

1 months before then.

2 Q Okay. So in spring of 2009?

3 A That might be reasonable.

4 Q Okay.

5 A It was -- because initially it was -- I was
6 contacted by a law firm in Los Angeles who was doing some of
7 the work for the Bernstein group, because it was the
8 Washington case.

9 Q And you have testified -- well, strike that.
10 What were you specifically retained to do in the Michael
11 Washington case?

12 A Well, initially it was supposed to be for a
13 medical malpractice suit. That's all.

14 Q Okay. Did it become something else?

15 A It became a product liability case.

16 Q So you were retained. Were there two separate
17 lawsuits filed, one for medical malpractice, one for products
18 liability?

19 A Well, that was -- the initial was for that. But
20 then it quickly generated into the product liability.

21 Q So the medical malpractice case went away?

22 A I -- I was never in any jury trial that had
23 anything to do with the medical malpractice. But the initial
24 deposition was for that.

25 Q Were you in a jury trial for the products

1 liability case?

2 A For Michael Washington?

3 Q Yes.

4 A Yes, sir.

5 Q Okay. And -- and what were you retained to
6 testify about in that case? I mean, what were you an expert
7 qualified to testify in that case about?

8 A It was about things that to some degree we have
9 discussed today. What the -- what a anesthesia practice is,
10 what aseptic technique is, what safe injection practices are,
11 appropriate use of propofol, those were some of the primary
12 reasons.

13 Also, when, in terms of 50 and 20 cc vials and what
14 that might have -- where that came into all this. Because we
15 only use 50 cc vials in a critical care unit, an intensive
16 care unit. We use it no other place in our hospital. And a
17 lot of that had to do with the safety issues that have come up
18 in this case.

19 Q And these were specific to the product liability
20 case?

21 A That's correct.

22 Q You weren't retained, or in fact you didn't
23 opine, give an opinion as to the mechanism of transmission of
24 the disease in that case; is that correct?

25 A That is correct. I -- I deferred to the CDC and

1 the Southern Nevada Health -- their final investigation
2 report.

3 Q And, in fact, in order to have been able to give
4 a opinion, expert opinion, you'd have to be an epidemiologist,
5 correct?

6 A That is correct.

7 Q And you are not that?

8 A I am not an epidemiologist.

9 Q I need to know a little bit more about you. In
10 these cases, you testified on behalf of plaintiffs, correct?

11 A No, sir.

12 Q On these cases that we just identified? Have
13 you ever received any compensation directly or indirectly from
14 a manufacturer of propofol?

15 A No, sir.

16 Q Do you remember a study that you were involved
17 in --

18 A Oh --

19 Q -- in San Francisco?

20 A Yes. I -- I take that back. That is correct.

21 Q You have received compensation from
22 manufacturers of propofol indirectly, correct?

23 A That's correct. That was way back before any of
24 this transpired.

25 Q Okay. In your practice as an anesthesiologist,

1 have you ever been sued for medical malpractice?

2 A The only time that it has ever come up was for a
3 dental injury that occurred. Other than that I have never
4 been sued.

5 Q Okay. Were you ever sued for medical
6 malpractice?

7 A For medical malpractice?

8 Q Yes, sir.

9 A Well, I guess if you call that suit a medical
10 malpractice suit, then I would have been.

11 Q Well, there was a lawsuit filed against you, was
12 there not?

13 A Yeah, for a dental injury. That's what I said.

14 Q Are you a dentist?

15 A I am not a dentist.

16 Q Okay. You were sued for a dental malpractice
17 case as an anesthesiologist?

18 A I was -- they initiated a proceeding to sue;
19 that's correct.

20 Q And you were a named party, a named defendant?

21 A That's correct.

22 Q And you settled that case for money?

23 A That is correct.

24 Q Prior to these lawsuits that we've identified
25 regarding hep-C here in Clark County, Nevada, had you ever

1 testified or worked on a case involving propofol?

2 A Not that I can remember.

3 Q Prior to these cases where you identified in
4 Clark County, had you ever testified in any proceedings
5 regarding hep-C outbreaks?

6 A Not that I remember.

7 Q Have you ever been employed as an expert in a
8 case involving the outbreak of blood-borne pathogens?

9 A None that I remember.

10 Q Do you have any background that would make you
11 an expert in infectious disease?

12 A No, sir.

13 Q You are not an expert in hepatitis C, correct?

14 A That is correct.

15 Q You're not an expert in the treatment of
16 hepatitis C, correct?

17 A That is correct.

18 Q You've never worked with CRNAs in an ambulatory
19 surgical center, correct?

20 A That is correct.

21 Q You're not an expert in gastroenterology,
22 correct?

23 A That is correct.

24 Q You don't do any treatment of hepatitis C,
25 correct?

1 A That is correct.

2 MR. SANTACROCE: I don't think I have anything else
3 for him.

4 THE COURT: All right. Thank you. Mr. Staudaher.

5 REDIRECT EXAMINATION

6 BY MR. STAUDAHER:

7 Q Did the State ask you about any of those items?
8 Were you ever brought in and asked questions about those for
9 the State?

10 A I have been asked before in -- you mean, one of
11 the other previous --

12 Q No, this case. Have you ever been asked --

13 A No.

14 Q -- about -- asked to come in and testify about
15 hepatitis C and --

16 A No.

17 Q --- epidemiology --

18 A No, sir.

19 Q -- anything like that?

20 A No, sir.

21 Q Matter of fact, the only questions I've asked
22 you today relate to your practice as an anesthesiologist?

23 A That is correct.

24 Q Is that fair?

25 A That is correct.

1 Q Now, you were asked some questions about the
2 dental malpractice case. I mean, is that a common issue with
3 anesthesiologists?

4 MR. SANTACROCE: I'm going to object as to
5 foundation. What's common, what is he even talking about? Is
6 what a common situation?

7 THE COURT: Yeah, that's sustained.

8 MR. STAUDAHER: A direct issue. It was -- well...

9 THE COURT: You can rephrase the question.

10 MR. STAUDAHER: I'll rephrase it.

11 BY MR. STAUDAHER:

12 Q Dental issues with anesthesiologists, is that
13 something that you take care in when you do procedures? Watch
14 the dentition, the -- the teeth of patients?

15 THE COURT: Well, wait a minute. Were you performing
16 anesthesiology for a dental procedure or an oral surgery, or
17 was there a dental injury as a result of something that
18 occurred in another type of a surgery?

19 THE WITNESS: This was a gentleman who was coming for
20 a coronary artery bypass graft. He had an anaphylactic
21 reaction to a drug. During the attempt at --

22 THE COURT: The intubation?

23 THE WITNESS: -- lifesaving, I had to emergently
24 intubate him, and I also had to push epinephrine. He had
25 dental injuries that occurred from that. And we settled it.

1 His life was saved. And he ended up having a good result
2 except for the new dental work that had to be done.

3 BY MR. STAUDAHER:

4 Q You were asked about this provider, I mean, ad
5 nauseam about this provider education --

6 A Right.

7 Q -- thing. Do I understand you correctly that
8 your reading of that paragraph regarding multiple use had to
9 do with what you consider -- you -- you named three of them, I
10 think, was the chemotherapy drugs, the radio --

11 A Pharmaceutical.

12 Q -- pharmaceuticals and so forth. Those are very
13 high cost drugs --

14 A And the --

15 Q -- but that's what you believed that was about?

16 A And the biological, which was the Botox.

17 Q Okay. And you think that that paragraph has to
18 do with propofol?

19 A Absolutely not.

20 Q Okay. So when you say that it's unsafe
21 injection practice as related to propofol, is that what you're
22 talking about? I mean, that that is unsafe if it's used to --
23 for propofol?

24 A That is correct.

25 Q Now, one of the other things. What size

1 syringes do you typically use when you use a 20 cc bottle of
2 propofol?

3 A A 20 cc syringe.

4 Q So when counsel was asking you questions about
5 the drawing up of this -- of the -- the various bottles, when
6 you have a 20, would you use a 20 cc syringe?

7 A Yes.

8 Q Why would you do that?

9 A Because I don't have to worry about ever having
10 to go ahead and using it in the bolus fashion, ever have to go
11 back into a vial which could be contaminated, that's number
12 one.

13 Number two, I never have to worry about wastage,
14 because I always waste from the syringe if anything is left
15 over. That leaves nothing on my cart between cases, which
16 leaves nothing that I could even possibly contaminate the next
17 patient that I take care of.

18 Q Did you know when you were asked some questions
19 about this specific cases in this particular case that we're
20 in, I'm talking about the individuals like Michael Washington
21 and Patty -- those people that the counsel asked you about,
22 did you have a knowledge that the clinic used 10 cc syringes
23 only for anesthesia?

24 A I believe that that's what I had read in --

25 MR. SANTACROCE: I'm going to object to outside the

1 cross.

2 MR. STAUDAHER: Actually, it doesn't --

3 THE COURT: State your question -- state your
4 question again.

5 BY MR. STAUDAHER:

6 Q Did he know that only 10 cc syringes were used?

7 A Did he, meaning -- who's he?

8 Q You, did you know?

9 A Okay. That's what I read --

10 MR. SANTACROCE: Objection. Still --

11 THE COURT: No. Well, overruled.

12 THE WITNESS: What?

13 THE COURT: You can -- you can answer. You can
14 answer the question.

15 THE WITNESS: Okay. Yes.

16 BY MR. STAUDAHER:

17 Q So you knew that?

18 A That he had -- yes.

19 Q So in that sense, even on a 20, you'd have to at
20 least draw two syringes full or -- two syringes, two 10 cc
21 syringes, to get all of the medication out of the bottle at
22 one time, or you would have to go back into the bottle with
23 the same syringe or a new syringe to get the rest of it out,
24 correct?

25 A That's correct.

1 Q Okay. No question that even though it's not
2 good practice, you can do that if you use the -- with the
3 caveat that you do it aseptically as you've described?

4 A That's correct.

5 Q Now, with regard to the whole thing that we went
6 through about the -- the publicizing or not publicizing of
7 safe injection practices or not safe injections practices, you
8 -- you went -- they went through -- or Mr. Wright went through
9 that with you on initially those things get published,
10 outbreaks and the like get published in journal virology and
11 the CDC, MMWR, things like that; is that right?

12 A Correct.

13 Q And is -- was your testimony that those are
14 journals that are not typically read by an anesthesiologist?

15 A That's correct.

16 Q Did I understand you, though, that those
17 reports, even though they don't initially start in the
18 journals that you would read, eventually end up in those
19 journals?

20 A That's correct.

21 Q And, in fact, did you not say that in the -- the
22 AANA, which is what?

23 A The American Association of Nurse Anesthetists.

24 Q The AASA, what is that?

25 A ASA, one A, I'm sorry.

1 Q ASA, I'm sorry.

2 A The American Society of Anesthesiology.

3 Q Is that a journal you read or --

4 A Yes.

5 Q -- a society you're part of?

6 A It's a society I'm part of and they have one of
7 the two most prestigious journals, which is Anesthesiology.

8 Q Okay. And CDC?

9 A The CDC.

10 Q Okay. So at least for -- for you the ASA and
11 for anesthesia nurses, or maybe they would even subscribe to
12 -- to that journal. But anesthesia-related journals, would
13 you have access to that information?

14 A Yes, sir.

15 Q Okay. So when -- when you say -- or would you
16 say that it was publicized or well publicized about unsafe
17 injection practices in those journals?

18 A Yes, sir.

19 Q So even though it didn't start off that way, do
20 you get that information?

21 A Yes, sir.

22 Q Any -- any cloak and dagger there that you're
23 not aware of as far as unsafe injection practices?

24 MR. SANTACROCE: I'm going to object. Cloak and
25 dagger.

1 THE COURT: Yeah, that's sustained.

2 MR. STAUDAHER: My words. Bad words. I'm sorry.

3 BY MR. STAUDAHER:

4 Q Has this been something that has been known
5 generally about safe injection practices for a long time?

6 A Yes, sir.

7 Q Many years?

8 A Yes, sir.

9 Q Is this something you were taught in your
10 training?

11 A Yes, sir.

12 MR. STAUDAHER: Court's indulgence, Your Honor.

13 THE COURT: That's fine.

14 BY MR. STAUDAHER:

15 Q I just have one last thing. You had mentioned
16 that you believe that there's equal responsibility, and I
17 think you mentioned something about the practitioners have
18 responsibility in what they do?

19 A Yes.

20 Q Can you explain that to us, what you meant by
21 that?

22 A You say, I'm sorry, equal --

23 Q The practitioners, do they have responsibility
24 in how they do their work with the equipment and supplies that
25 they have?

1 A Yes. Very much so.

2 Q Is it ultimately up to the practitioner to do
3 the right thing with the patients?

4 A Ultimately, it is their responsibility, both in
5 terms of -- in terms of outcomes and safety. Ultimately, it
6 is their responsibility.

7 Q And in your opinion, is safety or cost more of
8 an important factor?

9 A Safety always trumps profits and -- and
10 corporate -- the corporate entity for profit.

11 MR. STAUDAHER: Nothing further, Your Honor.

12 THE COURT: All right. Ladies and gentlemen, we're
13 going to go ahead and take -- we're going to go late today.
14 Is everybody --

15 MS. WECKERLY: Actually, Your Honor, can we approach
16 on that?

17 (Off-record bench conference.)

18 THE COURT: All right. Ladies and gentlemen, we're
19 going to just take a quick -- about a 10-minute recess.
20 During the recess you're --

21 I know. We're taking -- To back to an earlier point,
22 Mr. Wright, that you made, we're only human. So we're going
23 to take a quick 10-minute break.

24 And ladies and gentlemen, during the break you are
25 reminded that you're not to discuss the case or anything

1 relating to the case with each other or with anyone else.
2 You're not to read, watch, or listen to any reports of or
3 commentaries on the case, person, or subject matter relating
4 to the case. Don't do any kind of research. Please don't
5 form or express an opinion on the trial.

6 Notepads in your chairs, and follow the bailiff
7 through the rear door.

8 And for the lawyers and the witness, it's going to be
9 about a 10-minute break. You're not done yet.

10 It'll not be much longer, and we have a couple of
11 juror questions, too.

12 (Court recesses at 4:58 p.m., until 5:08 p.m.)

13 THE MARSHAL: Please rise for the presence of the
14 jury.

15 (Jury reconvenes at 5:08 p.m.)

16 THE MARSHAL: Thank you. You may be seated.

17 THE COURT: All right. Court is now back in session.
18 And Mr. Wright, you may begin your recross.

19 RE CROSS-EXAMINATION

20 BY MR. WRIGHT:

21 Q Very briefly, Dr. Friedman. I think you just
22 said for Mr. Staudaher that the safe injection practices were
23 -- propofol and injection practices -- as far as you know,
24 were widely known and widely established for the
25 anesthesiologists, correct?

1 A Yes, sir.

2 Q Okay. And is it still your correct testimony in
3 the civil case, page 116, 117, 118, when you were testifying
4 for the plaintiffs against the manufacturers?

5 "Tell me if you agree with the following statement:
6 Safe injection practices have been well established as well as
7 widely publicized.

8 Answer, under oath, "I disagree with that statement."

9 All right. Again, the question, "Safe injection
10 practices have been well established. The first part, okay.
11 They have been well established. Second part, well
12 publicized. The widely publicized is partly the anesthesia
13 people have not been informed in a lot of what they usually
14 read." Correct?

15 A That's consistent with --

16 Q Is that your correct testimony in the civil
17 case?

18 A Yes, sir. Very consistent with what I just --

19 Q Is that your testimony?

20 A Yes. I said yes.

21 Q Thank you. Now, injection practices. Let's
22 talk about at the time of the events in this case, July 2007.
23 You just talked about injection practices have always remained
24 the same and well known, correct?

25 A Yes, sir.

1 Q Okay. July, 2007, time of incident in this
2 case, "Is it within the standard of care to re-use a single
3 syringe on a single patient as long as the syringe and the
4 vial are thrown away?"

5 A I'm sorry, say that again?

6 Q July --

7 A Yeah, I --

8 Q -- 2007.

9 A Seven, yes.

10 Q "Is it within the standard of care to re-use a
11 single syringe on a single patient as long as the syringe and
12 vial are thrown away?"

13 A To re-use it?

14 Q Re-use.

15 A It is not within the standard of care.

16 Q In July 2007, not today.

17 A You mean in terms of what the CDC said?

18 Q No. I mean in terms of -- I'm going to read it
19 to you again, this is your testimony, sir.

20 A Right.

21 Q In July of 2007, "Is it within the standard of
22 care to re-use a single syringe" -- re-use -- "on a single
23 patient as long as the syringe and vial are thrown away?"

24 A Can I read the context of it?

25 Q No. You -- you want to know what your answer

1 was?

2 "Under these circumstances, yes.

3 "Question: Okay. So in July, 2007, there were
4 circumstances where the re-use of a syringe was within the
5 standard of care, right?

6 "Answer: With the vial being thrown away, that's
7 correct.

8 "Question: And today" -- this was 2009, this
9 testimony. "today, are there circumstances where re-use of
10 syringes is within the standard of care?

11 "Answer: Again, I think practices changed because of
12 the recent several cases that have occurred because of the
13 transmission of the hepatitis virus, and I think the standard
14 of practice now is to go to a single-use vial, defined as one
15 draw, and throw the vial away and the syringe away and one
16 needle.

17 "Question: So the standard of care has evolved from
18 July, 2007, to the present with respect to the re-use of
19 syringes?

20 "Answer: I think I -- it's hard to put a year on it.
21 I think this has been a evolution between, you know, saying
22 exact 2007 or a certain date. What I was trying to say is
23 that somewhere between 2002 and where we are presently" --
24 2009 -- "and where we are presently, with changes in JHACO in
25 terms of what they're coming up with. And again, some of

1 those happened in 2004 and 2005. We are seeing a much
2 stricter interpretation of re-using a syringe a second time on
3 a patient. I can't tell you an exact date. I can't tell you
4 an exact year. This is an evolution that has occurred."

5 "Question: All right. To make it clear" --

6 MR. STAUDAHER: Your Honor, I'm going to object at
7 this point. Are we just going to read the whole transcript or
8 is there a question?

9 MR. WRIGHT: I've got one more sentence.

10 THE COURT: All right. Let him finish.

11 BY MR. WRIGHT:

12 Q Question, "All right. Just to make it clear,
13 though, as of today, you believe it would be a violation of
14 the standard of care to re-use a syringe in any circumstance,
15 even if it was only on the same patient?

16 "Answer: With single-use vial, yes." That's your
17 testimony. Okay?

18 A I understand.

19 Q That is in -- that's the -- which civil case was
20 that? Do you remember?

21 MR. SANTACROCE: Michael Washington.

22 BY MR. WRIGHT:

23 Q Michael Washington. Now I hear you saying a
24 different -- testifying differently for the State here in
25 2013.

1 MR. STAUDAHER: Objection.

2 BY MR. WRIGHT:

3 Q Is that correct?

4 MR. STAUDAHER: Objection, Your Honor. That -- it's
5 not --

6 THE COURT: Well, if he disagrees, then he can answer
7 the question.

8 THE WITNESS: I do disagree. I don't --

9 BY MR. WRIGHT:

10 Q You don't understand?

11 A No.

12 Q You said these -- there was no change in these
13 practices. I just asked you in July, 2007, I asked you the
14 question, could you do it? You answered no. Now I read you
15 your testimony and the answer was yes in July 2007. Did you
16 not hear that?

17 A Can I see --

18 Q Yes.

19 A -- that in context? That's all I want -- that's
20 all I want to see right now.

21 Q You point out if I misread it. Better give you
22 your page. What page is that?

23 A That is the 20, 21 -- or 21 is what you have up
24 here. Or, excuse me, pages 78 to 81.

25 Q I guess I need 20. Started on page 77. Middle

1 of 77.

