's why I reduced the number of cases, knowing the usual cancellation rate, so we'd end around 3, 3:30.

Q Last question. If you rush a procedure, does that compromise a patient's care?

A Yes.

Q Last one.

THE COURT: Any recross?

MR. WRIGHT: Re, re, re, re.

FURTHER RECROSS-EXAMINATION

BY MR. WRIGHT:

Q I want to go back to that CRNA in two places at one time, okay?

A Yes, sir.

Q You can't -- there's some discrepancies in the records, correct?

A Yes.

Q You were there and one thing we know for certain, and you have testified to, is that Keith Mathahs was a CRNA on Kenneth Rubino on that procedure, correct?

A Yes.

Q And he -- Keith Mathahs did not leave the room at any time during Mr. Rubino's procedure, correct?

A Yes.

Q And you were -- have been previously asked, as you sit here today are you sure about that? And you answered,

yes, I am, correct?

A Yes.

Q And that was when you were deposed in these matters, correct?

A Yes.

Q And you are certain about that, correct, sir?

A Yes.

Q Thank you.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: Yeah. Thank you, Your Honor. Can I get the easel?

THE COURT: Easel?

MR. SANTACROCE: Yes.

THE COURT: Sure.

FURTHER RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q Doctor, I'm going to ask you to step down if you would, please.

A (Witness complied.)

Q Can everybody see that? Now, we went through a bunch of times -- Mr. Staudaher went through a bunch of times; quite frankly, I don't understand all those times, but we do know certain things to be correct.

You testified that the start times on the record were pretty accurate, correct?

A Again, I need to know what you mean by the "start times." For me, the most accurate time is when the doctor clicked the button and it stamps the official time.

Q And that would be procedure start time?

A Procedure end time.

Q End time? Okay. There was -- there's -- the recording of the times was done by several people, correct?

A Yes.

Q In other words, anesthesia was -- CRNAs would report a start time, correct?

A Right.

Q And they would record the end time, but you've already testified that the end times of 32 and 33 minutes were incorrect, correct?

A Correct.

Q But there's no reason to doubt what the start times were. You haven't seen any irregularities in the start times from the anesthesia records, have you?

A Well, the ones that I evaluated, I don't recall a problem with the start times, but I'd probably have to look again.

Q Okay. Well, I'm just asking you for your recollection right now. You don't recall any problems?

A Right.

Q And there was also nurse's recorded times on the

record, correct?

A Yes.

Q They would record, for example, when they observed the procedure time to start, correct?

A Yes.

Q And they would observe when they observed the procedure time end, correct?

A Yes.

Q These are nurses -- RNs that are in the room?

A Correct.

Q And then there were other times down here which -- these times here where they monitored times, correct?

A That's what it says, monitor times.

Q Okay. And what are these times for?

A Okay. So as best as I can tell, these are the initiation times where somebody starts to populate the note with the information. This column here.

Q Okay.

A And this column here is when the doctor stamped he was done.

Q So we have multiple recordations of start and stop times --

A Yes.

Q -- by many different people, correct?

A Yes.

Q Now, I represented to you that the State prepared this. They had an analyst come in and look at all the records and put in all these times and charts. The defense didn't do this. You understand that?

A Yes.

Q Now, Mr. Staudaher proposed a theory to you that somehow this Patient No. 18 -- can you see this -- who is between Stacy Hutchinson and Patty Aspinwall, somehow --

A 18? There's something [inaudible].

Q This one. I'm sorry. 43.

A Oh, okay.

Q Okay?

A Okay. Okay. But Patient 18.

Q Patient 18.

A Okay.

Q 43 is the number patient. This is the one he was referring to when he showed you this anesthesia record that had Keith's name written -- signed, and Ronald Lakeman's in some sort of computer-generated form, correct?

A Yes.

Q And your testimony before was that there was never two CRNAs in one room at the same time, correct?

A Correct.

Q You never saw that?

A Right.

Q And you also testified earlier that a CRNA would never leave the middle of a procedure, correct?

A Correct.