2 A Okay. Let me just -- thank you. Can I have the
3 page before that, please? Were you reading something also
4 from 2007? Or --

5 Or this is the -- this is the earliest one you have,
6 is this correct? Of the things that you read.

7 Q That's exactly what I read to you, sir.

8 A Okay. Okay.

9 Q On page --

10 A No, no. That's fine. Okay. No, I'm -- I'm
11 reading it and I'm --

12 Q Okay.

13 A -- I'm understanding this a little bit more.
14 Just a minute. Yeah, I see.

15 THE WITNESS: Okay. Your Honor, can I read this out
16 loud and take it and put it in context or not?

17 THE COURT: Okay. Well, Mr. Wright or Mr. Staudaher
18 can follow -- follow up.

19 MR. WRIGHT: I'll let Mr. Staudaher follow up. But
20 I'll let you use the pages.

21 THE COURT: Are you finished with your --

22 MR. WRIGHT: Go ahead, read it.

23 THE COURT: Oh, all right. Read it.

24 MR. WRIGHT: I don't -- I don't want to --

25 BY MR. WRIGHT:

1 Q Tell me what I misconstrued.

2 THE COURT: Doctor, you can read the -- whatever part
3 you want out loud.

4 THE WITNESS: Okay. How do you want to proceed?

5 BY MR. WRIGHT:

6 Q Did I misread it?

7 A You didn't read it in the context of the six
8 pages. What you read was correct. That's correct.

9 Q Do you want to read the whole thing to the jury?

10 A If you wish me to.

11 Q I don't wish you to do anything. I just want to
12 know, you tell me, the way I understand your testimony, July,
13 2007, it was within the standard of care, your words, single
14 use, single syringe, re-use it, toss both, one patient. And
15 it was only after, as a result of cases like what happened
16 here, that the standards evolved and became stricter; is that
17 correct?

18 A I think it became stricter years before then.
19 Obviously --

20 Q Did you say that there?

21 A Can I read this?

22 Q You want to read the whole thing? Just read the
23 parts you want to read, and then I'll read what you testified
24 to in the civil case.

25 A That's fine. That's fine.

1 THE COURT: You can read them out loud.

2 THE WITNESS: I know. I'm looking --

3 THE COURT: Oh.

4 THE WITNESS: -- to try to cut it a little short to
5 see where I should start.

6 BY MR. WRIGHT:

7 Q All I'm interested in is the standard of care in
8 July, 2007.

9 A Okay. "Question: Doctor, before we broke, you
10 had mentioned that there are some situations where re-use of a
11 syringe was not clearly inappropriate. That's at least how I
12 took your testimony. Are there any situations where a syringe
13 could be re-used on a single patient and it would be within
14 the standard of care?

15 "Answer: No. If a patient was being treated by an
16 Anesthesiologist, propofol was drawn from a propofol vial,
17 injection was made into the patient, could the syringe be
18 re-used a second time on that patient?

19 "Answer: Well, this is the difference between the
20 theory and the human use. The recommendations now are one
21 needle, one syringe, one draw, one vial. The reason is that
22 although, again, from a theoretical standpoint, an aseptic
23 technique, nothing bad should happen in terms of transmission
24 of viral particles. The reality is when you deal with the
25 human experience and the potential for human error and

1 cross-examination, that's what the recommendations now
2 presently are. So I think it is substandard.

3 "Question: When did the recommendations become not
4 to re-use a syringe?

5 "Well, I think that's what" -- answer, "Well, I think
6 that's what happened progressively is that if you look back,
7 whether it's the CDC, whether it's the American Society of
8 Anesthesia, whether it's the AANA, the Association for Nurse
9 Anesthetists, especially in 2002, when there were four
10 outbreaks that occurred, and those outbreaks have not gone
11 away, progressively more and more organizations are going to
12 much stricter interpretations so that these things can't
13 happen.

14 "Question: In 2007, July, 2007, was it within the
15 standard of care to re-use a syringe as long as the syringe
16 and the vial of medication were disposed of at the end of the
17 treatment of the patient?

18 "By the time, 2007, when the standard of care" --
19 this is the answer -- "in our community, meaning in the Los
20 Angeles area, was to go to not re-using syringes. To say that
21 there was a federal mandate when you look at even CDC
22 suggestions before 2007, clearly it made those comments. But
23 the reality is that the fact it wasn't until approximately
24 2004, based upon the incidents of medicines report and then
25 JCAHO taking a much more active role with medications in

1 general, it wasn't just unsafe intravenous practices, but
2 medications and medication errors, that they started looking
3 to see if there was a way in which they could significantly
4 cut down on a thing -- anything that had to do with
5 medications. And this is one of those things where definitely
6 safe practices were being breached. Safe intravenous
7 practices were being breached. And so you see it more and
8 more in the literature in terms of the CDC, FDA, ASA, AANA.

9 "Question: In July, 2007, was it within the standard
10 of care, a violation of the standard of care, to re-use a
11 syringe if the syringe was used on a single patient and the
12 vial of medication was disposed of at the end of the
13 procedure?

14 "Now you're saying" -- answer, "Now you're saying
15 something a little different. I don't believe it was below
16 the standard of care.

17 "Question: Tell me how you think those questions
18 were different.

19 "Answer: You said throw the vial out. You didn't
20 say that before.

21 "Question: I think I did, but that's the
22 difference."

23 Q Keep reading.

24 A I am. I am. "Your answer" -- question, "Your
25 answer was because you thought that the previous question

1 didn't assume that the vial would be thrown away?

2 "That is correct." That's my answer.

3 "Question: Okay. So there are instances where it is
4 within the standard of care currently to re-use a syringe?

5 "Answer: No.

6 "Question: Were there instances in July of 2007
7 where it was in -- where it was within the standard of care to
8 re-use a syringe?

9 "Answer: No. And let's see if we're not connecting
10 here somewhere. I think I asked you on July of 2007 whether
11 it was within the standard of care to re-use a single syringe
12 on a single patient as long as the syringe and the vial were
13 thrown away.

14 "Answer: Under those circumstances, yes.

15 "Question: Okay. So in July, 2007, there were
16 circumstances where re-use of a syringe was within the
17 standard of care, right?

18 "Answer: With the vial being thrown away; that's
19 correct.

20 "Question: And today are the circumstances where
21 re-use of syringes is within the standard of care?

22 "Answer: Again, I think practice has changed because
23 of the recent several cases that have occurred because of the
24 transmissions of the hepatitis virus, and I think the standard
25 of practice now is to go to a single-use vial defined as one

1 draw, and throw the vial away, and one syringe and one needle.

2 "Question: So the standard of care has evolved from
3 July, 2007, to the present with respect to re-use of syringe?

4 "I think it's hard to put a year on it. I think that
5 it has been an evolution between, you know, to say an exact
6 2007 or certain date. What I was trying to say is that
7 somewhere between the year 2002 and where we presently are
8 with changes in JAHCO and in terms of what they're coming up
9 with, and again, some of those things that happened in 2004
10 and 2005, we're seeing a much stricter interpretation of
11 re-using a syringe a second time on a patient. I can't tell
12 you an exact date. I can't tell you an exact year. This is
13 an evolution that has occurred.

14 "Question: All right. To make it clear, as of today
15 you believe it would be a violation of the standard of care to
16 re-use a syringe in any circumstance, even if it was only on
17 the same patient?

18 "Answer: With a single-use vial, yes.

19 "Question: As of exactly when the standard of care
20 changed, you couldn't pinpoint?

21 "Answer: I could not pinpoint. I could not exactly
22 say 2007 or 2006. As I said, it's an evolution from the
23 2002-'04 cases that occurred around the country that people
24 were becoming very worried about the transmission of hepatitis
25 B -- C or B viruses.

1 "Question: You are not prepared to say that in July
2 of 2007 it was a violation of the standard of care to re-use a
3 syringe on a single patient if the propofol vial was thrown
4 away?

5 "Answer: I can tell you that the immediate practice
6 of where I am in Los Angeles County, that was the standard of
7 practice. I can tell you -- I can't tell you that it was a
8 national practice. I can't tell you that you look
9 specifically -- you look and specifically say. But there
10 clearly were recommendations that it would be written for
11 2007 stating that that's what should be done.

12 "Question: And in July of 2007, you don't know
13 whether it was the standard of care in Clark County, Nevada,
14 to re-use a syringe on a single patient if the vial was thrown
15 away afterwards?

16 "Answer: I can tell you that the CDC's
17 recommendation is the national recommendation. That is not a
18 standard. In other words, I don't think when it comes to safe
19 intravenous practices, I don't think that this is something
20 that a country or a city or a state determines that. I think
21 that the authorities who -- I think the authorities who are
22 the most knowledgeable and who have written and made
23 suggestions, whether it's to physicians in practice or whether
24 it's through other agencies of the government, including
25 JAHCO, and they wish to go ahead and set a stringent standard,

1 I don't think that it is something that is community. I think
2 that is nationwide. That is the practice of medicine. And
3 when you say the standard, it is the standard for safe
4 practice, for safe intravenous practice.

5 "Question: Do you know what the standard of practice
6 of CRNA's anesthesiologists who administer anesthesia in Clark
7 County, Nevada, in July, 2007, was with respect to the re-use
8 of syringes on single patients?

9 "Question: Do you know or not?

10 "Answer: No." And that's what --

11 Q Okay.

12 A -- what is there.

13 Q So what I read to you was accurate, correct?

14 A In some of the context it was, and in some of
15 the context, it was something that -- it started earlier. But
16 what you read was accurate. What you read was accurate.

17 Q Okay.

18 A I just wanted to read --

19 Q And before --

20 A -- what was before.

21 Q -- and before -- before I read it, I asked you
22 the same question.

23 A Yes, sir.

24 Q We started this, you wanting to read it all --

25 A Yes, sir.

1 Q -- by me saying in July, 2007, was it within the
2 standard of care, and you answered no. And then I showed you
3 your testimony, and the answer's yes. Correct?

4 A Yes.

5 Q Okay.

6 MR. WRIGHT: No further questions.

7 THE WITNESS: Okay.

8 THE COURT: Mr. Santacroce?

9 MR. SANTACROCE: I have nothing.

10 THE COURT: Mr. Staudaher?

11 MR. STAUDAHER: No redirect, Your Honor.

12 THE COURT: Anything, any other juror questions? All
13 right. There's no further questions. Thank you for your
14 testimony. Please -- I was going to say don't discuss your
15 testimony, but since you're not here as a percipient witness,
16 I don't need to say that.

17 THE WITNESS: Okay.

18 THE COURT: You are excused at this time.

19 THE WITNESS: Thank you.

20 MR. STAUDAHER: May I walk him out to get his stuff,
21 Your Honor?

22 THE COURT: Sure.

23 MR. STAUDAHER: Thank you.

24 THE COURT: Shall we get started with the next
25 witness?

1 MS. WECKERLY: We have a witness, if you want us to
2 start.

3 THE COURT: Start.

4 MS. WECKERLY: Okay.

5 THE COURT: The next witness is whom?

6 MS. WECKERLY: Joaen Syler.

7 THE COURT: Ma'am, just right up here next to me, up
8 these couple of stairs, please. And then just please remain
9 standing, facing that lady right there who'll administer the
10 oath to you.

11 JOAEN SYLER, STATE'S WITNESS, SWORN

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

14 THE WITNESS: Joaen Syler, J-O-A-E-N S-Y-L-E-R.

15 THE COURT: All right. Thank you. Ms. Weckerly.

16 DIRECT EXAMINATION

17 BY MS. WECKERLY:

18 Q It's lucky to be the witness that gets called at
19 5:30.

20 Ma'am, how are you employed?

21 A As a consultant, an independent consultant.

22 Q In -- in what area?

23 A Different areas. I'm an RN. I don't do any
24 clinical practice anymore. But I get heavily involved in
25 medical record review and healthcare fraud investigations and

1 certified coding issues.

2 Q And before you worked as a consultant, can you
3 explain to the members of the jury your other employment?

4 A Prior to beginning as a consultant, I was
5 employed at Blue Cross Blue Shield of Tennessee for nine
6 years, for a year and a half in the Medicare division as a
7 supervisor in medical record review, and then into the special
8 investigations unit where I became a healthcare fraud
9 investigator, and then subsequently became accredited as a
10 healthcare fraud investigator. And prior to that it was
11 various hospitals and physician-based settings.

12 Q And right now you work as a consultant in --
13 partially in the area of healthcare fraud investigations or
14 expert testimony?

15 A Yes. Or medical record auditing. Sometimes
16 that comes into play.

17 Q And have you testified before in trials as an
18 expert in healthcare fraud or standards of practice in the
19 industry and -- and billing improprieties?

20 A Yes, I have.

21 Q And was that just in Tennessee, or have you
22 testified in other states?

23 A I've testified in Tennessee, Iowa, and Florida.

24 Q Okay. In your -- in your -- in all of your
25 experience, can you -- based on all of your experience, can

1 you tell the ladies and gentlemen of the jury how generally
2 industry practices in relation to healthcare ability come into
3 being? How are the practices or the industry standards set?

4 A The industry standards basically are set by
5 Medicare, CMS, Centers for Medicare and Medicaid Services.
6 CMS acts as, like, an umbrella with rules, regulations, and
7 guidelines. And in most other health insurers, private health
8 insurers will for the most part follow suit with what Medicare
9 says. Does that answer your question?

10 Q It does. And do you know why it is that
11 Medicare is the one that sets the standard, or CMS sets the
12 standard for the industry?

13 A Medicare, along with AMA, the American Medical
14 Association, physician organization, work hand in hand as well
15 as with some major insurers, such as Blue Cross Blue Shield,
16 in developing the coding, the codes, the descriptions of those
17 codes, how to bill those codes, the guidelines for those
18 codes, and then those, all that information, the guidelines,
19 the codes, are compiled in a book that is published annually
20 called CPT, Current Procedural Terminology, which is
21 physician-based coding for services and procedures.

22 Q And in your work as a consultant and then in
23 your -- at your prior work investigating fraud and -- and
24 doing medical auditing, are you familiar with the CMS
25 definition of anesthesia time?

1 A Yes, I am.

2 Q And how -- how is anesthesia time defined
3 according to the CMS standard?

4 A CMS says that anesthesia starts when the
5 anesthesia practitioner is in present with the patient and
6 begins to prepare the patient for anesthesia services. And
7 then it ends when that anesthesia practitioner is no longer
8 giving any anesthesia services, which equates to they're no
9 longer present face to face with the patient, and anesthesia
10 has passed safely the care of that patient to a post-operative
11 person and place, usually an RN.

12 Q Now, so anesthesia is a -- a continuous time of
13 being in attendance, I guess, or face time with a patient from
14 the start of the procedure until the patient is passed off to
15 a recovery room personnel?

16 A Yes.

17 Q Now, according to the industry standards and
18 guidelines, what if the anesthesia provider has to attend to
19 the patient in the recovery area; under the guidelines, how is
20 that supposed to be, one, documented, and two, does that get
21 to count in the anesthesia time?

22 A Well, it definitely would need to be documented
23 well in the medical record. Because it's not very common. In
24 fact, I would call it somewhat rare in my experience that
25 anesthesia would have to be -- an anesthesia practitioner

1 would have to be in attendance, face to face with the patient,
2 after the procedure ended. Because if something emergent were
3 to happen with that patient and they were already in the
4 recovery area, there's a possibility anesthesia practitioner
5 could immediately come to there, but it's not likely. Because
6 they're usually already in another procedure.

7 So the recovery area nurse would call the appropriate
8 person, whether it would be an emergency physician, the
9 patient's private physician, or the patient's specialist that
10 maybe had -- that would have done the procedure if that person
11 was -- that practitioner was not in another procedure, as
12 well. So it depends on what the situation with the patient
13 would be as to who you would call. But it's highly unlikely
14 that it would be anesthesia in my experience.

15 Q And let's just say it's that rare situation
16 where it is the actual provider, the person that provided
17 anesthesia during the procedure, pass the person off to the
18 patient, off to the recovery room personnel. And for some
19 reason, you know, 5, 10, minutes later had to be called back
20 to the patient and was available. How would that be
21 documented according to industry guidelines?

22 A It would have to be documented what the
23 circumstances were, and that would be documented by the RN.
24 And then if anesthesia did come back in, anesthesia should
25 even make reference in their documentation why they were

1 called back in, what services the patient needed that
2 anesthesia would provide to that patient.

3 Billing-wise, I think it would depend on what the
4 circumstance was as to whether it was part of the anesthesia
5 services already rendered, or whether it was something more
6 significant. For example, if the patient in the recovery area
7 had a respiratory arrest and anesthesia was available, the
8 same anesthesia practitioner that had administered anesthesia
9 to the patient, then the coding and the billing would be
10 different, because it would have to do with the emergency
11 situation, not the anesthesia that was given during a
12 procedure.

13 Q So you can't, like, tack it on to the -- the
14 procedure time?

15 A That would be highly unlikely and in my
16 experience and in my experience in -- as an RN, as well as the
17 medical review of the -- of records, many over the years, I've
18 not ever seen that happen, actually.

19 Q Okay. How about on -- on the opposite end; what
20 if you are an anesthesia person and for some reason you go out
21 into a preop area and talk to the patient, then leave the
22 patient for a few minutes and go do something else, and then
23 that patient rolls in for their procedure. How -- what's the
24 standard for how you would calculate that type of time?

25 A If you're talking about, like, a preop

1 evaluation --

2 Q Yes.

3 A -- prior to a procedure, that is included in the
4 base code for the anesthesia service that's going to be given
5 during the procedure. It's not separately billable item under
6 CMS, Medicare.

7 Q Okay. And so that's part -- that's actually
8 supposed to be included in the -- the base amount that you
9 bill for the actual procedure?

10 A Yes.

11 Q Okay. And while we're on that, can you explain
12 to the members of the jury in terms of anesthesia time what
13 you mean by base units and the other time, how is that -- how
14 is that, I guess, documented, or explained in units of time?

15 A The base unit is basically the -- the code for
16 the anesthesia. Then you have to add to that the minutes in
17 anesthesia and those are usually divided into 15-minute
18 increments. And reimbursement usually occurs by so many
19 dollars per unit.

20 Q And so various medical procedures, I would
21 assume, depending on how complicated they are, have a set
22 amount of base units?

23 A I'm not -- I don't -- unless I'm not
24 understanding the question, there's not very much set in stone
25 when it comes to base units, because it can vary per patient,

1 just like every person is an individual, then what occurs with
2 them, it could be totally different than the very next
3 patient.

4 Q Okay. And are there -- are there, like,
5 standard, to your knowledge, units that are associated with
6 certain procedures or is it -- and then you get to add on the
7 anesthesia time and those -- in the units, or is it different
8 than that?

9 A Are you asking is there common times?

10 Q Well, the -- the time is 15 minutes, correct?

11 A Yes.

12 Q Okay.

13 A The -- a unit, 15 minutes, yes.

14 Q Okay. And I -- maybe I misunderstood you
15 earlier, but when I'd asked about if a person -- if the
16 anesthesia provider comes out to the preop area and interviews
17 the patient, then has a -- a break from that patient, but
18 eventually that patient is who they administer the anesthesia
19 to -- maybe I'll say that again.

20 How is that calculated? Or --

21 A They do not add --

22 Q Okay.

23 A -- minutes for that preop evaluation time.

24 Q That's included in the procedure?

25 A Yes.

1 Q Okay.

2 A Yes. I'm sorry if I misunderstood you.

3 Q No, that's okay. I think I confused myself.

4 But in -- in terms of anesthesia billing and in terms of your
5 experience in the industry, are you allowed to be billing
6 anesthesia for two patients at the same times, or are you
7 allowed to have overlap?

8 A One practitioner, one anesthesia practitioner?

9 Q Right.

10 A No. The only -- if nothing else, it becomes a
11 quality of care issue. Because if an anesthesia practitioner
12 is giving anesthesia to one patient, except in unusual
13 circumstances, they stay with that patient until that
14 procedure is finished, until that anesthesia is done for that
15 patient, before they would move on to another patient.

16 Q So you're not allowed to --

17 A Simultaneously --

18 Q Right. Uh-huh.

19 A No. The only time you can do something like
20 that is an anesthesiologist, an MD, can supervise and go from
21 room to room up to four patients if they were CRNAs giving
22 anesthesia. But then that's kind of a different sort of
23 billing, because they're -- they're doing medical supervision
24 billing. They're not actually administering anesthesia to
25 those patients simultaneously.

1 Q So, I mean, one anesthesiologist could
2 theoretically supervise four CRNAs doing different procedures?

3 A Right. But the anesthesiologist is not giving
4 the anesthesia.

5 Q Right. But a single CRNA can only be billing
6 one -- for one patient at a time?

7 A Absolutely. One at a time.

8 Q Okay. How about is it proper in the industry to
9 bill for more hours than there are in the work day?

10 A Absolutely no. I mean, there's only 24 hours in
11 a day, a calendar day, period. And I've never, in my many
12 years of practice, seen anybody work 24 hours a day, much less
13 more than 24 hours a day.

14 Q Now, in the -- in the industry, I guess within
15 the last decade, has there been change in how claims are
16 processed? Is it -- is it a paper system or has it -- is it
17 an electronic system how claims are submitted to the insurers
18 to pay?

19 A To my knowledge, all claims submissions now are
20 done electronically from the provider, whoever the provider
21 may be, whether it's an anesthesiologist or a
22 gastroenterologist or a neurologist. It's electronic
23 submissions. And then the claims are processed
24 electronically. And then the pay -- the payment, the
25 reimbursement is electronic, as well.

1 Q Okay. And in that -- in that system, is there,
2 for the insurers, is there a human being revealing those
3 claims that are submitted?

4 A No. The only time a human would review any
5 claims is when those claims come in electronically, and they
6 hit up against the electronic processing system, that system
7 has built in edits, some insurers have some artificial
8 intelligence, you know, to review certain points on a claim.
9 But unless some of those things stop that claim for some
10 reason, meaning there would be something wrong on the face of
11 the claim, then it's just going to process right through the
12 system.

13 Q So unless there's something that gets caught by
14 the computer system, the claim gets processed and paid?

15 A Yes.

16 Q In the -- in the industry, if there's false
17 information on a claim, does the provider have to pay or can
18 they reject the claim?

19 A You mean the insurer?

20 Q The insurer.

21 A The insurer can -- they -- it's normal that the
22 claim would just be rejected and then frequently some notice
23 is mailed to the provider that had originally filed the claim
24 saying, you know, we rejected this claim. Or there's some
25 notification. It may not be a letter. It may be on the

1 explanation of payment that goes with their next monthly
2 check, you know, on John Doe patient we rejected this claim
3 because. And then the provider can re-file it with the
4 correct information.

5 Q In -- in preparation for your testimony this
6 evening, did we ask you to review patient records from July
7 the 25th of 2007 and September the 21st of 2007?

8 A Yes. I reviewed approximately 140 medical
9 records.

10 Q And in terms of your review and the anesthesia
11 times on those two dates, on both of those dates -- well, I'll
12 just take the first one. On July the 25th of 2007, did you
13 see overlapping anesthesia times on those records?

14 A Yes, I did.

15 Q And did you see billing for more hours than
16 there was in the day?

17 A Yes.

18 Q And on September the 21st of 2007, did you see
19 the same thing? Did you see overlapping anesthesia forms
20 indicating that the CRNA was apparently attending to more than
21 one patient at the same time, or at least that's what the
22 anesthesia form indicated?

23 A Yes.

24 Q Yeah. And did you, on that second date,
25 September the 21st, see billing or anesthesia records for more

1 hours than there was in the day?

2 A Yes.

3 MS. WECKERLY: I'll pass the witness.

4 THE COURT: All right. Ladies and gentlemen, we'll
5 go ahead, then, and take our evening recess. We'll reconvene
6 tomorrow morning at 9:15.

7 During the recess you are reminded you are not to
8 discuss the case or anything relating to the case with each
9 other or with anyone else. You're not to read, watch, or
10 listen to any reports of or commentaries on this case, any
11 person or subject matter relating to the case. Please don't
12 do any independent research by way of the Internet or any
13 other medium. And please don't form or express an opinion on
14 the trial.

15 Notepads in your chairs. And follow the bailiff
16 through the rear door.

17 (Jury recesses at 5:54 p.m.)

18 THE COURT: Okay. We'll see you back here at 9:15
19 tomorrow.

20 MR. WRIGHT: I want to put on the record these hours
21 my client is unable to assist me. I've said this over and
22 over throughout the trial. Yesterday we ended at 6:00 last
23 night, he does not have the ability, he cannot assist me. I
24 do not have the time to work with him. I made the record at
25 the beginning. We were going to have accommodations. Now it

1 has gone to where it's yesterday it was 9:30 --

2 THE COURT: Well, yesterday we had --

3 MR. WRIGHT: -- till 6:00 last night.

4 THE COURT: -- we -- yesterday we ended at 5:30 with
5 the jury --

6 MR. WRIGHT: We were here till 6:00.

7 THE COURT: And I'm putting it on the record. And
8 then there was argument later that took time. Today we had
9 you report at 10:30 and I think wound up starting later, which
10 is why we went later tonight, because we didn't have an early
11 start today. Other than yesterday, we were ending pretty much
12 at 5:00 every day. Some days even earlier than 5:00. So if
13 you're telling me that you need additional time, you can't go
14 this late --

15 MR. WRIGHT: I've been telling --

16 THE COURT: -- even on a late start, a late start
17 today, then fine. Okay. But again, we had a later start for
18 the lawyers and Dr. Desai and everybody today, which was
19 10:30. And then we didn't actually -- I know you had to sit
20 around and everything.

21 MR. WRIGHT: Correct.

22 THE COURT: But I don't think we got started with the
23 jury because some of them were late. We didn't get started
24 with the jury till I think 11:00 today. Now, I know he still
25 has to sit around. But it's not to me as tiring as starting

1 -- as being in trial. So, okay, I get it. You're saying you
2 can't make accommodations or whatever. I would just -- look,
3 before you say, Oh, you've never been a defense attorney, I'll
4 say it, I've never been a defense attorney. But isn't some of
5 the discussing what transpired during the day, isn't that
6 maybe things that you can save for the weekend?

7 MR. WRIGHT: No. Because his memory isn't there. He
8 doesn't -- he doesn't remember and he mixes up the -- the
9 witnesses who have testified. And so when I go over the day,
10 then I'm going to prepare for tomorrow for Dr. Nemecek. And
11 when am I supposed to do it, at 10:00 at night? Have him sit
12 in my office or bring him in early in the morning?

13 I asked this at the beginning. I put the case law
14 in. I asked for shortened sessions --

15 THE COURT: Okay. Well, we've been --

16 MR. WRIGHT: -- and I get --

17 THE COURT: All right.

18 MR. WRIGHT: -- longer sessions.

19 THE COURT: No, you didn't get longer sessions,
20 because we started at 11:00 --

21 MR. WRIGHT: Longer than I requested.

22 THE COURT: We started at 11:00 today and, you
23 know --

24 MR. WRIGHT: I was here at 10:15 sitting out front.

25 THE COURT: Okay. Well, in any event. Going

1 forward, I mean, I think we've done everything to accommodate,
2 not just the Court, but the State, with providing advance
3 notice of things and doing other things that they're not
4 required to do. So it's not just the Court that's tried to
5 provide reasonable accommodations, it's the State. Look, a
6 lot of today was just repetitive over and over again. Not
7 blaming anyone due to a lot of things with the witness, just
8 reading from depositions and things like that. It took a lot
9 of time, but really was no new information. It's just the
10 same thing over and over again.

11 So I don't know how long that's going to take to
12 synthesize and discuss with your client. But, you know, he
13 was on all day and saying not a lot. A lot of it was fighting
14 back and forth and other things. But, you know, be that, I
15 don't know that that's really something that needs to be gone
16 over and discussed, the yelling and the fighting and the
17 joking and the, you know, other things.

18 So, all right, we'll -- again, I didn't feel like we
19 were doing so badly in making the accommodations when we had a
20 late start today. But you say that we are, and so we'll be
21 mindful of this going forward. You know, this would be moving
22 a lot faster if everybody didn't ask the same questions over
23 and over again. I get it with this last witness was, shall I
24 say, difficult. But, okay. You know, you need more
25 accommodations and that's fine. But, you know, like I said, I

1 mean, the State, in terms of aiding with the accommodations,
2 they've been really doing a lot here, and I know you're
3 talking to the Court --

4 MR. WRIGHT: I don't disagree.

5 THE COURT: -- right now. But, you know, a lot of
6 this wouldn't have to go as long if it wasn't repetitive. So
7 tomorrow is what it is. You know, it's a Friday. So you're
8 going to have two days to review, prepare, whatever.

9 What are you asking me for right now tonight? Part
10 of the reason we go long is for all of this fighting back and
11 forth and you constantly interrupting me and then me having to
12 chastise you for constantly interrupting me and back and
13 forth. If we would just engage in tell me what you want, and
14 then I'll tell you what I'm going to do, then maybe we could
15 cut these days shorter and, you know, whatever.

16 So what are you asking me for right now? 6:04 p.m.
17 on Thursday, Mr. Wright. What are you asking me for before
18 tomorrow --

19 MR. WRIGHT: Nothing further.

20 THE COURT: -- at 9:15 when we come back?

21 MR. WRIGHT: Nothing further. Nothing further.

22 THE COURT: Okay.

23 MR. WRIGHT: Sorry I took the time.

24 THE COURT: No, I'm not saying that. All I'm saying
25 is, you know, if you didn't cut me off all the time, then

1 maybe a lot of this arguing could -- could go faster.

2 Now, in terms of tomorrow morning, we're probably not
3 going to start with the jury right away, because I want to
4 make two calls or make at least one call to juror employers
5 and I want to do that in the presence of the lawyers. So,
6 lawyers, just, you know, get here at 9:15 or whatever, but we
7 may not start immediately with the jury. So if Dr. Desai's a
8 few minutes later than that, that's, you know, fine. But I
9 want to at least get started by 9:30 with the jury.

10 All right, then. That's it for tonight.

11 (Court recessed for the evening at 6:02 p.m.)

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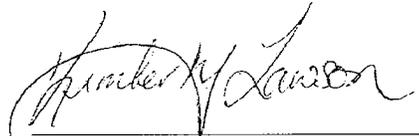
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I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

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1 an expert on --

2 THE COURT: Well --

3 MR. STAUDAHER: -- whatever he's asked to come in as
4 an expert for.

5 MR. WRIGHT: I didn't mean use of them.

6 THE COURT: Well, overruled.

7 MR. WRIGHT: That's just a figure of speech.

8 THE COURT: That -- that was the factual basis for
9 this claim.

10 BY MR. WRIGHT:

11 Q Is that correct?

12 MR. STAUDAHER: Speculation, then. If he knows.

13 THE COURT: Well, if he knows.

14 BY MR. WRIGHT:

15 Q Well, you know that, don't you?

16 A Let's -- ask it again.

17 Q Okay. If -- if the hepatitis C was spread by
18 another mechanism, like dirty scopes or improper use of
19 multi-use saline, or improper use of multi-use lidocaine,
20 someone was just angry and did something wrong, if those were
21 the methods by which this outbreak occurred on two dates here,
22 then there wouldn't be this lawsuit and cause of action
23 against the big manufacturers, correct?

24 MR. STAUDAHER: Objection. Speculation, Your Honor.

25 THE COURT: Oh, overruled. Just -- I mean, it's --

1 the answer's obvious.

2 THE WITNESS: If that's what the cause was. But
3 that's not what was found in the investigation.

4 BY MR. WRIGHT:

5 Q Did I ask you what was found in the
6 investigation? You want to hear my last question? What did I
7 ask you?

8 MR. STAUDAHER: Objection. Argumentative.

9 THE COURT: Yeah, that's argument. I mean,
10 badgering.

11 BY MR. WRIGHT:

12 Q Would you --

13 THE COURT: Argumentative.

14 BY MR. WRIGHT:

15 Q -- answer my question.

16 A If those were the causes that were found, there
17 would not be a suit against the manufacturer.

18 Q Correct. Are you an epidemiologist?

19 A No, sir.

20 Q Okay. Now, the verdict here in this case could
21 have an impact on that civil litigation?

22 MR. STAUDAHER: Objection, Your Honor.

23 MS. WECKERLY: Your Honor --

24 THE COURT: That's sustained.

25 BY MR. WRIGHT:

1 Q Could --

2 THE COURT: Well, it calls for --

3 MR. STAUDAHER: Objection.

4 THE COURT: -- speculation and a legal conclusion
5 and --

6 BY MR. WRIGHT:

7 Q Well do you --

8 THE COURT: -- you know, if we want him here as a --
9 as a lawyer, a legal expert, then let's just let the State,
10 you know, ask him legal questions, too.

11 BY MR. WRIGHT:

12 Q Were you --

13 THE COURT: He's not here as a legal expert.

14 MR. WRIGHT: Okay.

15 THE COURT: And whether -- what legal impact it could
16 or may not -- could or could not have is beyond his testimony
17 as a medical expert. Or --

18 MR. WRIGHT: Okay.

19 THE COURT: -- as a physician.

20 MR. WRIGHT: Okay.

21 THE COURT: An anesthesiologist. So.

22 BY MR. WRIGHT:

23 Q You had no conversations with Kellebrew or any
24 of the other plaintiffs' lawyers you have worked for about
25 your assessments in this case and why it would be in their

1 benefit for you to help here, correct?

2 A That is correct. I've had -- that's correct.

3 Q Okay. You didn't discuss that subject. Did you
4 discuss with any lawyers, not the district attorney, any
5 lawyers for which you worked as an expert your testimony here?

6 A That's correct.

7 Q No, I said, did you?

8 A No, I did not.

9 Q Okay. That's what I was asking.

10 A That's --

11 Q Now, I want to talk to you about propofol.
12 You've used, like, 1,000 a times a year, right?

13 A Yes, sir.

14 Q Okay. And mainly you use it -- bear in mind I
15 don't know the terminology real well, but in the clinic we've
16 learned that they used hep-locks, what we call here in the
17 courtroom, and then they inject a dose into the hep-lock, or
18 the needle and syringe. There's that method, or there's
19 another IV method. Do you know what I'm distinguishing
20 between?

21 A There are several ways. One is directly into
22 the hep-lock. Two, you go ahead and you hook an infusion bag
23 up; in other words, it can be saline with the injection ports
24 that lead to the hep-lock, and you can inject propofol through
25 it. Three, you can hook up the constant infusion of propofol.

1 Those are the three methods.

2 Q Okay.

3 A So you can bolus two of them, one through the
4 hep-lock and one through an IV setup hooked to a bag of
5 saline, or two, constant infusion with an infusion pump.

6 Q I don't get boluses and aliquots. Are you
7 talking about a dose?

8 A A dose.

9 Q Okay.

10 A A single dose.

11 Q So you can dose or constant infusion?

12 A That's correct.

13 Q Okay. And our main practice is which of the
14 three?

15 A I do -- the one I don't do is through a
16 hep-lock. Number one, that's the unsafest of the three. And
17 the reason is, is that because if you have unsafe practices,
18 that's the closest to a patient's bloodstream so that the
19 transmission can occur into the needle or into the syringe,
20 that's one.

21 Two, if you get a patient that gets a peculiar
22 reaction and you can get an anaphylactic reaction to the
23 emulsion, you are not that close to being able to give
24 epinephrine to resuscitate your patient if you just have a
25 hep-lock, as opposed to if you hook up an infusion bag, you

1 have a constant source of being able to resuscitate your
2 patient easier and put them on drugs to maintain their blood
3 pressure until that reaction goes away.

4 Q Well, you don't do hep-locks with doses?

5 A I dose, but not directly into the hep-lock.

6 Q Okay. You do mainly infusion?

7 A No. You --

8 Q I'm asking.

9 A There are two ways --

10 Q That's a question.

11 A -- in which you have --

12 Q Which do you --

13 A -- an IV bag, let's say with saline, you have
14 the connection between that and the hep-lock that you can go
15 ahead and give. That's an infusion of fluid. You can hook up
16 an infusion pump and give propofol that way, or you can go
17 ahead and give a dose bolus, aliquot, into that infusion, but
18 it allows you to be much further away from the source of the
19 contamination. It allows you to resus a patient --

20 Q I got that.

21 A -- resuscitation --

22 Q Which do you do --

23 A I do the --

24 Q -- the majority of your practice?

25 A I do both a bolus that goes into a constant --

1 Q Got it.

2 A -- infusion or I do a constant infusion of the
3 propofol into the port of that hookup to the saline bag.

4 Q Okay. What -- what do -- if you know, do you
5 know what they normally do here as standard in ambulatory
6 surgical centers for propofol? Do you know in Las Vegas --

7 THE COURT: You mean here in Clark County?

8 THE WITNESS: I do not know what they do as standard
9 of care in Los Angeles. I mean, excuse me, in Las Vegas.

10 BY MR. WRIGHT:

11 Q No, I said --

12 A In Las Vegas.

13 Q I didn't say standard of care, I just meant do
14 you know what they do?

15 A I don't know what they do --

16 Q Okay.

17 A -- in terms of Las Vegas.

18 Q Okay. And so if -- I -- I guess in California,
19 hep-locks, just plain hep-lock dose, that's -- they don't do
20 that in California because it's dangerous?

21 A I'm saying that --

22 Q Is that correct?

23 A I'm saying it is -- there's a reason to have a
24 constant --

25 Q I asked you if they do that in California?

1 A I don't know of anyone who does it.

2 Q Okay. You don't know of any ambulatory surgical
3 center in California for any type of procedures where propofol
4 is given for a short procedure where they just use a hep-lock
5 and a needle and syringe for a dose, correct?

6 A California is a big state.

7 Q Is that correct?

8 A I do not know how everybody practices in the
9 state of California.

10 Q Okay. Whether they --

11 A So I --

12 Q -- we just have no knowledge whether they do or
13 don't in California, correct, sir?

14 A That is correct.

15 Q Okay. Have -- have you told your colleagues or
16 broadcast in California the dangers of using a hep-lock?

17 A I have not.

18 Q Okay. Now, propofol, you're aware that they
19 were using -- they, meaning the clinic here in this case, okay
20 -- what I call 20s and 50s, okay.

21 A Yes, sir.

22 Q And tell me about using a 50 for multiple
23 patients when I use proper safe injection practices? I think
24 the example given by Mr. Staudaher was start with a 50, okay,
25 open it, gloves, alcohol on top, whatever, all the things you

1 do to make for a safe injection practice. Okay. Brand new
2 needle and syringe, withdraw one, another brand new needle
3 syringe, two, three, four, five, okay. If it -- if that were
4 done and then those five needles and syringes were separately
5 used on -- two on one patient, one on another patient, two on
6 a third patient, is there any way that could cause the
7 transmission of hepatitis C?

8 A If you're asking whether if they have -- they
9 kept aseptic technique under those circumstances, there
10 wouldn't have been any transmission of hepatitis C.

11 Q Okay. And that would be I think you said
12 theoretically correct?

13 A No. I said if they had --

14 Q Okay.

15 A -- aseptic technique --

16 Q Right.

17 A -- that --

18 Q My example --

19 A -- there would have been no -- that's what you
20 were asking --

21 Q Yes.

22 A -- there would be no transmission --

23 Q Okay.

24 A -- from a 50 cc vial.

25 Q And that's true whether it's a multi-dose vial

1 or a single-dose vial that says 50 on it, correct?

2 A Absolutely. It's correct.

3 Q Okay.

4 A If the aseptic technique is there.

5 Q And you've -- you've indicated that, also for
6 Mr. Staudaher, that I could take a 20 propofol if I wanted to
7 and I could draw up a syringe full of propofol, inject patient
8 I am treating. Patient needs another dose. I could use same
9 needle, same syringe, empty the 20 propofol vial, use same
10 needle, same syringe, inject the patient. And that there is
11 no way that's going to cause a transmission of anything, any
12 blood-borne pathogen, correct?

13 A If there's aseptic technique.

14 Q Okay.

15 A That is correct.

16 Q And that's true whether it's a 20 cc saline vial
17 or propofol vial, correct?

18 A That is correct.

19 Q Is the -- does it make any difference, we've
20 heard evidence in this case of injecting a patient, drawing up
21 out of a propofol vial, call it first injection, okay, then
22 individual practitioner takes the same syringe, takes off the
23 needle, puts on a new sterile needle, throws away old needle,
24 and goes back into propofol vial and re-doses the patient.
25 What's the significance of that?

1 A If he uses aseptic technique and he injects it
2 back into the same patient, there's no significance at all.
3 There shouldn't be any transmission of any -- of any disease
4 as long as he uses aseptic technique.

5 Q Okay. And what does -- I mean, we have heard in
6 this courtroom evidence that I -- I could use the same needle
7 and syringe to re-dose the same patient. Okay. Do you have
8 -- what's the significance, does it add some protection or
9 something by changing the needle?