Q Now, if we take Kenneth Rubino, and you can take any time you want on this timeline, okay? It says that his procedure start time started at 9:45, if you go by this one; 9:49, if you go by this one; and 9:49, if you go by this one. Fairly accurate, aren't they?

A They're close.

Q Very close. And then you can look at this next page and in between Kenneth Rubino and Mr. Meana -- come on over here. This start time says 10:00, correct?

A Right.

Q This one says 10:05, correct? This one says 10:05, correct?

A Yes.

Q Fairly accurate from all these different people recording times, right?

A They seem pretty close.

Q Okay. Now, I want you to go down to Stacy Hutchinson. Her procedure started at 9:55, correct?

A That's what it says.

Q And there's a 9:55, correct?

A Correct.

Q 9:58, correct?

A Correct.

Q Where was Mr. Mathahs when Stacy Hutchinson's procedure had been -- was started?

A According to this, he was with Patient 11.

Q So he couldn't have been doing a procedure on Stacy Hutchinson, could he? And this sort of bears that out. You'll see here where it says who -- Mathahs was here; Lakeman was here, correct?

A Correct.

Q So can you tell me how the source patient, Kenneth Rubino, hep C infection, migrated to a different room, infected a patient that was already in the recovery room when Mathahs started Patient 18? Can you tell me how that happens? Tell the jury your answer.

A No.

Q And those were the sorts of things that caused you great concern when you talked to Brian Labus, correct?

A Yes.

Q And the State gave you all sorts of hypotheticals, like, was there half-used propofol bottles left laying around for anyone to come take and use? You never saw that, did you?

A No.

Q You never saw a staff member carrying around a tray of half-used propofol bottles saying, Here, do you need

one? You need one? Take it to this room. That never happened, did it?

A No.

Q In fact, what happened was propofol bottles were loaded in the morning in one room, and loaded in the morning in the other room, correct?

A Yes.

Q And those propofol bottles were used in room one and the room -- two bottles that were assigned to room two were used in room two; isn't that correct?

A That's what I observed.

Q I have nothing further. Thank you.

THE COURT: Anything else, Mr. Staudaher?

MR. STAUDAHER: No, Your Honor.

THE COURT: Well, the -- I guess we have time for a couple of juror questions up here that come in over the days.

A juror wanted to know, in your experience is it as important to view the colon through the endoscope on the scope's insertion or removal?

THE WITNESS: It's important to -- to look both going in and coming out. Going in we see things like diverticulosis and tumors. Coming out we see more subtle polyps that are hiding behind folds. Both are important. And we see sort of different things when we do it going in and when we're coming out.

THE COURT: All right. A juror wants to know, if you're exposed to hep C, how long until symptoms start to show up?

THE WITNESS: So like I said when I was here last week, the average is 4 to 12 weeks before symptoms occur if you've got an acute form. If you've been inoculated -- for example, you had some bad tattoos, or you got a blood transfusion before 1992, or you had an operation before we knew all about this -- you may not have had any single symptom, not even a sniffle or a cold-like symptom at all, but many, many years later -- and this is how most people come to know that they have hepatitis C, you get a blood test and the doctor calls you and says you're positive.

That's why the CDC wants to test everybody between 1945 and 1965 because the huge majority of those folks have no clue that they have the disease.

THE COURT: A juror question, can someone be exposed to hepatitis C and not have it show up in blood tests?

THE WITNESS: The answer is you can be exposed to hepatitis C and not develop the infection. Your own immune system can clear it quickly and not have a symptom or a long-term infection.

THE COURT: So in other words, you can be exposed to it and your own immune system clears the virus, and then later if you have a blood test -- some time later -- it may not

manifest at all?

THE WITNESS: Right. And the rate at which that happens is around 15 percent.

THE COURT: 15 you said?

THE WITNESS: Yes.

THE COURT: Okay. Can hepatitis C be treated to a point where a patient no longer needs any further treatment throughout their lifetime?