10 A It just means that if either -- when you do that
11 with the first -- with the first amount that you give, that
12 that contaminates the needle and the syringe. If you go back
13 and use either the needle or the syringe, it contaminates the
14 vial. If you inject the rest of the amount into that patient,
15 that patient already, if they were contaminated, has the
16 disease and has the antibody to it. So nothing happens to
17 that patient.

18 The problem occurs if you then go ahead and use it
19 again with a larger vial and you use a new needle or a new
20 syringe in that vial, the next person gets contaminated.

21 Q I'll get to that. I'm just trying to focus in
22 on why someone -- what -- any idea what the practitioner would
23 be thinking, like the extra precaution --

24 MR. STAUDAHER: Objection. Speculation, Your Honor.

25 THE COURT: Yeah, that's sustained.

1 BY MR. WRIGHT:

2 Q Well, you tell me when -- when you're -- there
3 are circumstances where you use the same syringe and change
4 the needle before adding more to the syringe?

5 A Not me.

6 Q You.

7 A No, not me. That's not my practice. I
8 believe --

9 Q Well, just quick --

10 A I've never said that. That is not my practice.

11 Q Well, tell --

12 A My practice is --

13 Q Tell me if you wanted to draw up 60 ccs of
14 propofol into a 60 cc syringe to use on the pump. Okay. You
15 use three 20-vial propofols. And do you get one syringe, put
16 on a brand new needle, go into a propofol vial, draw up 20,
17 toss the vial, take off the needle, put on a brand new needle,
18 go into the next propofol vial, draw it up, take it out, take
19 off the needle, throw it away, put on a new needle, draw up
20 the third, correct?

21 A That's correct.

22 Q I thought you didn't do that.

23 A No. What I said was, is that when I go ahead
24 and I finish what is in the syringe, what I draw it in the
25 syringe, I throw the needle away, I throw the syringe away, I

1 use a new needle, a new syringe, and a new vial.

2 Q I'm talking about drawing up a 60 syringe, where
3 you need three vials of propofol to put into it, to put onto
4 the pump. Follow me. You understand what I'm talking about,
5 correct?

6 A I understand what you're talking about.

7 Q Okay. So when you draw up the first 20, you've
8 got one syringe, a 60, correct?

9 A Correct.

10 Q Okay. And you put a new needle on it, correct?

11 A I put a new needle on it.

12 Q First needle. You draw up -- you empty one 20,
13 you've got 20 ccs into the syringe, correct? What do you then
14 do before drawing the next 20 out of the second vial?

15 A I'm wiping off the rubber stopper with alcohol
16 and I'm withdrawing the propofol.

17 Q With what?

18 A With the syringe.

19 Q With a new needle?

20 A With a new needle.

21 Q That's what I said. You're using a syringe --
22 I'm not sure we're on the same page. So you get out, you're
23 on the same syringe, you throw away the old needle, you put on
24 a new needle, you draw it again, now you still need 20 more,
25 you throw a needle away and you put on a new needle, and you

1 draw a third time. Now you've used three needles on one
2 syringe. Correct, sir?

3 A Yes.

4 Q Okay. And there must be some benefit that comes
5 from changing the needles that you perceive. Correct, sir?

6 A It would --

7 Q Correct?

8 A It's just a habit that I have that that's the
9 way I do it. Obviously, if it's aseptic, there's not going to
10 be a problem.

11 Q I'm not --

12 A And there's -- no, wait.

13 Q I'm not saying there's a problem. I'm just
14 delving into what the rationale could be of the practitioner,
15 because we have evidence in this case of CRNAs changing the
16 needle on a syringe they have used as if that were a reason
17 for it. And then I see you engage in the same behavior. And
18 so I understand you do it out of habit. But at some point in
19 your practice, there must have been some reason or benefit
20 that causes you to do that, that makes you think it's safer to
21 do it that way.

22 A It is safer than what was done in the clinic,
23 because they left remnants in the vial --

24 Q Did -- did I, sir, did I ask you what they did
25 in the clinic? Were you in the clinic?

1 A No, sir.

2 Q Ever?

3 A No, sir.

4 Q So you're going to come in here and tell us what
5 they're doing in the clinic?

6 MR. STAUDAHER: Objection. Argumentative, Your
7 Honor.

8 THE COURT: Yeah, that's argumentative.

9 BY MR. WRIGHT:

10 Q I asked you and your practices. That which you
11 know about. You have some reason when you developed the habit
12 of changing the needle before re-using the syringe. There --
13 you -- it -- you think somehow it makes it safer, correct?

14 A It's just the way that I have done it. What I
15 do is I take all of the contents out of whatever vial I use.

16 Q People -- people -- you've been doing it 30
17 years. We have CRNAs involved in this case that have been
18 doing it longer than you have. And so I guess people just
19 develop certain practices that they believe are safe even
20 though they can't explain them and they just go ahead with
21 them, right, sir?

22 MR. STAUDAHER: Objection. Speculation, Your Honor.
23 He can testify to what he knows, not what other people do and
24 why.

25 THE COURT: Well, he can -- if you can answer.

1 THE WITNESS: That is what I do because it's the
2 habit that I've developed that is consistent with what the CDC
3 says. That's --

4 BY MR. WRIGHT:

5 Q It's consistent with what the CDC says?

6 A Uh-huh.

7 Q Where does the CDC say change a needle and use
8 the same syringe?

9 A The CDC, again, doesn't say -- doesn't say it
10 exactly the way you're saying it.

11 Q Doesn't say it the way you're saying it, either,
12 do they?

13 A With all --

14 Q CD --

15 A With all due respect, the CDC does do it. I
16 don't reuse the syringe. I empty the contents. I throw the
17 waste away.

18 Q I know. What I'm trying to focus in on is that
19 extra safety and precaution that would cause you, out of
20 habit, to change the needle because that's the way you did it,
21 because some -- you don't think it's riskier changing the
22 needle, do you?

23 A It should not be riskier, it's just a habit I
24 have.

25 Q And you think it adds some safety?

1 MR. STAUDAHER: Asked and answered, Your Honor.

2 THE COURT: Well, overruled. Do you think it adds
3 some safety?

4 THE WITNESS: It's a habit I have. I don't think it
5 changes the safety with the way I do things.

6 BY MR. WRIGHT:

7 Q Isn't there something about once the needle's
8 been out, it could have, like, touched someone or something?
9 And -- seems I read that in someone's deposition.

10 A It could always happen.

11 Q Do you remember any explanation you gave about
12 it is the safest way to change the needle, because once you
13 have gone in and withdrawn something, that needle has been in
14 that vial, it's been out, there's bacteria in the air,
15 etcetera. Do you recall -- is that ringing a bell?

16 A Well, first of all, if it's me, I use a
17 needle-less system, which is different than a needle. And
18 that's because it protects the healthcare provider.

19 Q Okay. Well --

20 A But --

21 Q -- I'm sure it was you I was reading about that
22 drew up the 20, changed the needle, drew it up, changed the
23 needle, drew it up, changed the needle, drew it up, changed
24 the needle. Now you're telling me that wasn't you?

25 A I didn't say that it wasn't. Did I say it

1 wasn't? I don't believe so.

2 Q I ask the questions.

3 A And I said that if that's what you saw there,
4 I'll stand by it.

5 Q Okay. And did you explain why it was safe?

6 A It was never asked. That's the way I do it.

7 Q Okay. Now, CDC, what you say has put there in
8 perimeter on this needle changing. I thought CDC was today
9 one vial, one needle, one syringe, one patient, throw
10 everything away except the patient. Right?

11 A And one patient. That's correct.

12 Q Okay. And that's CDC best practices today,
13 correct?

14 A Yes, sir.

15 Q Where's re-use the needle in there? Re-use the
16 syringe, change the needle, I mean.

17 A I'm not sure what you're saying again. Say that
18 again.

19 Q Well, you're the one that said the CD -- you
20 were following CDC practices.

21 MR. STAUDAHER: Actually, Your Honor, he said he was
22 consistent with, and I would object to --

23 MR. WRIGHT: Okay. Consist --

24 THE COURT: That is true, he said consistent.

25 MR. WRIGHT: I misstated it.

1 THE WITNESS: So what are you asking now?

2 BY MR. WRIGHT:

3 Q How does -- how do you make that consistent with
4 current CDC practices which say every single time a needle is
5 used, throw it away, every single time, syringe, throw it
6 away?

7 A Because that way you never use it on another
8 patient.

9 Q Okay. So that'd be aseptic, right?

10 A That would be part of aseptic approach.

11 Q Okay. Well, that would be clean, what do you
12 call it?

13 A It's safe injection practice.

14 Q Safe injection practice.

15 A Which is part of aseptic practice.

16 Q Okay. Aseptic's bigger?

17 A That is correct.

18 Q Okay.

19 A The injection is part of aseptic technique.

20 Q Okay. That would be safe injection practices,
21 right?

22 A That's correct.

23 Q Okay. And... Safe injection practices have --
24 have evolved over the last 10 years?

25 A Longer than that.

1 Q Longer than that? Okay. What we've heard here
2 in this courtroom is like the most forbidden, I mean the
3 totally off-the-charts, re-use needle and syringe, multiple
4 patients. That's -- that's forbidden, correct?

5 A Yes, sir.

6 Q Okay. For as long as anyone can remember?

7 A Yes, sir.

8 Q Okay. And there have been instances you're
9 aware of where -- I don't mean you, I mean just from national
10 publicity of where at a clinic in Oklahoma a practitioner used
11 the same needle -- same needle and syringe on 24 patients,
12 correct?

13 A That's correct.

14 Q Okay. And so that has -- has always been an
15 unsafe injection practice, or for quite a while, anyway?

16 A Yes, sir.

17 Q Okay. And today, 2013, in your opinion it would
18 be an unsafe injection practice if I dose the patient with a
19 20, re-use needle and syringe, same patient, threw away needle
20 and syringe, threw away propofol, that would be an unsafe
21 injection practice in your opinion today; is that right?

22 A Didn't follow that one.

23 Q Okay. The -- it was -- it was the example I
24 gave of simply -- you -- one 20. Okay. Needle and syringe,
25 draw it out, inject the patient, patient needs another dose.

1 Same needle and syringe, or change the needle out of habit.
2 Back into same propofol vial, re-dose the patient. Done with
3 that patient. Throw away propofol vial, throw away needle and
4 syringe. Is that a safe injection practice?

5 A You said some -- I'm sorry, but you said
6 something a little consistent.

7 Q Okay.

8 A Did you -- you meant that after you withdrew the
9 first 20 ccs from the first vial, you threw away the vial, you
10 have another new vial, is that what you meant, with --

11 Q No. I'm talking one vial.

12 A But you've emptied all the contents. How are
13 you going to go ahead --

14 THE COURT: What if it's a 50 milliliter vial?

15 THE WITNESS: The way he --

16 BY MR. WRIGHT:

17 Q What do you mean, all the contents?

18 A The way he -- 50's a different story. He said
19 20, though.

20 THE COURT: Oh.

21 THE WITNESS: That's what he said.

22 BY MR. WRIGHT:

23 Q I give the patient a -- a dose of 10. Okay.

24 A Uh-huh.

25 Q Now there's 10 left in the bottle. I go back in

1 a second time. I withdraw the other 10. Now the bottle's
2 empty. Okay. Throw the bottle away. Same needle, same
3 syringe. Dose the patient. Either 5 or 10, full amount.
4 Taken -- patient's done. Procedure's over, roll him out.
5 Throw away the needle and syringe. Safe injection practice?

6 A What their preferred method would be is to take
7 the 20 cc syringe and empty all the contents out, and then
8 throw away vial, needle, and syringe. That's the preference.
9 And the reason is, is that because when you take the first 10
10 out, until you need it, you don't know that what you're going
11 to do with the remnants of that vial. And as you go in with
12 20 ccs, if you do it the way you said, with aseptic technique,
13 it would not be a problem.

14 They're worried about, and rightfully so, that if you
15 have a larger vial, 50 ccs, and you do that technique, you
16 will have remnants or leftover propofol and you will then go
17 ahead, if the patient is infected, you can infect, obviously,
18 the other 30 ccs that you haven't used, because you've used
19 20. And you'll come along and use another needle and syringe.
20 What they're trying to do is to get a practice that it is
21 failsafe for public safety.

22 Q Okay. Who's they're?

23 A That's the CDC --

24 Q Okay.

25 A The Centers of Disease Control.

1 Q And so they -- they put out their best
2 practices --

3 A Right.

4 Q -- correct? Okay. And so my question was, and
5 you -- you follow CDC practices, best practices --

6 A Yes, sir.

7 Q -- correct? So what I said you -- you believed
8 by hypothetical, re-use needle and syringe, one bottle of
9 propofol, same patient, throw away propofol and needle and
10 syringe, you believe that's an unsafe injection practice,
11 correct?

12 A If you use aseptic technique, it's a safe
13 practice.

14 Q Okay.

15 A If you use a small vial of propofol, it can be a
16 safe practice.

17 Q Okay.

18 A But when you start going ahead and putting
19 together that you can have a larger vial, that you may have
20 people who have unsafe techniques, it increases markedly the
21 potential transmission of a blood-borne disease, like
22 hepatitis C.

23 Q Okay. Well, let's go to a 50, then. The -- but
24 what you're telling me, if I follow it correctly, is as long
25 as I'm using aseptic technique, it's safe injection practice.

1 And the only time something can happen is if I make a mistake
2 or use poor judgment?

3 A That's -- that's why you don't do it that way.
4 Because then a safe injection practice becomes an unsafe
5 injection practice. And if you don't develop habits that are
6 foolproof, that's why these things continue to happen. And
7 they do continue to happen. Because people -- the weakest
8 link in all this is the human link. It's the desire not to
9 waste a drug. It's the desire to go ahead and do things the
10 most efficient way. It's the desire to have things that are
11 least costly. There's the desire to go ahead, the cost of
12 performance, to get people through the system as quickly as
13 possible. Mistakes occur. If you don't adhere to a certain
14 practice that is failsafe, the human element is what is the
15 weakest link. And it -- and there are studies out there to
16 show that people are still practicing with unsafe injection
17 practices, unfortunately.

18 Q And the studies show a large percentage, even
19 today, correct?

20 A I wouldn't use the word large. But it's a
21 significant -- if you have one person who does it, that's
22 significant.

23 Q Okay. But it's --

24 A But it's -- large, to me, means over 50 percent.
25 That's not --

1 Q Okay.

2 A -- what the literature says. It's significantly
3 less than that. But it is an appalling number still.

4 Q And you -- and you don't think -- say it's 28
5 percent, okay, would -- would believe it's okay, safe -- safe
6 injection practice to use same needle, same syringe, same
7 patient, and throw it away. Okay. People still do that,
8 correct? Despite best practices.

9 A What people are doing predominantly is either
10 reusing the syringes --

11 Q Okay.

12 A -- or they are using --

13 Q All the time?

14 A -- the -- the medication on multiple patients
15 that are single patient unit vials.

16 Q Okay.

17 A That's what the literature says.

18 Q Okay.

19 A And so that is a prescription for transmission
20 in the future of hepatitis C again.

21 Q Right. That's a prescription for mistake and
22 human error, correct?

23 A Correct.

24 Q Okay. We're not dealing -- this isn't a civil
25 case with mistake and human error. Okay. This is a criminal

1 case in which we deal with people and issues of whether they
2 are consciously engaging in reckless conduct, knowing the --
3 reasonably knowing the consequences of it. Okay. And when
4 those -- all those people out there are still doing that, do
5 you think all those people --

6 MR. STAUDAHER: Objection. Speculation, Your Honor.

7 BY MR. WRIGHT:

8 Q -- are --

9 THE COURT: Let's hear how he asks the question.

10 BY MR. WRIGHT:

11 Q -- conscious -- are conscious of the gravity of
12 the risk they are engaging in?

13 MR. STAUDAHER: Objection. Speculation.

14 THE COURT: Well --

15 MR. STAUDAHER: Are -- are you aware of the -- what
16 they are thinking?

17 MR. WRIGHT: If he can answer it.

18 THE COURT: If he can answer.

19 THE WITNESS: I don't know.

20 MR. STAUDAHER: Your Honor --

21 THE COURT: Obviously, he doesn't --

22 THE WITNESS: I -- I don't know.

23 THE COURT: -- know what individuals --

24 MR. WRIGHT: Sorry.

25 THE COURT: -- are thinking. But if he wants to

1 comment statistically on what he thinks the number reflects,
2 then he can comment like that. But, obviously, he can't
3 comment on what individuals may or may not be thinking. If,
4 like he said, if he can make a statistical assessment, which
5 he said he can't, so we're going to move on.

6 BY MR. WRIGHT:

7 Q There's evidence in this case that the -- the
8 practice of multi-using propofol vials -- by multi-using, I
9 mean more than one patient, take 50 or 20, using it till it's
10 empty, was widespread throughout the state of Nevada.

11 MR. STAUDAHER: Objection.

12 BY MR. WRIGHT:

13 Q Does that --

14 MR. STAUDAHER: Assumes facts not in evidence, Your
15 Honor.

16 THE COURT: That's sustained. Ask it a different
17 way, Mr. Wright.

18 BY MR. WRIGHT:

19 Q There's -- there has been --

20 THE COURT: If there were evidence or...

21 MR. WRIGHT: No. There has been testimony --

22 THE COURT: Well, again, ladies and gentlemen of the
23 jury, you'll recall what the evidence would be or was.

24 BY MR. WRIGHT:

25 Q Well, let me put it this way. We've had CRNA in

1 here who testified, but he -- he's practicing in California
2 where they're using hep-locks in these ASCs, these -- these
3 clinics. He works at two of them in Santa Maria and somewhere
4 else. And he's worked there for years. And he was a CRNA
5 here in Las Vegas, went through the CDC thing. And he's back
6 working in this clinic, and they are still multi-using
7 propofol vials between patients. Does that surprise you?

8 A It happens. Unsafe practices happen.

9 Q Okay. And that's an unsafe practice?

10 A Yes.

11 Q Okay. To take a 50, fill it up with 5, as my
12 first example, aseptically or whatever you call it, safe
13 injection practice, 50, use it, just as Mr. Sagendorf does,
14 you're saying that's an unsafe practice?

15 A If you use it on multiple patients, it is not a
16 safe practice. That's what you started this with.

17 Q Okay. Because?

18 A Because you could contaminate the remnants of
19 the other 45 ccs if you --

20 Q You're changing the hypothetical. I said --

21 A There was no hypothetical --

22 MR. STAUDAHER: Objection, Your Honor.

23 THE WITNESS: -- in your question.

24 MR. STAUDAHER: That was the hypothetical.

25 THE COURT: All right.

1 MR. WRIGHT: No. I said if it's -- I started it off
2 with safe injection practices. Safe injection practices.

3 BY MR. WRIGHT:

4 Q Just use -- use safe -- use a multi-use vial,
5 saline. Okay. Right? Saline comes in multi-use vials?

6 A Yes, sir.

7 Q Okay. So I use safe injection practices. I can
8 multi-use that vial on all the patients, right?

9 A Yes, sir.

10 Q Okay. If I use a 50, propofol, safe injection
11 practices, I can use it on multiple patients, correct?

12 A If you take a look, the answer is no.

13 Q Okay. Distinguish between the two for me.

14 A The first one says multi-dose vial on the labor
15 [sic].

16 Q Says on the what --

17 A The second one says single patient use vial.

18 Q Okay.

19 A That is a big difference.

20 Q Okay.

21 A And it's because of the contents that are in
22 there, it's because of retardants that are in there. And
23 there is a certain period of time when propofol, because of
24 its proclivity to potentially be a substrate for bacterial
25 growth, can be a problem. There's a reason that it

1 specifically says that on the vial.

2 Q That it says what on the vial?

3 A Single patient use vial.

4 Q Okay. Isn't that --

5 THE COURT: But that's -- oh, I'm sorry. Go ahead.

6 BY MR. WRIGHT:

7 Q Isn't that where -- so it's -- it's what's
8 written on the vial on the label that makes it unsafe,
9 correct?

10 A Not necessarily.

11 Q Okay. Take my hypothetical again. Saline. 50
12 cc. Okay. With preservatives in it. Draw it up, multi-use.
13 Propofol, draw it up, use within one hour on five patients.
14 What -- in either, any difference in transmission of hepatitis
15 C, identical, correct?