THE WITNESS: Yes. And that's why some of the reports about incurable are very frustrating. That's not true. So when I say to you, like I said last week, we have new medication on the horizon with a nearly 100 percent effectiveness rate, what I mean by that, resolution and clearance of the virus forever. That means killing the virus and no longer having it in your system to cause disease.

So when I went through that we used to have 3 percent, then it jumped to 30, and then it went to 50 or 60, and now we have new treatments that are near 95 to 100, that's what I'm talking about. Cured of the disease.

THE COURT: And, Mr. Staudaher, maybe you can help me out. The last question asks for that map, the drawing of where everything was. If you could just put that up on the overhead.

MR. STAUDAHER: The map.

MR. WRIGHT: Organization chart?

THE COURT: It was, I think, a drawing Endo 1.

MR. STAUDAHER: Oh. Oh.

THE COURT: You used it on the first day.

Well, I can start the question --

THE WITNESS: Okay.

THE COURT: -- while he's looking for that. A juror wants to know, was there a scrub room where the physicians and the anesthetists washed their hands?

THE WITNESS: No, each -- so just remember these are not operating suites, they're endoscopy rooms. They're not sterile. That's why when I testified that they didn't get mopped down because they didn't need to be mopped down. If something happened or something is on the floor it gets cleaned up. But it's not a surgical suite and it's not sterile.

The sinks that we used were in each room. Between the two rooms was where the scopes got cleaned and processed.

THE COURT: Okay. And then I think you testified a previous day that you didn't necessarily wash your hands between each patient?

THE WITNESS: No, because again, I'm not -- I'm only holding a scope, and each time the gloves are coming off and new gloves are going on.

THE COURT: Okay. And if you did wash your hands you did it within the room where the procedures are performed?

THE WITNESS: Right. So --

THE COURT: Put that -- for the record, that's now up on the -- what's the Exhibit number, Mr. Staudaher?

MR. STAUDAHER: 103.

THE COURT: Exhibit 103 is now up. So just show us where you would wash your hands.

THE WITNESS: All right. So here's procedure room one and procedure room two. You see this door right here and this door right here, that led into this -- where it says "medical room," that was really the processing room for the endoscopes, and where it says "storage," that's where the closet was for the endoscopes.

If we needed to wash our hands, the sinks were in each room.

THE COURT: Okay. And then the juror wants to know where did the discharge nurse sit and speak with patients? If you can show us where her area was.

THE WITNESS: Okay. So -- so these are the rooms. Here's the waiting room. A patient gets called back and is brought back, right? I don't want to mess it all up, but over here is where a patient got changed and ready, and when the patient was ready for discharge, it happened -- where it says "supply office," it happened right in here. That's where the nurse was for discharge.

THE COURT: So this actually wasn't a supply office,

it was actually a nurse's station?

THE WITNESS: Yes.

THE COURT: Or a nurse's area. Okay.

Mr. Staudaher, any follow-up based on those last juror questions?

MR. STAUDAHER: No, Your Honor.

THE COURT: Mr. Wright, any follow-up based on those last juror questions?

MR. WRIGHT: No.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: No, Your Honor.

THE COURT: Now there's peer pressure to say no.

Any additional juror questions for this witness before we excuse him? Don't be shy.

All right. No additional juror questions. Dr. Carrol, there being no further questions, you are excused. But remember that you are not to discuss your testimony with anyone else who may be a witness in this matter.

THE WITNESS: Thank you.

THE COURT: All right. Thank you. And you are excused.

All right, ladies and gentlemen, this brings us to the time for our evening recess. We'll reconvene tomorrow morning at 9 a.m.

During the evening recess, you're reminded that you

are not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, person, or subject matter relating to the case, by any means of information; 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 until you begin deliberating with one another.

If you'd all please place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 4:55 p.m.)

THE COURT: Ms. Weckerly or Mr. Staudaher, who do we have lined up for tomorrow?

MS. WECKERLY: I've given the defense a list, but we'll also call Lakota Quanah because he's out of state.

THE COURT: Right. And he --

MS. WECKERLY: So we'll call --

THE COURT: -- had to wait --

MS. WECKERLY: -- him first.

THE COURT: -- around.

MS. WECKERLY: And then it's Larry Preston.

MR. WRIGHT: Who?

MR. STAUDAHER: Lakota Quanah.

MS. WECKERLY: One of the ones that doesn't have it --

MR. WRIGHT: Oh.

MS. WECKERLY: -- but has it.

MR. WRIGHT: Oh, okay.

THE COURT: Who is Larry Preston?

MS. WECKERLY: He is, I guess, a medical business consultant of Dr. Desai's.

THE COURT: Okay. Is he a long one?

MS. WECKERLY: That's --

MR. STAUDAHER: Not for us.

MS. WECKERLY: -- according to the defense those two could only be done in the morning, and then in the afternoon we have Orderly Naheris Russom and Lisa Falzone, who were all employees, nurses, and --

THE COURT: Okay.

MS. WECKERLY: -- GI techs.

THE COURT: All right. Did you need me? All right.

MR. SANTACROCE: Your Honor, I think we need to put our objection on the record where we were at the bench.

THE COURT: Okay. Can we do it tomorrow?

MR. SANTACROCE: You must direct me because quite frankly, I forgot.

THE COURT: You'll remember. Well, search your mind and we'll do that in the morning.

MR. WRIGHT: Okay.

(Court recessed for the evening at 4:57 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.

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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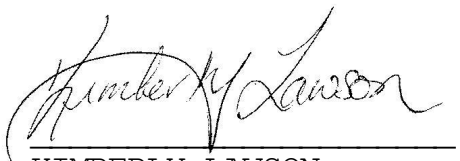

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CLERK OF THE COURT

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 19

TUESDAY, MAY 21, 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.

WITNESSES FOR THE STATE:

LAS VEGAS, NEVADA, TUESDAY, MAY 21, 2013, 9:09 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: Mr. Santacroce -- we had -- we may as well do the out of the presence while we can. You said you wanted to put something on the record yesterday.

MR. SANTACROCE: Yes. I wanted to object to the State referencing or making any reference to the hundreds of patients that have gotten hep C. These are the patients that supposedly the Health District is aware of, but the defense has never been aware of these people, have never seen any medical records from them. So I'm going to move that State not be allowed to reference anybody that the Health District has that we haven't gotten the records or discovery for.

THE COURT: State?

MR. STAUDAHER: With regard to the hundreds, that is clearly in the report that the Health District produced that they went through as part of their patient notification, the follow up testing of all of the thousands of the patients that they did, the interviews that they did with those patients. Brian Labus is going to come in here and talk about the investigation itself, not just focused on the two days in question, but what they did in general.

There's no indication that -- we're not going to get into the details of this person had this or this person had

that, but they found that there was a subpopulation and counsel clearly -- both counsel clearly opened the door indicating that there was -- we believe that there was issues with regard to other patients. Other lawsuits have come in. Other days when we talked about the Burnham clinic --

THE COURT: What other law -- just the Rexford lawsuit for timing.

MR. STAUDAHER: There have been many lawsuits in plural that are out there. I think there's been a number of references in that --

THE COURT: Well --

MR. STAUDAHER: -- situation.

THE COURT: -- I think the -- well, in the opening you're talking about the lawsuits, but every single victim who has come in has had several lawsuits or one lawsuit against multiple defendants. So to me the comment the lawsuits could easily be interpreted -- and I'll tell you the way I heard it. I'm hearing it they're talking about the lawsuits concerning the victims in this case.

Because, again, every victim that's come in had a lawsuit, multiple defendant lawsuit, and some of these are still pending, some have been settled. The HMOs are still out there. So that's how I heard it, and I'm going to assume the jury heard the lawsuit comment to lawsuits to mean just the lawsuits we've talked about in this case, which are the ones

each victim talked about and the wives had or the husbands had for loss of consortium claims. So I didn't hear that a different way and like I said, I have to assume that the jury heard it that way as well.