16 A If it is aseptic technique, you would get no
17 transmission of the virus.

18 Q Okay.

19 A We have talked about that. And we have also
20 talked about that the weakest link --

21 Q I understand that.

22 A -- is the human link.

23 Q And so --

24 A We've also talked about the fact --

25 Q We're human.

1 A -- we're human.

2 Q I understand that.

3 A And errors continue to occur. And that's why we
4 still have the spread of hepatitis C in healthcare facilities.

5 Q I understand that. I'm -- I'm trying to take
6 this incrementally to understand why the different -- why the
7 50 is still being used multi-use aseptically despite saying
8 single use on it. And -- and what I'm hearing is if I am
9 aseptic and I do things properly and I'm a good practitioner,
10 the only reason I can't is because what the manufacturer wrote
11 on the label, under my hypothetical of using it within an
12 hour, correct, sir?

13 A There are reasons that they have it on the
14 label.

15 Q Go ahead.

16 A The reasons they have it on the label is because
17 of there's a certain half-life which you have to go ahead and
18 have this given to a patient, there are certain reasons, based
19 upon the fact that propofol transmission of HCV has occurred,
20 that there things in the literature that suggest that
21 certainly a large vial portends toward multi-dosing in the
22 sense of going from one patient to the next patient to another
23 patient. And it was based upon first the bacterial infection,
24 which was in 1995 in the New England Journal of Medicine, that
25 the -- everybody went overboard with the bacterial infections

1 and people didn't stress the problems with the viral
2 transmission.

3 THE COURT: I think we all need a break. I'm being
4 signaled by the jury.

5 Ladies and gentlemen, we're going to go ahead and
6 take our afternoon recess.

7 During the recess you are reminded you are not to
8 discuss the case or anything relating to the case with each
9 other or with anyone else. You're not to read, watch, or
10 listen to any reports of or commentaries on this case, person
11 or subject matter relating to the case. Don't do any kind of
12 research. And please don't form or express an opinion on the
13 trial.

14 Notepads in your chairs. Follow the bailiff through
15 the rear door.

16 (Jury recessed at 3:17 p.m.)

17 THE COURT: Doctor, you're free, obviously, to take a
18 break. They're in the back so the bailiff controls them. Ten
19 minutes for the lawyers.

20 I have a question for the State. Do you have the
21 other expert waiting around? Good.

22 MR. STAUDAHER: Sitting out there.

23 THE COURT: We'll -- we'll stay late. I just -- huh?

24 THE CLERK: I said, Oh, good.

25 THE COURT: I just wanted to make a record of what

1 had happened previously with this statement from Mr. Chaffee.
2 I pulled all the minutes. There was a motion in front of
3 Judge Barker, which Judge Barker initially denied and later
4 granted, that it was privileged on a Motion for
5 Reconsideration. But Judge Barker did it anyway, even though
6 he said there should be some testimony or an affidavit from
7 Mr. Weiner, the criminal attorney.

8 I initially had one and I said that I could -- was
9 not going to grant it without an affidavit from Mr. Weiner
10 that he understood the privilege to -- that, you know, why did
11 he disseminate it and what he understood. They refused to
12 provide an affidavit. So the next time it came up it had
13 already been granted as privileged by Barker and Judge Weiss.
14 And so I just went along with the group and granted it.

15 And then Judge Weiss had it first and he found it to
16 be privileged and granted their motion. It was basically a
17 motion to exclude so that it couldn't be used in the civil
18 cases.

19 So that's the history there. Like I said, it was
20 distributed to Mr. Labus. How it got to the civil lawyers, I
21 really don't know. We've made copies. I think that the
22 interest, first of all, Mr. Weiner never provided affidavits
23 or testimony as far as I know to any of us on the question of
24 privilege.

25 Secondly, to the extent it may even be privileged,

1 even though it's been seen by many, many people, I think the
2 defense is right to have the statement both for questioning of
3 Mr. Labus, possibly the detective, and certainly to look for
4 any inconsistencies in Mr. Chaffee's testimony, supercedes any
5 privacy or any privilege concerns that Mr. Chaffee might have
6 had.

7 So here they are. We made copies. A copy for the
8 State and the lawyers.

9 MR. WRIGHT: Thank you.

10 (Court recessed at 3:20 p.m., until 3:42 p.m.)

11 (Outside the presence of the jury.)

12 THE COURT: So you're -- the e-mail was from the
13 lawyer saying I sent the witness home?

14 MS. WECKERLY: I didn't get that one. Michael did.

15 MR. STAUDAHER: It says, "I told her" --

16 THE COURT: Can you read --

17 MR. STAUDAHER: I can read the e-mail.

18 THE COURT: Yeah.

19 MR. STAUDAHER: It says, "Thanks for your e-mail."
20 When I sent her -- told her that -- reformed her that she
21 needed to be here at 1:30, she said, "Thanks for your e-mail."
22 Since we did not hear from you earlier, Ms. Kalka is on her
23 way back to Minnesota. Please advise if you wish Corrine
24 Spaeth to report this afternoon to testify and we will contact
25 her."

1 So they -- it appears to me as though they sent her
2 home, because that wasn't our out-of-state witness desk. And
3 when our out-of-state witness desk apparently was contacted,
4 they checked the hotel and she'd already checked out. So.

5 THE COURT: So, for the record, that was an e-mail
6 from Constance Akridge.

7 MR. STAUDAHER: Yes.

8 THE COURT: All right.

9 THE MARSHAL: Rise for the jury.

10 (Jury reconvenes at 3:44 p.m.)

11 THE MARSHAL: Thank you. Everybody may be seated.

12 THE COURT: All right. Court is now back in session.
13 The record should reflect the State, the defense and counsel,
14 the officers of the Court, ladies and gentlemen of the jury.

15 And Mr. Wright, you may resume your
16 cross-examination.

17 CROSS-EXAMINATION (Continued)

18 BY MR. WRIGHT:

19 Q Dr. Friedman.

20 A Yes, sir.

21 Q The -- the 50s, if -- basically, can be used if
22 proper injection practices are used, can be used
23 multi-patient, but it's single use. And as -- as I understand
24 you, it's the big bottle induces the propensity to abuse it.

25 A Well, first of all, I don't believe I said you

1 could ever use it safely. And it's not for multi-use,
2 multiple patients. All I said was, is that from the
3 theoretical standpoint, if you use aseptic technique, you
4 can't transmit the hep-C virus. That's what I said.

5 Q Okay.

6 A But the -- I never said that it was made for
7 multi --

8 Q I didn't --

9 A -- use --

10 Q -- I'm sorry.

11 A Okay.

12 Q I didn't say you said it was made for that. I
13 didn't mean to infer that.

14 A Well, that's --

15 Q I thought we had established that I could use
16 the 50 of propofol, just like a 50 of saline, that I can use
17 it, if I use safe injection practices and I use it within the
18 timeframe in which it's not going to go bad, that that would
19 be safe to use.

20 A Only in the context of the theoretical aspect of
21 aseptic technique. But again, a multi-dose vial that's
22 labeled that is different than a single-use vial, or a
23 single-patient-use vial.

24 Q Right.

25 A And we should make no mistake of that.

1 Q I'm making no mistake. The confusion arises
2 because it's a big bottle, correct?

3 A That's one of the reasons.

4 Q Okay.

5 A If you draw 5 ccs out, okay, or it will -- let's
6 say they were 10 cc syringes. And you take a 10 cc syringe,
7 it leaves 40 in the 50 ccs. It leaves 10 if you go ahead and
8 use the 20 ccs. You have more of a propensity, and if it is
9 contaminated because you go back in, you have the temptation
10 for the healthcare provider to go in many more times and
11 transmit the blood-borne virus if it gets into that vial.

12 THE COURT: If they go in with clean needles and
13 clean syringes, and it's within the expiration window so that
14 bacteria isn't growing in it, then Mr. Wright's question is
15 would that be safe?

16 THE WITNESS: It -- it would be safe if it was used
17 that way, but, again --

18 THE COURT: Okay. But what you're saying --

19 THE WITNESS: -- we have gone into an --

20 THE COURT: -- is there's human temptation and people
21 make mistakes and the bottle's sitting there, so somebody
22 could use a dirty needle or a dirty syringe in that open
23 bottle?

24 THE WITNESS: That is correct.

25 THE COURT: Okay. But then somebody could use a

1 dirty needle and a dirty syringe in any other bottle.

2 THE WITNESS: They could. But because it is larger,
3 there is more of a propensity for it to happen and infect
4 more --

5 THE COURT: Because it --

6 THE WITNESS: -- people.

7 THE COURT: -- because the more propofol you have,
8 the more patients you're likely to use it on.

9 THE WITNESS: That's one.

10 THE COURT: Is that fair?

11 THE WITNESS: That's one. But it also sends the
12 message, we have nothing in the armamentarium of anesthesia
13 that is a 50 cc medication vial. And when you see that, you
14 automatically -- and this is what was written in the 1995
15 editorial in the New England Journal of Medicine, you think
16 that that is a multi-dose vial, and you use it as a multi-dose
17 vial, because it is large.

18 THE COURT: But that doesn't have anything to do with
19 whether or not a healthcare provider would have to stick to
20 aseptic technique, does it?

21 THE WITNESS: No. We're talking about two
22 independent things here.

23 THE COURT: All right.

24 THE WITNESS: What we're seeing is, is that --

25 THE COURT: I'm going to -- I'm going to --

1 THE WITNESS: Yes.

2 THE COURT: I'm going to stop. I'm going to let Mr.
3 Wright take over.

4 BY MR. WRIGHT:

5 Q I agree with you. And that's why it's written
6 in an editorial in 1995. It lulls the good provider to
7 believe he can use it for multiple patients, because it's a
8 big bottle. And it comes with a spike, correct?

9 A And the spike, when you read what is on the
10 spike, it is for a multi-use because of additives and
11 diluents.

12 Q Right. And so a -- a person could believe he is
13 acting properly in using it multi-use, correct?

14 MR. STAUDAHER: Objection. Speculation. A person or
15 him?

16 THE COURT: Well, overruled, because he's already
17 talked about human temptation and error and -- and things.
18 So.

19 BY MR. WRIGHT:

20 Q Correct?

21 THE COURT: You can answer if you can. If you -- if
22 you can't --

23 THE WITNESS: Okay. Ask -- ask again.

24 BY MR. WRIGHT:

25 Q Okay. The -- I -- I think what we're saying,

1 it's a -- it's a big bottle. Written on it, on the label, is
2 single use, right?

3 A Yes, sir.

4 Q Okay. Is it single use, single patient use --

5 A It says single patient.

6 Q -- or single dose?

7 A It says single patient use.

8 Q Okay. So that means -- we'll get into that in a
9 minute, the difference between single dose, single use, and
10 single patient. Okay. But when I get it, when a
11 practitioner, he -- he orders this, or whoever orders it, do
12 you think a 50 should be used in an ambulatory -- an endoscopy
13 center?

14 A No. It should never be used.

15 Q What should be used there, 20s at the most?

16 A The smaller it is, the safer it is.

17 Q Okay.

18 A And I think there's plenty of testimonies from
19 the Teva people, including the -- the people who is the vice
20 president of, you know, consumer affairs, it's all in there.

21 Q What -- why -- why -- if it leads to the -- if
22 it leads the CRNA to believe it's multi-use because they send
23 it to him with a spike to use multi-use, why would the Baxter
24 salesman call up Jeff at the clinic and say, We've got 50s,
25 you want some?

1 MR. STAUDAHER: Objection. Speculation, Your Honor.

2 THE COURT: Yeah. It's sustained.

3 BY MR. WRIGHT:

4 Q You know what? Oh, I'm sorry. It's sustained.

5 Shouldn't have been sold to the clinic, correct?

6 A It shouldn't have been sold and it shouldn't
7 have been used.

8 Q Okay.

9 A There is -- there is equal --

10 Q Okay.

11 A -- responsibility for safety when it comes to
12 drugs. That means that the people at the clinic who are
13 responsible for ordering it and using it and not having things
14 such as policies and procedures in places and the ability to
15 go ahead and --

16 Q Okay.

17 A -- do quality control --

18 Q I understand.

19 A -- etcetera...

20 Q I understand you want to go broader. I just
21 want to take it step by step. Okay. The 50, how's it --
22 how's the labeling? How about the pamphlet in there? What's
23 it tell you in the 50?

24 A It says single use.

25 Q Where's it -- the pamphlet I'm talking about?

1 A That's what you asked.

2 Q I thought -- I thought I read your testimony
3 that the pamphlet was totally inadequate and it misleads the
4 person?

5 A This --

6 Q Wasn't that your testimony?

7 A It says single use and it is at the end of the
8 entire pamphlet. You've got thousands of words. Okay. The
9 manufacturer, when they go ahead and do that, that should be
10 front and center.

11 Q It wasn't, was it?

12 A It was not front and center.

13 Q It was buried at the ends of thousands of words
14 at the end back there talking about bacterial, correct?

15 A It was.

16 Q Isn't that your testimony?

17 A That's my testimony along with the fact that on
18 the vial, when you look at it and you aspirate it for
19 multi-use --

20 Q What's that mean?

21 A Okay. You take it out of the vial, you're
22 looking at the words Single Patient Use on the vial. The
23 pamphlets don't come into usually the operating room area.
24 They may not come into the inventory surgical center because
25 of the way in which it's packaged. It may be just the vial

1 itself. So it's prudent that what you have on the vial is
2 accurately placed.

3 Q Okay. And you have ---

4 A And it is single-patient-use vial.

5 Q And you thought the label wasn't good enough.
6 That was your testimony, that it didn't put them on notice,
7 correct, sir?

8 A Do you want me to expand on that, why I didn't?

9 Q Was that your testimony?

10 A Yes. Yes.

11 Q Okay. Is your testimony different whether it's
12 a civil trial for the manufacturer or whether it's a case
13 here?

14 A It makes no difference.

15 Q Okay. Then tell me why the label was bad, the
16 pamphlet was bad, and sending the spikes was bad. Tell me
17 first the label, it left off what?

18 A It didn't --

19 Q And why was it confusing?

20 A It didn't have anything in there about viral
21 transmission.

22 Q Correct. And the history of propofol had been
23 there, had been bacterial problems, correct?

24 A Initially it was. And then there got to be,
25 when they got the bacterial infections under control, there

1 was an increase in the viral transmission that was being
2 reported. There was no change that was made on the label.
3 That's what I complain about.

4 Q Right. There were -- there were problems with
5 viral transmission that were being reported in these obscure
6 journals, which no one reads. Yet nothing was done to put the
7 practitioners --

8 MR. STAUDAHER: Objection. Facts not in evidence.

9 BY MR. WRIGHT:

10 Q -- on notice, correct, sir?

11 MR. STAUDAHER: Journals nobody reads?

12 THE COURT: All right. That's sustained whether
13 anybody reads them --

14 MR. WRIGHT: Okay.

15 THE COURT: -- or doesn't read them.

16 BY MR. WRIGHT:

17 Q Let's talk about those journals. I think I was
18 just parroting your testimony you've given, correct?

19 A Which testimony?

20 Q The -- these obscure viral journals don't give
21 notice to the anesthesiology?

22 A First of all, I never said any -- you're
23 absolutely misquoting me. I never said anything about any of
24 these journals being obscure.

25 Q Okay. I thought --

1 A You're saying that.

2 Q I thought you said you -- you don't even read --
3 I mean you've -- you had never read the whole label, the whole
4 pamphlet of propofol, correct, when you were practicing?

5 A I have not read the entire pamphlet --

6 Q Okay.

7 A -- that's correct.

8 Q And I thought you said that the -- there was a
9 problem in that the message isn't getting out to the
10 practitioners, because it's put in things like the MMWR,
11 morbidity report or something, that no one reads other than,
12 like -- do you get it?

13 A I do not get it.

14 Q Okay. Let me find your testimony. If this
15 sounds familiar, okay.

16 Question was, "Have safe injection practices been
17 widely publicized?" Okay. Let me strike that.

18 "Tell me if you agree with the following statement."

19 MR. STAUDAHER: Objection, Your Honor. Is he -- is
20 he refreshing his memory or what's he doing?

21 MR. WRIGHT: I'm reading in something.

22 MR. STAUDAHER: Reading what?

23 THE COURT: I don't want to try to read Mr. Wright's
24 mind.

25 MR. WRIGHT: In this deposition.

1 THE COURT: So maybe Mr. Wright can tell us all what
2 he's doing.

3 MR. WRIGHT: Page 116.

4 THE COURT: Is this an inconsistent statement, Mr.
5 Wright?

6 MR. WRIGHT: Yes.

7 THE COURT: All right. Go ahead.

8 MR. WRIGHT: I'm just laying the --

9 THE COURT: And this is from his deposition taken in
10 one of the civil cases?

11 MR. WRIGHT: Yes.

12 THE COURT: And did you direct counsel to what page
13 you're reading from?

14 MR. WRIGHT: Yes. I was just setting the framework.

15 THE COURT: All right. That's fine.

16 MR. WRIGHT: I didn't want to mischaracterize the
17 question to him.

18 BY MR. WRIGHT:

19 Q The question to you was: "Tell me if you agree
20 with the following statement. Safe injection practices have
21 been well established as well as widely publicized." Do you
22 recall your answer?

23 A I would like to see where you're taking that
24 from. I want to see what deposition, please.

25 Q Does it make a difference?

1 A Yes, sir.

2 Q You testified differently in different cases?

3 A No. I can't remember the thousands of sheets or
4 trees that have been utilized.

5 Q Oh, I'm sorry. Did I give you my index or the
6 testimony?

7 THE COURT: Looked like -- is that the testimony?
8 Looked like it's --

9 BY MR. WRIGHT:

10 Q Did I give you the testimony? Yeah, that's it.
11 There the --

12 A Uh-huh. Thank you.

13 Q I didn't hand him the full transcript. I just
14 handed a portion of it.

15 MR. STAUDAHER: Isn't that page 117, as well, the
16 full answer to his question? Is it on this page and this
17 page?

18 BY MR. WRIGHT:

19 Q 117 there?

20 A 116 and 117 are there. Can I read it?

21 THE COURT: To yourself.

22 THE WITNESS: Out loud? So it's taken in the context
23 of what is said here. I think it's quite clear.

24 BY MR. WRIGHT::

25 Q Okay.

1 THE COURT: Well, let Mr. -- okay.

2 THE WITNESS: Or you can read it --

3 BY MR. WRIGHT:

4 Q No, you read it.

5 A -- if you'll read --

6 THE COURT: Okay.

7 THE WITNESS: Okay. I'll read it.

8 THE COURT: In a minute I'm going to read it.

9 THE WITNESS: All right. Here it is.

10 THE COURT: If Mr. Wright would like you to read it,
11 he can ask you to read it. If Mr. Wright wants to read it and
12 ask you if he read it correctly, he can do that.

13 So, Mr. Wright, apparently you --

14 MR. WRIGHT: Go ahead.

15 THE COURT: -- you fine with allowing the witness to
16 read his own deposition testimony?

17 MR. WRIGHT: Yes.

18 THE COURT: All right. Go ahead, Doctor.

19 THE WITNESS: Okay. "Tell me if you agree with the
20 following statement: Safe injection practices have been
21 well-established as well as widely publicized.

22 "I disagree with that statement.

23 "And why do you disagree with that statement?

24 "The reason is that I" --

25 THE COURT: Can you go question/answer,

1 question/answer.

2 THE WITNESS: Okay. Answer. The answer that I'm now
3 giving --

4 THE COURT: No, no. You just need to read it
5 directly.

6 THE WITNESS: Question -- okay, right.

7 THE COURT: Question, blah blah blah.

8 THE WITNESS: I understand. I understand.

9 THE COURT: Answer, blah blah blah. Question, blah
10 blah blah.

11 MR. WRIGHT: Start again.

12 THE COURT: Answer, blah blah blah. Question, blah
13 blah blah.

14 THE WITNESS: "Question: Tell me if you agree with
15 the following statement: Safe injection practices have been
16 well established as well as widely publicized.

17 "Answer: I disagree with that statement.

18 "Question: Why do you disagree with that statement?

19 "Answer: The reason is, and I have to qualify it,
20 so I'm glad you allow me to do it. I think that the CDC has
21 written a lot about it. I think that the ASA," which is the
22 American Society of Anesthesiology --

23 BY MR. WRIGHT:

24 Q You're not reading; you're editorializing.

25 A Well, I don't know if they know what ASA means.

1 THE COURT: Well, sir. Okay.

2 THE WITNESS: Okay. I'm sorry.

3 THE COURT: Okay. First of all, couple of things
4 again.

5 THE WITNESS: Okay.

6 THE COURT: Mr. Wright can follow up. Mr. Staudaher
7 gets an opportunity to follow up.

8 THE WITNESS: Okay. I apologize.

9 THE COURT: And I don't believe they do this in the
10 state of California, so you may not be familiar with it. Here
11 in the state of Nevada, jurors are permitted to ask questions.
12 So they write down questions. And if they -- if you use terms
13 and things like that they don't know or if you use a term and
14 I think maybe they don't know it or I don't know it, I'm going
15 to ask you.

16 THE WITNESS: That's fine.

17 THE COURT: And so --

18 THE WITNESS: Okay.

19 THE COURT: -- just read it verbatim.

20 THE WITNESS: We don't do that in the way in
21 California. Okay.

22 THE COURT: I know they do it in Arizona --

23 THE WITNESS: Yes.

24 THE COURT: -- they do it here. Many states don't
25 allow juror questions. It's a relatively new phenomenon.

1 THE WITNESS: "I think the CDC has written a lot
2 about it. I think the ASA has written a lot about it. I
3 think the AANA has written a lot about it. Part of the
4 problem is, is that a lot of the cases that occur were not
5 written in anesthesia journals. They were written in
6 infectious disease journals, virology journals. And so that
7 the ANA and the anesthesiologist healthcare professionals, it
8 wouldn't be readily available to them except through their
9 society are reading about it on the Internet or in the
10 newspaper when an outbreak like this occurs.

11 "But it is well known. It has been here for since at
12 least the early '90s in terms of the bacterial infections that
13 occurred with propofol with the original Diprivan and then
14 transitioned over into the viral transmission. And I think we
15 have not seen the fact that even though it is well known, that
16 all the factors have not been pieced together to try to change
17 the practice of the practitioners. So, in other words, it
18 isn't only just potentially getting information in the
19 anesthesia literature, it's going through exactly all the
20 things that occur."

21 That's what I said.

22 BY MR. WRIGHT:

23 Q Okay. I -- I read that, tell me if I'm wrong, I
24 read it, I understood when you don't agree with the statement.
25 You were asked: "Do you agree with the statement, Safe

1 injection practices have been well established as well as
2 widely publicized?" You answered, "I disagree with that
3 statement." Correct?

4 A That's what I said.

5 Q Okay. And then the part you disagree with is
6 that it had not been widely publicized. You agreed that it
7 was well established, yet not widely publicized, and explained
8 that it's written in what -- my word, obscure journals -- and
9 the message doesn't get out there to the practitioners. Is
10 that a fair characterization?

11 A I think it is not a fair --

12 Q Okay.

13 A The way I interpret it, because I said, and I
14 digressed on it, was the fact that it had been well publicized
15 in the ASA, the CDC, and the AANA. But that the original
16 transmissions of the virus were an infectious disease or viral
17 journals, which had been brought to the practitioner's
18 attention through their own society journals.

19 Q Keep reading. 118, maybe 119. Out loud.

20 MR. STAUDAHER: Out loud? I object, Your Honor.

21 MR. WRIGHT: Out loud.

22 MR. STAUDAHER: Is there a question pending?

23 MR. WRIGHT: Right.

24 THE WITNESS: Where would you like me to --

25 MR. WRIGHT: I'm going to impeach him.

1 THE COURT: Is it -- all right.
2 MR. WRIGHT: Yes it's inconsistent.
3 THE COURT: If it's -- I -- I'm going to trust you.
4 THE WITNESS: Where you would like me to start, sir?
5 BY MR. WRIGHT:
6 Q Well, you read 116, 117.
7 A Right.
8 Q I'll read the question and you finish the
9 question and --
10 A That's fine.
11 Q -- then go question and answer. I'll start it
12 for you.
13 A Okay.
14 Q "All right. Again, the question was, and then
15 I'll wrap it up. Safe injection practices"...
16 A "Have been well established as well as widely
17 publicized. You disagree with that statement?"
18 And I said: "Wait, okay, let's now." And the -- Mr.
19 Sharpe says, "Do you have" -- Mr. Sharpe is the --
20 Q Questioner.
21 A "Do you have a page number that you can
22 reference if you're reading on there?"
23 Mr. Couric says: "It's a general statement."
24 Mr. Sharpe: "You're reading it off the report. I
25 mean, you don't want to show him the report?"

1 "Answer: Okay. Let's break it up in terms of two
2 things. Start with the first portion of what you said.

3 Mr. Couric: "Safe injections practices have been well
4 established, first part."

5 Answer: They have been well established. Second
6 part" -- question. "Second part. As well as widely
7 publicized? Again, the widely publicized is partly because
8 the anesthesia had not been informed in a lot of what they
9 usually read. It's been through their own societies. But
10 again, part of that again goes back to duplicitousness. What
11 is the responsibility of the drug providers, meaning the
12 manufacturers even and the distributors. Do they have a
13 reason to go ahead and publicize this in ways that they can?"

14 You want me continue, right?

15 Q I can't remember. Is it still the same copy?

16 A Okay.

17 Q I don't want to tell you wrong.

18 A That's all right.

19 Q I think that -- the end of that sentence there.

20 A Okay. Okay.

21 Q I once, again, tell me if I'm wrong. I read
22 that, that you were explaining that although these problems
23 with injection practices and viral contamination were well
24 known, they were not widely publicized to the people who need
25 the information from the manufacturers, and/or in the stuff

1 these individuals read; is that a fair characterization?

2 A My characterization, again, is the same as what
3 I've said before. I interpret this as it would have been nice
4 to have the actual publication of what happened with the case
5 in an anesthesia literature rather than in a viral or an
6 infectious disease. What usually happens is because it's
7 vented through epidemiology and CDC, they publish in their own
8 journals. But there were certainly articles in the
9 anesthesiology, anesthesia and analgesia, in the American
10 Society of Anesthesia's monthly journal that they send out,
11 and the Anesthesia Patient Safety Foundation, which comes
12 quarterly. They've all written extensively about unsafe
13 practices and they've referred to these.

14 Q Okay. But the fact remains it's your testimony
15 that it was not widely publicized, correct, sir?

16 A The information was publicized. The actual
17 epidemiology and when it happened weren't published in the
18 journal. They were published in epidemiology journals.

19 Q Okay.

20 A But the information --

21 Q Do you read epidemiology journals?

22 A I have enough to read with just --

23 Q Okay.

24 A -- reading anesthesiology.

25 Q And so it's public --

1 A And that's why --

2 Q -- would you call an epidemiology journal an
3 obscure journal that anesthesiologists don't read?

4 A I never used the word obscure. But --

5 Q I said would --

6 A But I don't read it.

7 Q Do you know -- do all you anesthesiologists
8 gather around waiting for the next epidemiology journal to
9 come out?

10 A I --

11 MR. STAUDAHER: Objection, Your Honor.

12 THE WITNESS: No, we do not.

13 BY MR. WRIGHT:

14 Q Okay. And is that what you're meaning by it was
15 -- the information was not well publicized to the practitioner
16 who needs it and to be educated; isn't that part of the
17 problem?

18 A The -- the outbreaks were not put in the
19 anesthesia journal.

20 Q Okay.

21 A That is correct. But that they were well vetted
22 in anesthesia journals and through the American Society of
23 Anesthesia and the Anesthesia Patient Safety Foundation.

24 Q Okay. Are you -- you were also -- you're also
25 of the opinion that if Baxter had not sold 50s to the clinic

1 here, this would not have happened, correct, sir?

2 A That is -- that is true that it -- well, it may
3 or may not. We can go back to what we said before.

4 Q Well, have you --

5 A We --

6 Q -- previously testified --

7 A I have testified that it is more of a chance of
8 multiple patients being injected with a larger vial. I've
9 also said that you can still, with -- with unsafe injection
10 practices, will get viral spread with 20 ccs.

11 Q Did you --

12 A But the reality is, again, and I have said that
13 the propensity increases with the larger vial and more waste
14 and not throwing things away, and it leads to temptation.

15 Q If I succumb to the temptation, or whatever that
16 word is. Succumb?

17 THE COURT: Succumb.

18 BY MR. WRIGHT:

19 Q Succumb. I didn't do fancy.

20 THE COURT: Glad you clarified that.

21 BY MR. WRIGHT:

22 Q If I succumb to the temptation, as long as I use
23 safe practices, there's not a problem, correct?

24 A But we know that that does not occur in society.

25 Q Because of human error, correct?

1 A Correct.

2 Q Did you state that if Teva and Baxter had only
3 sold 20s, no one -- nobody would have got infected in spite of
4 the practice?

5 A We know my --

6 Q Did you testify to that?

7 A We know that if they had a 20 -- if they had --
8 well, actually, is that what I said? Can I see it?

9 THE COURT: Yeah. I think that was a yes or no, a
10 yes or no question.

11 THE WITNESS: Oh, was I --

12 THE COURT: Believe it or not, I think if we just
13 stick to the questions, we may move through this more -- more
14 quickly.

15 BY MR. WRIGHT:

16 Q Do you think you testified that way?

17 A Ask the question again.

18 Q Did you state that if Teva and Baxter would have
19 only sold 20s, nobody would have got infected in spite of the
20 practice?

21 A Certainly Mr. Washington would not have gotten
22 infected.

23 Q Okay. Well, this was your deposition in the
24 Martin and Hutchinson case, same there?

25 A I don't have all the data in front of me. It is

1 less likely that Martin would have gotten infected or Meana
2 would have gotten infected, and we could go on and on and on.

3 Q Okay. Now, the -- does -- see if I can phrase
4 this properly. Is part of the problem on the evolution of
5 single use and how it can be used with propofol, is part of
6 the problem evolve around its six-hour shelf life and
7 bacterial infection; do you understand what I'm saying? No,
8 didn't come out right.

9 A No. I -- I'm sorry. I don't -- I -- I --

10 Q I think the -- is -- is -- what's single use
11 mean?

12 A Single use as defined -- again, single use is
13 single patient use.

14 Q Okay. What does -- what's single dose vial?

15 A You give one dose.

16 Q Okay. And is there confusion with the evolution
17 of safe injection practices between single-use vial, single
18 patient file -- vial, single use vial, single patient vial,
19 and single dose vial?

20 A Not in my mind there isn't. Because it's just,
21 again, what the literature and the CDC says. They are all
22 single patient use vial. In other words, you use that vial
23 that you take that dose out of and you use it for one patient.

24 Q Okay. Well, is that a single dose or a single
25 patient?

1 A You can call it what --

2 Q It might take six doses out of one vial --
3 single-dose vial for one patient?

4 A It's a single-patient-use vial, no matter what
5 you call it.

6 Q Even though I call it single-dose vial?

7 A Whatever. That is correct.

8 Q Okay. And you think that's been consistent from
9 2002 till today?

10 A It is from my standpoint. Yes, sir.

11 Q Okay. Are you familiar with Medicare's
12 definition that a single-use vial -- for you that means single
13 patient, right? Medicare definition, "A single-use vial is a
14 vial that has a volume suitable for administration to one or
15 more patients." Familiar with that?

16 A Can I see it, please?

17 Q Are you familiar with it? Have you ever heard
18 it?

19 A I would like to see where you're finding that.

20 Q I don't want to show you yet.

21 THE COURT: Well...

22 BY MR. WRIGHT:

23 Q I want an answer. Are you familiar with that
24 definition from Medicare?

25 THE COURT: That's a yes or no question and --

1 THE WITNESS: I don't know.

2 BY MR. WRIGHT:

3 Q You don't know? Do you recall having previously
4 testified about it?

5 A That's why I want to see it.

6 THE COURT: Okay. You need to -- the way this works,
7 if you can't answer the question, then you say I don't know or
8 I don't remember, or I can't answer the question.

9 THE WITNESS: I said I don't know.

10 BY MR. WRIGHT:

11 Q Do you have --

12 THE COURT: Okay, you don't know.

13 THE WITNESS: Without seeing --

14 THE COURT: That's not what you said.

15 THE WITNESS: I can't recall.

16 THE COURT: Okay.

17 THE WITNESS: I can't recall without looking.

18 BY MR. WRIGHT:

19 Q Do you have any recollection of previously
20 testifying about a Medicare definition of a single-use vial as
21 a vial that has a volume suitable for administration to one or
22 more patients?

23 A I don't remember.

24 Q Okay. Do you want to see -- what do you want to
25 see, your testimony?

1 A Show me, first of all, where you're getting the
2 information from, and then I would like to see the testimony.
3 I would like to see both.

4 Q Okay. Exhibit N1. Ever seen that before?

5 A Yes, sir.

6 Q Where did you see it?

7 A I see it right here.

8 Q I said have you seen it before?

9 A I have seen it before. Yes, sir.

10 Q And where did you see it before?

11 A It was in my possession.

12 Q Did you testify about it?

13 A I can't remember what I testified. But --

14 Q I can't either, at the moment.

15 A Would you like -- then what are you asking?

16 Q Is that a correct definition?

17 A Okay. Let's take this in the context of what
18 this is. Okay. This is a provide -- this is a provider
19 education California Medicare Part B. And it has to do with
20 billing by Medicare or CMS for a single-use vial. Is it okay
21 if I read this?

22 Q Sure.

23 A I mean -- okay. "Single-use vial. Medicare's
24 definition of a single-use vial is a vial that has a volume
25 suitable for administration to one or more patients. For

1 example, a vial of medication contains enough for three
2 patients, and all three patients are scheduled to come in for
3 administration on the same day, likely for the same reason.
4 The manufacturer states that after opening, the open vial is
5 good only for 24 hours -- or 20 -- 12 hours, at which time any
6 remaining medication must be discarded. Administering the
7 medication to all three patients within 12 hours of opening
8 the container fits the definition of single use."

9 I want you to listen to the next sentence. "Medicare
10 will cover reasonable amounts of wasted drug from single-use
11 vials." Medicare is talking strictly about payment of certain
12 vials that you can use on more than one patient. And we
13 talked about this several hours ago. Let me refresh
14 everyone's memory.

15 The radio pharmaceuticals. It was the oncology drugs
16 for cancer, it was for Botox. And there are very rigid
17 regulations to be able to do that. You have to be in a
18 completely sterile environment, not an operating room, with
19 certain air exchanges with gloves and the bunny suits in a
20 sterile environment to be able to do this. That is the only
21 exception.

22 And Medicare did this because of questions of how it
23 was billed. This has nothing to do with safe practices.

24 Q What -- what that says, if I can get three doses
25 out of a vial, do you disagree with that reading, if it --

1 A But you have to put it into the context of the
2 fact that Medicare will cover reasonable amounts of wasted
3 drug from single use. They're talking about how to go ahead
4 and -- and bill this out if this is what you are using it for.

5 Medicare, this is not anything to do with injection
6 safe -- safe injection practices. It is --

7 Q Do you --

8 A -- absolutely nothing --

9 Q Do you recall testifying that that directive is
10 a perfect example of one arm of the government not knowing
11 what the other arm is doing, and that Medicare is talking
12 about saving money and what they propose is unsafe injection
13 practices?

14 A But they --

15 Q Did you testify to that, sir?

16 A Yes.

17 Q Okay. Why didn't you say that when I asked you
18 the question? Why didn't you say that when I asked you the
19 question? When you knew it?

20 A I did not know it until we reviewed this.

21 Q Well, you know, you testified that Medicare
22 wants you, because of saving money, if you can get multi doses
23 out of a single use, they want you to do that. And your
24 explanation was one arm of the federal government doesn't know
25 what the other arm is doing and Medicare shouldn't concern

1 themselves with unsafe practices. That's your testimony,
2 correct, sir?

3 A You're adding a little more than what my
4 testimony was. Okay.

5 Q Okay. Well, now you remember it.

6 A No, I don't. Shall you give it to me and I will
7 read it.

8 Q I can't find it.

9 A Because --

10 MR. STAUDAHER: Hold on, mis -- object. It
11 mischaracterizes his testimony, Your Honor. He says he
12 doesn't recall saying it in that way.

13 MR. WRIGHT: Well, I'll find it, then.

14 THE COURT: And also, if the State has it handy, the
15 State is also welcome to give that to Mr. Wright in the
16 interest --

17 MR. STAUDAHER: I mean, I have the transcript, but I
18 don't know if -- I don't have the paper.

19 THE COURT: Okay. No, that's fine. I just -- in the
20 interests of -- of moving things along.

21 MR. SANTACROCE: It's on pages 149, 150, and 151 of
22 his deposition on Michael Washington.

23 MR. WRIGHT: Okay. Thank you.

24 MR. SANTACROCE: And it's the July 13, 2009,
25 deposition.

1 MR. WRIGHT: Got it.

2 MR. SANTACROCE: July 13, 2009, deposition on Michael
3 Washington.

4 MR. WRIGHT: Pages again?

5 MR. SANTACROCE: 149, 150.

6 MR. WRIGHT: Look at that, as computer savvy as I am,
7 a yellow sticky. It says, "California Medicare."

8 BY MR. WRIGHT:

9 Q Little tiny writing.

10 A Where do you want me to start?

11 Q It starts --

12 A With Mr. Madden?

13 Q Mr. Madden.

14 A "Question: We've marked as Exhibit 3 a provider
15 education Medicare Part B California from
16 www.medicare@hic.com. Do you see that?

17 "Answer: But this is from California.

18 "Question: Yes. Which is where you practice, Right?

19 "Answer: That is correct.

20 "Question: Would you look at the billing for drug
21 wastage example on the second page under the heading,
22 'Single-Use Vial, Multiple Patients;' do you see that?

23 "Answer: I do.

24 "Question: Where it begins, 'A physician schedules
25 three Medicare patients to receive 30 milligrams each.'.

1 "Yes -- "answer: Yes.

2 "Question: Given that example, reviewing that
3 example, do you believe that -- strike that. Let me just put
4 on the record. It gives an example. A physician schedules
5 three Medicare patients to receive 30 milligrams each of Drug
6 A on the same day and within the designated shelf life of the
7 product. Currently, Drug A is available in 100-milligram size
8 and has a shelf life of only 12 hours. The physician
9 administers 30 milligrams to each patient. The remaining 10
10 milligrams are billed to Medicare on account, the account of
11 the last patient. Do you see that?"

12 "Uh-huh." That's the answer. The question: "Is it
13 your opinion that if a physician administered propofol in
14 compliance with the example that I just read to you, it would
15 be a violation of the standard of care?"

16 "Answer: It's absolutely below the standard of --
17 it's -- of care. And it's interesting that you bring this up,
18 because it tells you what happens when the billing portion of
19 our government, who is not responsible for patient safety, are
20 getting drugs out in the community, puts something like this,
21 which may be meant not for a drug like propofol, but it could
22 be for a chemotherapeutic agent, it could be for, you know,
23 one of the tests, radiopharmaceuticals that are used for
24 stress tests. Things that I have no knowledge in terms of how
25 they bill."

1 Q Okay.

2 MR. STAUDAHER: And for the record, that was not
3 inconsistent with what he's testified to, so I'm --

4 MR. SANTACROCE: Objection. That's argument, Judge.

5 MR. STAUDAHER: That was what this was offered for.

6 MR. SANTACROCE: That's not objection, that's
7 argument.

8 THE COURT: Well.

9 MR. STAUDAHER: Well, that's what it was offered for.

10 THE COURT: Okay. It's up to the ladies and
11 gentlemen of the jury to determine whether or not it's
12 inconsistent or consistent with his prior testimony.

13 Going forward, obviously be mindful that, going to
14 use his depositions, it needs to either be inconsistent or
15 cover an area where he has no current memory.

16 BY MR. WRIGHT:

17 Q Page 153. "Question: The recommendation set
18 forth in Exhibit No. 3" --

19 That's that document. What did I do with it?

20 A It's the one in your hand, I think.

21 Q -- "in your opinion, conflict with the standard
22 set by the CDC, U.S. Pharmacopeia, and FDA; is that right?

23 "Answer: That is correct." That's correct, right?"

24 A Relative to the safety issue; that is correct.

25 It's --

1 Q So, what you --

2 A -- it's -- because one is billing and it has to
3 do with certain things that I have explained about what you
4 can do, the only time that you can do that. It's consistent
5 with that.