MR. STAUDAHER: Well, certainly the questioning about these witnesses, at least that have come out with regard to making it appear from the grand jury's -- excuse me, from the jury's perspective that this is just an isolated thing on these two days, that there were no other clusters. They weren't even questioned about other clusters that Dr. Sharma himself, one of the last witnesses we had, talking about --

THE COURT: Started about --

MR. STAUDAHER: -- other people.

THE COURT: -- a third group, that he was aware of --

MR. STAUDAHER: Right.

THE COURT: -- a third group.

MR. STAUDAHER: And it's not just -- it's not just another single cluster somewhere else. It is a large amount of people in the patient notification that the Health District determined were not genetically linked because they couldn't go back and do that at that point because they were in the -- in the past.

But they found people who, you know, this 104, I think it was 106 or whatever it was, people that -- that were

no prior records of any kind of hepatitis infection, no risk factors, they fell into a category of those individuals who they believed got a clinic acquired infection, but they could not go back and genetically match them because the testimony came out from Yury Khudyakov that that's not possible down the road. In that sense, to have the jury have the belief that, oh, we're just talking about a few patients on two individual days, I don't think that's -- that's -- that's valid.

THE COURT: I think that's misleading. I mean, I think it's misleading to the jury to suggest that, oh, you know, it didn't happen all these other times, and even by some of the juror questions you can see that that was --

MR. SANTACROCE: But, Your Honor --

THE COURT: -- a few days ago.

MR. WRIGHT: Let me --

THE COURT: Yeah, you can be heard. I mean, I'm just telling you how I'm hearing it. I'm listening to the evidence just like the jury is. I mean, and the way I'm hearing it is the suggestion from the defense side and what's coming in is, oh, it just happened on these two days.

And of these thousands, tens of thousands of other patients there was no infection and so it had to have been some crazy rogue employee on this day or something like -- on these two days because it never happened any other time, so how dirty could the clinic really have been and how unsafe

could their clinic practices really have been if you had, you know, however many fifty-five thousand, you know, nine hundred something other patients who, you know, 59,900 other patients who weren't infected.

That's the impression. And while evidence may not come in, by the same token you can't exploit the fact that it doesn't come in by creating a false impression when you know the evidence is -- is out there.

MR. SANTACROCE: What the --

THE COURT: That's my feeling.

MR. SANTACROCE: -- prosecutors -- the prosecutors have pled their indictment by naming individuals that were infected and claiming that my client was the source of that infection.

THE COURT: Right.

MR. SANTACROCE: If they want to amend their indictment and then allege all of these hundreds or thousands of other people, at least we would have notice of what we're defending against. Right now I'm on notice of defending against these people that are infected. I can't now be in the middle of a trial, have all of these other theories that the prosecution is going to bring forward and I'm expected to defend against that? That's not fair and it's -- it's not permissible.

MR. STAUDAHER: Well, one of the other issues is

that that whole thing about going through and doing the patient notification, about checking out other patients led, and as my co-counsel pointed out, was part of the analysis that the Health District used for the mode of transmission. It wasn't just looking at an isolated day or patient. I mean, they looked at the whole investigation.

They didn't -- if they had just looked at those two days in question, they would have put it in their report and been done with it. They didn't. They went back and they waited to put out their report for a long time until they had all of -- all of the data. The report itself analyzes that in context with the other information they got specifically for that. We're not charging their people with all of those individuals.

But to have the impression with the jury that it's just isolated to these people and, therefore, boy, there was no problem with the clinic is not -- not proper, and we think that we believe we should be able to get into that. It's clearly something that went into the analysis for the detection and mode of transmission and we think that it's proper to bring before the jury.

THE COURT: Mr. Wright.

MR. WRIGHT: Yeah. He's overlooking what we want in and how you lawfully get it in. I told him at the beginning of the case I would object to the Health District's report.

The problem with the 105 who are connected, but not genetically, is one of confrontation. Because the use of their interviews to say I have no prior risk factors is what is used to link them. Did they have it before, or didn't they have it before?

THE COURT: Right. And some people --

MR. WRIGHT: So I said --

THE COURT: -- are not going to -- I agree. Some people won't accurately report.

MR. WRIGHT: Right.

THE COURT: People who may have engaged in risky sexual behavior and IV drug use and other things in the past may not accurately report. Many people will accurately report.

So, you know, there's probably a lesser number within that bigger number of people who may have gotten it other ways. But I think it's safe to assume within that number you're going to have some accurate reporters, people who really are accurately saying I didn't use IV drugs, I didn't have surgery, I didn't engage in any kind of high risk, you know, other behaviors.

MR. WRIGHT: Right. But the -- but the way we test that in a criminal case is if they want it in, I need to examine each of those people. And I told him that and I told Mr. Staudaher even on the genetically -- the non-genetically

connected one on the 21st who is going to come in and testify, I said I don't agree that the information on Mr. Lakota can come in unless he is available to testify. So that's why they then called him to get in that he's not genetically connected but --

THE COURT: He had no --

MR. WRIGHT: -- we can examine him.

THE COURT: -- risk factors and he went to --

MR. WRIGHT: I view the same as to the other 105. And I didn't -- the other 105, if they want to put in that 105 other patients were infected at the clinic, which is what they want to say, and they are relying upon the interviews of the patients to establish that, they have to produce them. It's a Crawford issue. And I -- it's -- I don't even know how it -- how it can get in that they -- they were all 105 of them were interviewed and said blah blah blah blah blah --

THE COURT: Well, actually --

MR. WRIGHT: -- and therefore they were there.

THE COURT: -- I think that there is another way. I'm just thinking out loud here, but epidemiologically you can look at a patient population and there is a way to say, okay, well, some of these people statistically within the population, just like we heard from Dr. Carrol, within this age range they're going to have been exposed to surgical methods that were pre-HIV/AIDS, and so they were doing things

differently, pre-testing of blood transfusions, so those people may be higher. You're going to have IV drug users in there and other things.

So there's probably epidemiologically a way that you can assess, well, some of this is -- is not going to be based on high-risk factors. Some of it is going to have to -- I mean, it's like a statistical mathematical analysis I'm sure that can be done that's beyond the confrontation clause. You can just look at the numbers and what are the factors and what are the chances in the population that these people would all have gone to the clinic and have had independent risk factors. And I think that you could say that that's not likely.

MR. WRIGHT: I don't --

THE COURT: And I think --

MR. WRIGHT: -- mind the --

THE COURT: -- someone with a health --

MR. WRIGHT: I don't mind that.

THE COURT: Yeah. Well --

MR. WRIGHT: I don't mind a --

THE COURT: -- that's what I'm saying.

MR. WRIGHT: -- mathematical calculation and projections on it. What I mind is them saying 105 got hepatitis C at the clinic because their interviews of them show they did not have it before they went to the clinic.

THE COURT: Well --

MR. WRIGHT: If that's what they want to put on --

THE COURT: -- that's one factor.

MR. WRIGHT: -- I think that --

THE COURT: But all I'm saying is it's not, you know, just a straightforward Crawford thing. When you're looking at disease spread in populations, there's other ways you can consider this to say that it's not likely that all of these people would have had separate risk factors and have gone to the endoscopy clinic where we're aware of a hepatitis C spread and these people also got it.

And then within the population you can probably assume, like I said, some people are not going to be accurate reporters. Some people may not remember, some people may be embarrassed, some people may have engaged in extramarital activities that they're not going to want to admit to or whatever. And the -- you know, so I mean there is some number.

All I'm saying, and I'm not going to -- I'm not sure --we don't need to deal with it for this witness -- how it's going to come in. But what I am saying is I don't think it's right to put out the suggestion that, well, it's just these two days and it's just these people when we all in this room know that there are other people. Now, whether it's 109 people or you have to take 20 percent of that away for inaccurate reporting or 25 percent or 10 percent, I don't know

what that number would be.

There is some lesser number that I think is probably accurate, but it's still going to be a sizeable number, whether it's 50 -- it's definitely probably over 50. 50, 60 people, whatever it is. And I just don't -- what I'm saying is I don't think it's fair to make a false suggestion to the jury when we're all aware that there are other people out there who probably -- who have been infected through the clinic.