6 Q Right. And if you want to get paid, you've got
7 to use it all, correct? Or you eat it under Medicare,
8 correct, sir?

9 A You are not able to go ahead and bill propofol
10 as a -- in multiple doses if it's a single-patient-use vial.

11 Q Okay. Was that your accurate testimony in that
12 case, but it's one arm of the government not knowing what the
13 other is doing and their directive violates the standard of
14 care; is that correct, sir?

15 A It is two different forms of government who have
16 two different things that they are responsible for. One is
17 the billing arm and the other is the safety arm. And if you
18 understand the context, it's totally consistent.

19 Q So that's all -- that's totally consistent to
20 you, despite you saying they're in contradiction, correct?

21 MR. STAUDAHER: Objection.

22 THE COURT: Overruled.

23 MR. STAUDAHER: Mischaracterizes his testimony.

24 THE COURT: Overruled.

25 BY MR. WRIGHT:

1 Q Correct? Is that correct?

2 A There are two different arms that have said two
3 different things.

4 Q Okay. Let me ask you about [indiscernible].
5 Are you familiar with a February 2008 CDC release on injection
6 safety, a patient safety threat syringe re-use?

7 A I would have to see it.

8 Q Look from there to there and tell me if you have
9 seen that. Just read it to yourself.

10 MR. STAUDAHER: Could -- could I come up and see what
11 he's looking at, Your Honor?

12 THE COURT: Of course.

13 MR. WRIGHT: Yes.

14 BY MR. WRIGHT:

15 Q I said from there to there.

16 A I just wanted to see where you took it from.

17 Q Come out of my notes.

18 MR. STAUDAHER: Are these your notes or are these --
19 what is this?

20 MR. WRIGHT: Those are my notes quoting things. I
21 want to know if he has seen that.

22 What are you looking at?

23 MR. STAUDAHER: I'm just trying to find out what the
24 document is you're handing him.

25 MR. WRIGHT: Says --

1 MR. STAUDAHER: I have a right to look at whatever
2 he's handing the witness, Your Honor.

3 MR. WRIGHT: Okay. Well, what I asked the witness to
4 do was --

5 THE COURT: Okay. Excuse me. Mr. Staudaher has a
6 right to look at whatever Mr. Wright is showing the witness
7 and should be given an opportunity while he stands there for
8 all of you to look at it together or what have you.

9 MR. STAUDAHER: What he's doing to the document.

10 THE COURT: Okay. Well, the only thing relevant for
11 you to look at, Mr. Staudaher, is that portion of the document
12 which Mr. Wright is showing the witness. If the witness has
13 had an opportunity to see any other portion of the document,
14 then Mr. Wright, you are directed that you must show that
15 portion of the document to Mr. Staudaher.

16 MR. STAUDAHER: So we're --

17 THE COURT: So, basically, if he viewed anything
18 other than that little folded-up part up there, then you have
19 to show the entire thing to Mr. Staudaher.

20 MR. STAUDAHER: I just want to know what this is that
21 we're looking at. Because it's not a paper. I thought it was
22 a paper he was showing me or some sort of article.

23 MR. WRIGHT: It isn't.

24 THE COURT: For the record --

25 MR. WRIGHT: Do you want me to tell you what it is?

1 MR. STAUDAHER: Well, no. What is this document
2 you're folding up?

3 THE COURT: What is the document?

4 MR. WRIGHT: What is the document I'm folding up?
5 It's my legal memo on --

6 MR. STAUDAHER: Well, I know -- he's showing him his
7 legal memo?

8 MR. WRIGHT: I have a quote -- it --

9 MR. STAUDAHER: To refresh his memory?

10 MR. WRIGHT: I have a quote in there out of a
11 journal.

12 THE COURT: Okay. Show me what you're -- okay.

13 MR. WRIGHT: Jeez.

14 THE COURT: So you're showing a memo that you wrote
15 to yourself or Ms. Stanish that --

16 MR. WRIGHT: Quotes --

17 THE COURT: -- quotes the CDC. Okay. So you want
18 him to read this quote, which you're maintaining here today is
19 an accurate quote from a CDC source, and then you're going to
20 say, okay, you've read a quote. Is that --

21 MR. WRIGHT: I'm going to ask him if he's familiar
22 with that -- if it identifies with the publication and where
23 it is.

24 THE COURT: Okay.

25 MR. WRIGHT: That's how I started with him.

1 THE COURT: So before you can -- Okay. Doctor, I'm
2 going to show you this part here. I want you to read it
3 quietly to yourself. All right.

4 The question is: Are you familiar with that as being
5 a quote from a publication or the CDC?

6 MR. STAUDAHER: May I look at it also, Your Honor?

7 THE COURT: Of course.

8 THE WITNESS: I'm -- I have not read this particular
9 CDC release, but I am --

10 BY MR. WRIGHT:

11 Q Okay. Well, then --

12 A -- if that's -- if you want me stop there, I'll
13 stop there.

14 Q Well, I don't -- I don't --

15 A That was your question, have I seen this.

16 Q Correct. That is my question.

17 A I have not seen this before.

18 Q Because I can't -- if I can't establish what it
19 is and you're not familiar with it, then I don't get to
20 question you about it.

21 THE COURT: He can't ask you about it.

22 BY MR. WRIGHT:

23 Q So I didn't want you to go on explaining it.

24 A Thank you very much.

25 Q I'll take that.

1 A Okay. Thank you.

2 Q I think I'm almost done, sir.

3 MR. WRIGHT: Thank you.

4 THE COURT: All right. Does anyone need a break
5 before -- everybody's good?

6 All right. Mr. Santacroce.

7 MR. SANTACROCE: Thank you.

8 CROSS-EXAMINATION

9 BY MR. SANTACROCE:

10 Q Dr. Friedman, you testified that you were
11 employed by plaintiff's counsel in the civil cases; is that
12 correct? Some of them?

13 A Yes, sir.

14 Q And can you tell me the cases that you were
15 employed in, of the -- specific -- let me rephrase that. I
16 don't want you to go through a whole bunch of them.

17 I only want to talk about the relevant ones in this
18 case. That might save us -- if you look on this chart here,
19 were you retained in -- for Kenneth Rubino?

20 A No, sir.

21 Q Lakota Quannah?

22 A Yes, sir.

23 Q Rodolfo Meana?

24 A Yes, sir.

25 Q Somnia Ariano [phonetic]?

1 A No, sir.

2 Q Gwendolyn Martin?

3 A Yes, sir.

4 Q And Nguyen Huynh?

5 A Yes, sir.

6 Q How about down here, Stacy Hutchinson?

7 A Yes, sir.

8 Q Patty Aspinwall?

9 A No.

10 Q Carol Grueskin?

11 A Yes, sir.

12 Q So of these people on this list, everybody

13 except Rubino, Grueskin, and it was one other one.

14 A Aspinwall.

15 Q Okay. And then for the infection on July 25th,

16 2007, Michael Washington; is that correct?

17 A Yes, sir.

18 Q And with regard to Michael Washington, when were

19 you retained by the plaintiff's law firm on that case?

20 A I'd -- I'd have to go back and look at the

21 files. I would say...

22 Q Well, if I -- if I help you out and tell you you

23 gave a deposition in that case in July of 2009, would that

24 help you?

25 A I was pegging it that it was done a couple of

1 record your time, are you recording it the same regardless of
2 who the insurer happens to be?

3 THE WITNESS: Yes.

4 THE COURT: So you bill out your time the same, and
5 then the billing people worry about is this Medicare, is this
6 Blue Cross Blue Shield, what have you; is that -- is that
7 correct?

8 THE WITNESS: Yes, ma'am. That's correct.

9 THE COURT: Okay.

10 BY MR. STAUDAHER:

11 Q So the time that you record actually does not
12 change, it is always the same?

13 A That's correct.

14 Q And so when you go to these classes and they
15 tell you these things or instruct you on it as far as that's
16 concerned, what is the purpose of that, those kinds of
17 classes? How do you stay in compliance?

18 A Well, it's just to make sure that if there are
19 any regulatory agency changes, that everybody knows and
20 everybody does it the same way within a department. But we
21 have new people that come all the time. We have people who
22 have been there 20 years. Those people usually know that
23 unless there is a change, that this is the way we've been
24 doing it all the time. But regulatory changes occur all the
25 time, but most of the time they don't occur very much when it

1 comes to billing.

2 Q So the times issue doesn't get changed very
3 much; is that correct?

4 A I can't remember in all the years of practice
5 since 1982 in anesthesia that there has been any change, that
6 this has always been the standard.

7 Q Meaning the face-to-face time calculated to put
8 down the time as it is?

9 A That's correct.

10 Q And we're talking about to the minute kind of
11 thing?

12 A To the minute.

13 THE COURT: I have a question. Do you do it the same
14 regardless of whether you're in a hospital, an outpatient or
15 an ambulatory -- well, you said you haven't been in an
16 ambulatory surgical center in roughly ten years; is that true?

17 THE WITNESS: That is correct.

18 THE COURT: And then what about an outpatient center,
19 when was the last time you billed in an outpatient center?

20 THE WITNESS: Within the last five years.

21 THE COURT: Okay. So most of your recent work has
22 been in the hospital setting?

23 THE WITNESS: Yeah. If you want to say I do mostly
24 in the hospital setting than in the outpatient facility.

25 THE COURT: Is that because of the type of procedures

1 you're doing?

2 THE WITNESS: It's because everything in my life has
3 been high risk patients.

4 THE COURT: Right.

5 THE WITNESS: That's the way I've been trained.

6 THE COURT: Okay. So are you doing simple -- I'm
7 just curious. Are you doing simple procedures on high risk
8 patients, or are you doing higher risk procedures on high risk
9 patients; meaning, I'm assuming, open heart surgery is more
10 risky than, you know, a colonoscopy generally?

11 THE WITNESS: That's correct. But usually if I'm
12 asked to do an outpatient, it's a high risk patient in a
13 procedure that usually is low risk, or it's a VIP patient who
14 I have done somewhere because of all the years I've been
15 there, they want me to do that procedure. And that turns out
16 to be in an outpatient facility.

17 THE COURT: Okay.

18 MR. STAUDAHER: Two documents --

19 THE COURT: Do you have follow-up to that line of
20 questions?

21 MR. STAUDAHER: Just for a couple. I've probably got
22 three, four minutes and that's it, Your Honor.

23 THE COURT: That's fine.

24 MR. STAUDAHER: I'm going to show you a couple of
25 documents now. Okay. The first is Exhibit 82.

1 THE COURT: Is that admitted Exhibit 82?

2 MR. STAUDAHER: It is admitted 82.

3 BY MR. STAUDAHER:

4 Q And this is, I'll represent to you, from the
5 clinic. And the part that I want you to --- can you see that
6 on your screen?

7 A I can.

8 Q Okay. And if that's hard for you to read
9 [inaudible] need to at any time, you just draw on the screen
10 [inaudible].

11 MS. STANISH: Excuse me. May we see the exhibit?

12 MR. STAUDAHER: While counsel is looking at that one,
13 I'll look at another one, Your Honor. And this is 86, by the
14 way.

15 I'm going to show you a highlighted version of --

16 MS. STANISH: Can we see that too? I'm sorry. We
17 don't have them memorized for copies. Thank you.

18 THE COURT: Maybe we should go to lunch. I need a
19 break actually, not just to eat. We were in session, as I
20 told you, ladies and gentlemen, I don't want you to think that
21 when we have late starts, you know, we're all reading gossip
22 magazines and eating donuts. We're actually in session on
23 hearings on unrelated, you know, matters. We have hundreds of
24 cases and sometimes we have to handle our other matters.

25 So we obviously had a break, but it's been a long

1 morning for us and so we're going to go ahead and take our
2 lunch break now. Ladies and gentlemen, it's now 12:30. We'll
3 be in recess for the lunch break until 1:50.

4 During the lunch recess, you are reminded you are not
5 to discuss the case or anything relating to the case with each
6 other or with anyone else. You are not to read, watch, listen
7 to any reports of or commentaries on this case, any person or
8 subject matter relating to the case by any medium of
9 information. Please do not do any independent research on any
10 subject connected with the trial, and please do not form or
11 express an opinion on the case.

12 I know you all want letters for your employers.
13 We'll get that to you today. Some of you have given letters
14 from your employers to me. We're not able -- well, I am
15 ignoring you, but I'm not in my head. I am aware of these
16 issues. I'm trying to address them, so just be aware of that.

17 I am told that we should be concluding prior to
18 the 4th of July holiday. I know there were questions about
19 that if we went past the 4th of July holiday, if you could
20 take a Friday off. I told Kenny I promise we won't be there,
21 but if we are, that will be a majority vote of the jurors if
22 people wanted to take it off, then I'm fine with that.

23 So those are to answer some of the issues that I know
24 you've been talking to Kenny about. Any other issue you need
25 brought up to me, please, he's always available to all of you.

1 So having said that, notepads in your chairs, and follow the
2 bailiff through the rear door.

3 (Jurors recessed at 12:31 p.m.)

4 THE COURT: Doctor, we are going to excuse you for
5 the lunch break.

6 I don't know if you want him available to talk to you
7 folks.

8 So you're free to go to lunch, whatever you want
9 to do. Just be back --

10 THE WITNESS: Just be back, 1:50.

11 THE COURT: Yeah. Be back before 1:50.

12 THE WITNESS: Okay.

13 THE COURT: If anyone needs to use the facilities, do
14 that. My staff and I need to take a quick break, then we'll
15 come back on the record to address what has come up with the
16 witness, as well as the lab fee memorandum.

17 (Court recessed at 12:33 p.m. until 12:39 p.m.)

18 (Outside the presence of the jury.)

19 THE COURT: All right. Out of the presence of the
20 jury, we're on the record.

21 Mr. Wright, you indicated you wanted to go on the
22 record at the bench --

23 MR. WRIGHT: Yep.

24 THE COURT: -- regarding the qualifications of the
25 expert.

1 MR. WRIGHT: Yep.

2 THE COURT: Go ahead.

3 MR. WRIGHT: Yes. I move to strike his testimony
4 regarding billing, because I had -- he isn't listed as a
5 billing expert. All I've read, and I --

6 THE COURT: I had asked for this previously, but I
7 never got it to my knowledge, is a copy of the expert -- you
8 might have given it to me or I've seen it, a copy of the --
9 but I may have given it back, a copy of the expert disclosure.
10 So as these issues come up, I can see what the disclosure was
11 and whether I think it was --

12 MR. WRIGHT: Well --

13 THE COURT: -- sufficient notice.

14 MR. WRIGHT: -- I'll -- I'll read it --

15 THE COURT: Just read it.

16 MR. WRIGHT: -- I'll read it to you.

17 THE COURT: That's fine.

18 MR. WRIGHT: Numbers -- Expert No. 63. "Dr. Arnold
19 Friedman, anesthesiologist, is expected to provide testimony
20 including, but not limited to, his direct involvement, review
21 of records and analysis of the victims in this case, as well
22 as proper anesthesia procedures, standards of care, proper use
23 and administration of anesthetic agents, anesthesiologist
24 supervision of certified registered nurse anesthetists, proper
25 aseptic technique, proper use and documentation of anesthesia

1 records, pre- and post-operative anesthetic care of patients
2 and ongoing procedures and related topics."

3 THE COURT: Well, he can -- I don't know what the
4 State's going to say, but to me the anesthesia records can be
5 -- this is how I write down my time. I don't write down 31
6 minutes for every single patient I see. I write -- and which
7 he actually has already testified to, I think, in response to
8 something I may have asked, trying to figure out if he had
9 knowledge to testify.

10 I think he can testify this is how I write down my
11 time. I write it down according to the time I spent with my
12 patient and that's how I would make an anesthesia record. I
13 think that's within the disclosure.

14 I think, you know, how it's --

15 MR. WRIGHT: He's an expert at that?

16 THE COURT: Well, any doctor --

17 MR. WRIGHT: From -- did he insert -- can I make my
18 argument?

19 THE COURT: Well --

20 MR. WRIGHT: He's at Cedars-Sinai; he's -- he's
21 brought in here as an expert. All I've read, and I've read
22 his depositions, everything in the case, never has he said a
23 word about billing. Okay.

24 THE COURT: Which, if you'd --

25 MR. WRIGHT: Or his time.

1 THE COURT: Okay. Wait a minute.

2 MR. WRIGHT: And --

3 THE COURT: If you hadn't interrupted me, Mr. Wright,
4 I would have said I think he can say how much time he puts on
5 the record. I haven't seen anything about billing the time.

6 MR. WRIGHT: Okay.

7 THE COURT: If you hadn't interrupted me --

8 MR. WRIGHT: I'm sorry. Then my motion to strike is
9 granted?

10 THE COURT: Well, I don't know what he said about
11 billing so far. I mean, because you -- you objected on the
12 foundation and Mr. Staudaher tried to lay a foundation. So
13 what is there to strike?

14 MR. WRIGHT: All of his testimony about his insurance
15 companies, the word Medicaid, Medicare, Med -- he --

16 THE COURT: I don't remember him getting there.

17 MR. WRIGHT: He -- he testified to all that.

18 THE COURT: What did he say?

19 MR. WRIGHT: I want to have it played back, then.
20 Because he testified --

21 THE COURT: Well, no, you tell me you remember --

22 MR. WRIGHT: He --

23 MR. SANTACROCE: He testified as to base units, he
24 testified to additional units of 15-minute increments, he
25 testified that this was CMS standards, start and stop time.

1 MR. WRIGHT: Start time, stop time, CMS, Medicaid,
2 anesthesia billing every 15 minutes --

3 THE COURT: Well --

4 MR. WRIGHT: -- base unit different with Medicaid,
5 Medicare, how private insurers do it, they follow state by
6 state. I do it, although you don't -- no, that's my voir dire
7 that he knows nothing. You take a guy who's an
8 anesthesiologist and his expertise is in California in his
9 hospital he changed -- he appears at an annual refresher
10 course. And so then he researches online so he can come in
11 here as a billing expert. He has no expertise in billing.
12 His records, anesthesia records, we have no idea what they
13 look like and they're -- if they're anything like the records
14 that are used here in Nevada or anything else.

15 THE COURT: Well, that to me is cross. I mean, I
16 think the -- just, look, the issue is basis of knowledge and
17 -- or expertise and sufficiency of the disclosure. On
18 sufficiency of the disclosure, he certainly can testify within
19 that disclosure as to how he records his time, because that's
20 part of the record. So I don't have a problem with that.

21 Now, you can point out on cross, as you've already
22 done on your voir dire, that this guy hasn't been in an
23 ambulatory surgical center in a decade. And he's only -- it's
24 half a decade since he's been in an outpatient clinic. So
25 he's only been doing this in a hospital setting pretty much.

1 So, I mean, that's cross.

2 But, you know, the disclosure was what he does in his
3 record. So the time he puts in his record, I'm fine with
4 that. That was in the disclosure. Now, I'm concerned about
5 the billing, from him to go from that disclosure to billing.

6 MR. SANTACROCE: And when I approached the bench --

7 MR. STAUDAHER: Well, and in the disclosure --

8 MR. SANTACROCE: -- I asked for an offer of proof as
9 to what he was going to be allowed to testify to as an expert.
10 And Mr. Staudaher said, Well, we gave you the disclosure.

11 There's nothing in the disclosure about the --

12 MR. STAUDAHER: You also said --

13 MR. WRIGHT: There's not a word --

14 MR. STAUDAHER: You also said it was going to --

15 MR. WRIGHT: -- about billing.

16 MR. SANTACROCE: And not a word about --

17 MR. STAUDAHER: -- be exactly --

18 MALE SPEAKER: One at a time.

19 MR. SANTACROCE: Not a word about billing in the
20 disclosure. And then he takes him on this long path of what
21 billing procedures are for providers and base units and
22 additional units and how anesthesiology is different in
23 billing because they get five base units because some
24 procedures are slower and some are longer and they shouldn't
25 be penalized. I mean, that's absolutely beyond what he was

1 qualified to be an expert in.

2 I'm joining Mr. Wright's motion to strike that
3 portion of his testimony.

4 MR. STAUDAHER: The disclosure said proper
5 documentation and use of anesthesia records. Those records
6 have no other purpose on the time issue than to use for
7 billing purposes. His limited knowledge is all that he's
8 testified to. His experience in how that is important, why he
9 goes and -- and takes these classes, so that he can be in
10 compliance when he's filling out those records and submitting
11 them for billing purposes.