Like I said, taking away for inaccurate reporting and other things, you've got a large number, 109 people, whatever it is. You know, even if you took half of that, that's 54 people which is a sizeable -- a sizeable number. So I'm not sure how we're going to tailor this to come in, but what I'm saying is right now I don't think it's right when we're all aware of information out there that, like I said, it's got to be -- you know, I'm going to give 50 -- knock it off 50 percent, which is generous, and that's still 54 other people who would have been infected.

So I don't think the defense can gain that sort of unfair advantage or -- you know, I mean, theoretically this is a search for the truth and I don't believe that it's right to create a false impression with the jury that this is an isolated day, two days, and that's all the Health Department found or the CDC found, the Health District, because that's

false. That's incorrect.

MR. WRIGHT: Tell me --

THE COURT: You know, again, whether it's 109 people or it's 50 people or it's 10 people.

MR. WRIGHT: Tell me what I did, what line of questioning I did that created a false --

THE COURT: You know what, I don't remember, but I know that was my impression, and I know that there were a couple of --

MR. WRIGHT: I don't --

THE COURT: -- juror questions a couple of days -- this is last -- maybe the first week even. I had that impression, and I know from some of the questions. I'll have to go back over the questions. When I looked at the juror questions that was an impression I had. Now, was that maybe an erroneous impression? Perhaps. But that was the impression that I had and I felt the jurors had that question or at least somebody who wrote down a question had it. So --

MR. WRIGHT: Let -- let me --

THE COURT: -- let's move on with the next witness and it's not going to be concerned with this.

MR. WRIGHT: Could I --

THE COURT: Like I said, I mean, I think there have to be limitations and a structure --

MR. WRIGHT: Can I --

THE COURT: -- and it's not willy-nilly how it's going to come in. We have to -- I have to think about that and try to figure out a solution. But, again, I don't -- I don't believe it's right, and I'm not saying a question -- I can't remember. That was an impression. Whether it was an impression just because we're only hearing about certain people on certain days or whatever, you know, if that's the impression, then that -- you have no control over that.

All I'm saying is, you know, again, we can't -- we know that there's some number out there of people who are infected on different days. What that accurate number is, I don't think -- at least, you know, maybe somebody had better kind of -- you know, I can't calculate that because I don't know.

You know, there are some probably statistics out there how often people inaccurately self report and things like that. Like for diet it's like 90 percent of people inaccurately report what they're eating in a given day. But I don't know what it is for that. But I suspect it's --

MR. WRIGHT: There are statistics from CDC.

THE COURT: Right. There are statistics --

MR. WRIGHT: 40 to 50 percent or something.

THE COURT: -- on inaccurate reporting, and I suspect it may be fairly high because some of this might involve behaviors that are sort of anti-social or taboo or

illegal or something like that like drug use. And so people, you know, or maybe somebody used cocaine with a -- you know, I guess you can transmit it with a snorting implement. They may not even remember that from 30 years ago, you know, or something like that. So, I mean, I think there's deliberate inaccurate reporting, I think there's actually people just don't remember. So we'll figure out how to ask the questions, but that's my --

MR. WRIGHT: Could --

THE COURT: -- initial impression of the situation.

MR. WRIGHT: Okay. Could I just state for the Court I intentionally -- I mean, I -- I did not want to leave that impression because I don't know -- I don't go for winning temporary rounds in front of a jury.

THE COURT: I know.

MR. WRIGHT: I expect I don't know what will ultimately come in or not come in. And so the last thing I want to do --

THE COURT: You don't want to --

MR. WRIGHT: -- was leave the --

THE COURT: -- seem incredible.

MR. WRIGHT: -- impression there are none out there, and then all of the sudden in comes the CDC report and my credibility goes --

THE COURT: I understand you want to keep your

credibility. I get that.

MR. WRIGHT: And so I -- I didn't think ever I did anything to indicate at all what -- that there was nothing else.

THE COURT: And I don't -- I'm not saying you did. I'm saying I was left with that impression. Now, whether it was just because of the focus of the trial or a question from a juror or something else, I don't remember. But I can't -- no, I can't sit here and say, oh, you asked that question and that was misleading or Mr. Santacroce asked that question and that was misleading. I can't say that because I don't remember any specific time that that occurred. Maybe Mr. Staudaher remembers something and he can certainly place that on the record if he does. I don't.

MS. WECKERLY: Well, from my perspective, that is the impression that's been left. I will go through my notes and try to -- I don't think anyone has done it intentionally and I don't think anybody has done anything improper, but I think it's definitely, you know, this person is infected, then it skips this person. And out of 50,000 people, you know, wow, we're only left with seven.

I mean, that's not true. It's 114. I mean, you know, by the -- by the CDC. And -- and, oh, it's the same nurse. Well, she didn't work at a bunch of clinics. I mean, these impressions are left. It's a concern to the State. I

understand we're not arguing it now, but I think that that's the impression that's left.

THE COURT: Yeah. I mean, that's the impression I have. And like I said, we can go back over the juror questions, but I got that impression from some of the juror questions earlier. Not -- not these last rounds of juror questions, but earlier.

MS. STANISH: Judge, I know you're anxious to seat the jury today, but I think we do need to resolve this because as I understand it, the next witness is going to be Mr. Lakota Quanah. And I had intended to ask him about any lawsuits that would --

THE COURT: That's fine.

MS. STANISH: -- go to his bias. But as I understand Mr. Staudaher, he believes that's going to open up the door --

THE COURT: No, I don't --

MS. STANISH: -- to the --

THE COURT: -- think so. I mean --

MS. STANISH: -- inquiries.

THE COURT: -- Lakota, you -- your confrontation clause problem is solved because he's here. He's already been admonished in the presence of his lawyer that he has to disclose his settlements and lawsuits. He can't disclose any other plaintiffs that he might be aware of, and he's not to

disclose the amounts of money his lawyers made. So I think we're good to go on him.

MS. STANISH: Okay. I just wanted to clarify because I understood Mr. Staudaher to say that would open up the door to all the other lawsuits --

THE COURT: No.

MS. STANISH: -- and all the other infections.

MS. WECKERLY: We're not saying that. And Mr. -- the next witness almost addresses a slightly different issue because he's on the day, you know, like why is there skips. Because he's there infected, but below the viral load. So to me it's a different issue than the -- the big health department notification and the conclusions they drew.

THE COURT: Well, it could -- right. It could say that the other patients were infected, but they didn't have a sufficient viral load. It could suggest that the other patients had good enough immune systems where by the time they were tested the virus cleared their system, or they simply weren't infected. I mean, there's three possible ways of looking at those sort of skipping patients.

And so, you know, that's -- you know, I mean, we had testify from Dr. Carrol that sometimes the virus just clears your system if you have a really strong immune system. And so we don't really know why we skipped patients. You know, a) they simply weren't infected, or b) -- well, and the other

thing, too, is if you, you know -- I mean, there's a couple ways, if their theory of transmission is correct, you wouldn't necessarily infect every single patient. Or if you're using, you know -- I don't know. I mean, probably you would never be able to just get somebody under with a single -- single syringe, but obviously if you used only one prefilled syringe and you didn't go back --

MR. STAUDAHER: There are some --

THE COURT: -- in the bottle --

MR. STAUDAHER: -- of those, actually, Your Honor.

THE COURT: -- and you didn't go back in the bottle you're not going to get an infection. Or the third way is like, you know, we heard is if -- is if they have a strong immune system and it cleared the immune system, it cleared their system before testing.

So, Kenny, let's get started.

I don't think that he opens up any new issues with other patients that aren't charged or anything like that.

MR. WRIGHT: I think the -- I think the juror's questions, some of them are just being sleuths themselves.

THE COURT: Well, they like to do that.

MR. WRIGHT: I know. I mean -- I mean, because sometimes they're just trying to solve the case.

MR. STAUDAHER: Well, Ms. Weckerly made a very good point. Part of the defense that's been out there so far is