12 THE COURT: Okay. He can testify what he puts in the
13 record, you know, if he tries to be accurate, why he tries to
14 be accurate. In terms of how it's all billed, I think that's
15 beyond the disclosure. But he can certainly, I think within
16 the disclosure, say this is how I record the time, this is why
17 it's important for it to be -- I mean, there are other reasons
18 they record the time, frankly.

19 Medical malpractice issues, you know, they need to
20 show that they were in attendance with the patient, they
21 didn't walk out of the room while this surgeon's there.
22 Because, as we've learned, and many of us knew before, you
23 know, they're responsible to make sure the guy's breathing.

24 So, I mean, there's other reasons they accurately
25 record the time that have nothing to do with billing. Now,

1 that's, of course, probably a primary area. But I'm sure
2 there's other reasons relating to claims -- later claims and
3 medical negligence and things like that. So they have to
4 document for a number of reasons. Some of which maybe their
5 carriers even care about.

6 I mean, they're -- I don't know. But I think, you
7 know, certainly the way he records it, why he's, you know,
8 accurate, what he does to see what time it is, anything like
9 that, I think is fine. I think beyond that, you know, you
10 know, what do you, you know, he can say, Is this the only
11 record you submit to your billing department regarding
12 compensation?

13 MR. STAUDAHER: The only thing I'm going --

14 THE COURT: Yes. Okay.

15 MR. STAUDAHER: -- I'm not asking him any further
16 questions if I've asked it.

17 THE COURT: How the gal bills it -- gal or guy, I
18 shouldn't be sexist -- bill it out from there I think is
19 beyond the disclosure.

20 MR. STAUDAHER: I mean, then, he clearly within his
21 knowledge with those anesthesia records that the time is -- is
22 15-minute increments. That's what he does. I mean, that's
23 not without -- that's not outside the scope of what we're
24 talking about. The reason to keep record time is to actually
25 document the time for billing purposes. That's what he told

1 -- testified to.

2 MR. WRIGHT: If the Court can't recall his testimony,
3 I want it played back. We went into question after question,
4 read them off, Mr. Staudaher. If the guy's out in the
5 recovery room and then a question is asked, Is it proper? No,
6 under CMS you can't. If it's face to face, No, you can't
7 under CMS. He even said under the law you can't. That's a
8 quote. Under the law you can't. And if -- if they come in
9 and ask you a question, can you, No.

10 Anesthesia's different than other things, under the
11 law, if you call your doctor, he can bill for it. If someone
12 comes in and asks me a question in recovery room, I can't bill
13 for it. That's the law. He testified for 15 minutes on this.
14 I want it stricken. That had nothing to do with time, 15
15 minutes, how I fill out my record.

16 He acknowledges he is not an expert. He has no
17 expertise, he has no billing. He had to go do some research
18 to come in and answer the questions that obviously Mr.
19 Staudaher told him, Here's what I'm going to ask you about. I
20 want to go into billing and whether you can do these things.
21 With no notice to us.

22 I've fully expected to hear this witness testify
23 about aseptic practices and multi-use of vials and everything
24 else. Because that's what -- that's what the discovery is on
25 him. And there's nothing about billing.

1 THE COURT: In any of his --

2 MR. STAUDAHER: When we were up at the bench we said
3 specifically that before we started questioning that witness
4 that we were going to ask him about start and stop times and
5 things like that.

6 THE COURT: I said start and stop times are fine.

7 MR. STAUDAHER: Yeah, and that's what --

8 THE COURT: That's fine. That's part of the record.

9 MR. STAUDAHER: So how do you define it?

10 THE COURT: And that's something he does as a doctor.
11 I'm fine with that. The -- and I think that's encompassed in,
12 ironically, civil expert disclosures are much more
13 comprehensive than criminal expert disclosures, which makes no
14 sense to me. But I think that that's sufficient under, you
15 know, as an expert disclosure for him to talk about the time,
16 because it says records and what they're used for.

17 You know, you can ask him, if you want, you know, Is
18 this what you turn over? Do you turn over any other records
19 to your billing department to bill your time? Beyond that, I
20 think you need a billing person, not this guy. It's not
21 disclosed.

22 MR. WRIGHT: I -- I want his testimony, all I'm
23 talking about on the billing, Can you bill for time spent with
24 patient? What about liability, is liability larger than the
25 time? Yes. Under CMS or CMT, whatever he's talking about.

1 THE COURT: Well, they're talking about malpractice
2 liability, I'm assuming.

3 MR. WRIGHT: But he -- he's not a billing expert,
4 Judge. He went into you cannot overlap. A billing --
5 according to the billings guides by CMS, you can't be treating
6 three patients or five patients at the same time. That has
7 nothing to do with his records and what I got notice of.

8 THE COURT: Sure it does. I mean --

9 MR. WRIGHT: That -- that the law says he can't do
10 that?

11 THE COURT: Well, okay. Here's the thing. I mean,
12 he can say, I can instruct them that this witness is not here
13 as a legal expert. Any testimony he gave regarding the law is
14 to be disregarded.

15 MR. WRIGHT: And billing.

16 THE COURT: But he can say, as a physician, if
17 somebody comes in and asks a question, he doesn't bill for
18 that time or -- or they're not allowed to do that. Because
19 it's what he fills out.

20 MR. WRIGHT: Why? Why is he not allowed to do that?

21 THE COURT: Well, he doesn't do that or whatever.

22 MR. WRIGHT: Well, why is that relevant what he does
23 in a hospital practice at Cedars-Sinai?

24 THE COURT: Well, how else are you going to get into
25 it? I mean --

1 MR. WRIGHT: They can call an expert --

2 THE COURT: -- that's all any --

3 MR. WRIGHT: -- on billing, Judge.

4 THE COURT: I said they had to -- that he can't talk
5 about billing and how it's done. He can say what kind of a
6 record he makes.

7 MR. STAUDAHER: And -- and why he makes the record.
8 I mean, that's -- that's the -- if he has knowledge of that,
9 that's the -- that's the --

10 THE COURT: Yeah, but --

11 MR. STAUDAHER: -- documentation --

12 MR. WRIGHT: Hearsay.

13 THE COURT: -- okay.

14 MR. STAUDAHER: -- and use of the item.

15 THE COURT: Looking up CMS today or yesterday isn't
16 why he makes the record. Because if -- if he knew why he made
17 the record, he wouldn't have to look up the CMS prior to
18 coming in to testify. I -- I mean, if it's something that's
19 part of your general basis of knowledge, hey, the billing gal
20 told me to do it this way, or, Hey, my senior partner did it
21 this way, or I've always done it this way, or I learned in med
22 school to do it this way, then why's he looking up the CMS?

23 I mean, so I'm comfortable, you know, saying he can't
24 make -- he's not -- here's a legal expert.

25 MR. STAUDAHER: We have no problem with that.

1 MR. WRIGHT: And --

2 MR. SANTACROCE: Or billing.

3 MR. WRIGHT: And --

4 MR. STAUDAHER: No. No and.

5 MR. WRIGHT: -- I want to strike his testimony.

6 That's my motion. He's -- he was called as an expert. He
7 himself says he's not an expert.

8 THE COURT: Well, he's given --

9 MR. WRIGHT: Therefore the information he provided
10 that he learned in classes once a year and that he looked up
11 is hearsay. It doesn't come in through a nonexpert. He is
12 not an expert. It's hearsay.

13 MR. STAUDAHER: It is -- how he fills out --

14 MR. WRIGHT: It's inadmissible.

15 MR. STAUDAHER: How he -- I'm sorry.

16 MR. WRIGHT: And -- and I don't care how he writes
17 down his time has nothing to do with all he testified about.
18 CMS out in recovery, if the patient's just a little farther
19 away in an ASC setting. He's never even been in a setting, or
20 billed in the HACHA [phonetic] setting.

21 MR. STAUDAHER: It is clearly within his knowledge
22 that he cannot deal with two patients at the same time.
23 That's what he's testifying to --

24 THE COURT: Well, that's what I said. He's fine --

25 MR. STAUDAHER: -- and it has to --

1 THE COURT: -- to record -- to testify how he records
2 his time. That as a physician he can't deal with two patients
3 at one time. To me, that's physician stuff. The gal in the
4 billing department can't say it's unethical or it's not good
5 procedure to run out into the recovery room when you've got a
6 patient on the bed. That's medical testimony. That's a
7 physician. And I'm fine with him doing that.

8 That would be inappropriate testimony for a billing
9 gal, some gal in billing is going to say, Oh, yeah, the doctor
10 has to stay with the patient and he can't -- I mean, come on.
11 That is medical testimony and you need a medical doctor to say
12 it. That is not billing testimony. So I'm fine with him
13 saying that about he doesn't write down the time, his duty is
14 to the patient in -- in the procedure room. That's medical
15 stuff. If they tried to put it onto a billing person, you'd
16 be standing here saying, Well, that's medical standard of
17 care --

18 MR. WRIGHT: Well, I would not.

19 THE COURT: -- test -- well, I'd be wondering why you
20 weren't saying it, then.

21 MR. WRIGHT: Saying -- saying I cannot bill if I have
22 three people under my care in -- in a -- in a prenatal unit --

23 THE COURT: No, he said they weren't really under his
24 care.

25 MR. WRIGHT: -- if I have four babies, I can bill for

1 all four of them. I tried the damn case. Don't -- I
2 understand there are different rules of procedures on when you
3 -- he had a word for it. It wasn't -- started with a C, about
4 when you can do it. Anesthesia's different. It's not like
5 other things. Because there are procedures where you can bill
6 co -- whatever the hell the word is, coterminously at the same
7 time. And -- and I am responsible for more than one.

8 And he's given a legal opinion that you cannot do
9 that, because anesthesia's different. And that isn't medical.
10 That is billing. I move to strike it.

11 THE COURT: I -- okay.

12 MR. WRIGHT: His billing testimony. And if then he
13 wants to say -- and -- and an instruction that how he fills
14 out his records and then it's -- the correct time, his start
15 time, stop time, I don't care about. What I care is he gave a
16 lecture to the jury, turned, looked to them and said, And
17 furthermore, if I'm in the recovery room -- he gave them eight
18 -- you have to have them written down in your questions to ask
19 him. And they -- they made hypotheticals that call for legal
20 conclusions. And he gave them. And he's not qualified.

21 THE COURT: Well, why didn't we get a contemporaneous
22 objection? Objection, calls for a legal, not a conclusion?

23 MR. WRIGHT: Because I'm moving to strike. Because I
24 thought he was an expert. And that's why I took him on voir
25 dire. Because I'm thinking, what's going on here?

1 THE COURT: Well, why weren't you looking at your
2 expert disclosure saying, Wait a minute, this stuff wasn't
3 disclosed to me, what's he doing? Objection. Exceeds the
4 scope of his expert disclosure. Then I would have hauled
5 everybody up here and said, Gee, let me read this. Oh, you
6 know what, it says --

7 MR. WRIGHT: I thought --

8 THE COURT: -- nothing about billing.

9 MR. WRIGHT: I thought --

10 THE COURT: I don't know, why not, Objection, exceeds
11 the scope of the expert disclosure?

12 MR. WRIGHT: My fault.

13 THE COURT: Objection, beyond the disclosed area of
14 testimony. I don't know, that's not that hard to me as
15 opposed to now trying to remember what exactly he said and we
16 want to do an instruction and not cut out the stuff that he
17 can say and cut out only the stuff he wasn't supposed to say.
18 I don't know, to me a contemporaneous objection, objection,
19 they haven't laid a foundation as to this type of testimony.
20 Like I said, to me, the obvious. Objection, exceeds the scope
21 of the expert disclosure. Then I can read it. I can say,
22 Gee, Mr. Staudaher, I don't see anything in here about
23 billing. You're blindsiding the defense. Why didn't you do
24 that instead of now sitting here trying to write some kind of
25 instruction to admonish the jury --

1 MR. WRIGHT: How --
2 THE COURT: -- to make the State look bad?
3 MR. WRIGHT: How tough is it to strike?
4 THE COURT: You know, I mean, this could have been
5 rectified --
6 MR. WRIGHT: The motion was to strike.
7 THE COURT: -- and we could have saved, you know, 20
8 minutes of testimony.
9 MR. WRIGHT: The motion is to strike. It wasn't to
10 instruct.
11 THE COURT: Strike what?
12 MR. WRIGHT: His testimony regarding billing only.
13 THE COURT: Well, then they're going to --
14 MR. WRIGHT: Billing practices and what the law is on
15 it. And I took him on voir dire and said, I'm going to want
16 to address this. And he said, You'll get the opportunity.
17 Okay. I'll wait. And then it's -- Wait, you should have been
18 -- we should have been doing it sooner.
19 THE COURT: Well, no. You took him on voir dire and
20 then Mr. Staudaher --
21 MR. WRIGHT: Right. And then -- and then --
22 THE COURT: -- tried to lay a foundation, and then --
23 MR. WRIGHT: Well, right. I --
24 THE COURT: -- I said let's go to lunch. I mean --
25 MR. WRIGHT: Okay. So I --

1 THE COURT: So that's my memory of what --

2 MR. WRIGHT: My motion is to strike.

3 THE COURT: Mr. Staudaher?

4 MR. STAUDAHER: Your Honor, he's an anesthesiologist.
5 You just said yourself that he -- that's his medicine side of
6 things, whether he can treat multiple patients at once,
7 whether he is able to do any of those things has nothing to do
8 with billings, per se. Although that's the ultimate result,
9 that he is able to either not bill or bill. The anesthesia
10 record was disclosed. How that record is used was disclosed.
11 That record is used for the purposes of billing and it has
12 very specific parameters by which it comes into existence and
13 how it's used and whether or not you can start a new one when
14 you've got one going on another patient, or you can start
15 three when you've got one going on a patient. All of that, I
16 believe, is subsumed within -- in the notice.

17 We disclosed up at the bench we were going to be
18 talking about start and stop times. That's why it's important
19 to even talk about start and stop times. Because if you have
20 a stop time, then you have a stop time. If it -- if it's
21 squishy and it goes on forever, you have no end time. And
22 that's what the issue here is in this case. That if there's
23 no end time, then you can bill for or five, six patients.
24 That was -- we talked about that at the bench before his
25 testimony started.

1 THE COURT: All right.

2 MR. STAUDAHER: There was no issue.

3 THE COURT: Here's what I --

4 MR. WRIGHT: Let me -- can I tell you, our -- our
5 next billing expert coming on. Let me tell you the notice
6 they gave us. "Joan Syler expected to provide testimony
7 including but not limited to medical record auditing, coding
8 compliance, documentation standards, auditing for
9 documentation to support charges billed to insurance company,
10 coding, healthcare financing guidelines and regulations,
11 provider insurance negotiation." This was the billing expert.
12 This was the notice, the next witness coming up. You tell me
13 that's the notice under Mr. Friedman.

14 THE COURT: I already said, Mr. Wright, why do you
15 keep fighting with me and screaming and yelling and carrying
16 on --

17 MR. WRIGHT: I talk loud.

18 THE COURT: -- about stuff that I've already agreed
19 with you? First of all, it's a waste of time, and second of
20 all, it's stressful for everyone concerned. And third of all,
21 in my view, it's completely unnecessary. So I don't know why,
22 when I've said it wasn't an adequate disclosure for billing,
23 why you have to keep saying it's not an adequate -- yeah, I
24 agree. It's not an adequate disclosure for billing.

25 In my view it is an adequate disclosure for how time

1 is recorded. I mean, records, what other records are we
2 talking about? There's, you know, the record, on cross you
3 can point out, is this the type of record you use? You've
4 never practiced in Nevada, you've only practiced in
5 California. You know, you haven't been in an ambulatory
6 center in 10 years? I mean, that you can, you know, bring up
7 on cross, that he's not really competent. I am willing to
8 give an instruction to the jury that they are not to consider
9 the last witness's testimony, this witness's testimony
10 regarding any legal conclusions. As to what is legally
11 permissible, as he was not, you know, he's not a legal expert.

12 I'm also willing to say that they can't consider his
13 testimony as to what he looked up on CMS, or what was told to
14 him in the annual billing classes or whatever. Beyond that
15 I'm not willing to do anything else. I will tell Mr.
16 Staudaher that he can't talk about how, then, his time is
17 billed out because he wasn't disclosed to do that. He can
18 only talk about how his time is recorded, you can ask him, you
19 know, how do you do it, do you synchronize your watches, what
20 do you, you know, when -- when do you start recording your
21 time, what about if you interview the patient, do you record
22 that, blah blah blah. That, I think, is permissible. All
23 right. That's what I'm willing to do.

24 MR. WRIGHT: That's what I'd like.

25 THE COURT: State, anything else on the proposed

1 instruction to the jury?

2 MR. STAUDAHER: No, that's fine, Your Honor.

3 THE COURT: From this point forward, Mr. Wright, I
4 would like a contemporaneous objection. Objection, exceeds
5 the scope of the disclosure. Objection, you know, I think
6 that's pretty easy, exceeds the scope of this witness's
7 knowledge, you know, if you don't want to call him an expert.
8 Exceeds, you know, the parameters of his knowledge or
9 expertise or whatever. Then we can maybe get a
10 contemporaneous ruling and save us all a bunch of time.

11 MR. WRIGHT: Yes, Your Honor.

12 THE COURT: Mr. Santacroce, you're standing up.

13 MR. SANTACROCE: I'm ready to go to lunch.

14 THE COURT: Yeah. You and I, you know, who would
15 have thought that...

16 MR. SANTACROCE: Like minds, you and I.

17 THE COURT: All right. Oh, before we go to lunch,
18 I'm sorry, Mr. Santacroce. As badly as my head is aching, I
19 want to bring up another issue. This whole disclosure thing.

20 Basically, according to this, you know, I'm not that
21 uncomfortable with releasing it to the lawyers here, because
22 the defense in some of these endoscopy cases had already
23 gotten it. The insurance defense, I don't remember, was Teva
24 all of them. But they had it. So it's been disseminated.

25 The important stuff in here, when I first read it, I

1 thought, Oh, no, this is all contrary. But when you get to
2 the end of it in my view, it's even worse about Dr. Desai when
3 he testified to. The important thing is it doesn't mention
4 that it was disclosed to Mr. Mitchell. It does mention that
5 it was disclosed to Mr. Labus, who received this. So I don't
6 know what was turned over from the what the Health District
7 had about this or not, but it says that it was given to Mr.
8 Labus. How it got from him to the civil lawyers, I do not
9 know. And that's not clear from the motions or anything.

10 Also, a few things that are different is he says he
11 was called several times by Geraldine and Lisa Falzone
12 encouraging her to call the CDC, or the Clark County Health
13 District. And then he says he spoke to Geraldine four or five
14 times and Maggie Murphy three or four times. He also says --
15 this is just I'm telling you what I remember as being
16 inconsistent with his testimony -- he began overcompensating
17 for the loss of self-esteem after his wife -- wife's death by
18 verbalizing his sexual liaisons to staff in both the
19 procedures rooms and in the common area, and that he no longer
20 was a team player based on his depression and -- depression is
21 my word.

22 So, other than that, I think that it's pretty much
23 the allegations consistent with what he testified to, and
24 sometimes even, like, worse than what actually came out. So
25 I'm going to re -- re-look at the briefing on the civil stuff.

1 But I think the gist of it was that the privilege belongs to
2 the client, not to the attorney. So if the attorney makes an
3 unauthorized disclosure, that doesn't mean that the client
4 can't still assert a privilege that he didn't intend any
5 disclosure to be made.

6 I think in this case, since it, you know, may have
7 impacted the Health District's investigation, I think that the
8 defense is right to be apprised of witness statements and
9 things like that, supercedes any privilege right that Mr.
10 Chaffee has, particularly since I've seen it, Mr. Labus has
11 seen it according to this, the civil lawyers have all seen it.
12 So it's not like there's some secret document that people
13 haven't seen.

14 So that's it.

15 MR. WRIGHT: So we get it?

16 THE COURT: Well, I'm just going to look over the
17 briefing again.

18 MR. WRIGHT: Okay.

19 THE COURT: But that's my initial impression.
20 Because, like I said, there's no big secret here and I think,
21 since the civil lawyers have all seen it, I don't see why the
22 criminal defense lawyers and the DAs can't see it when the
23 Health District's gotten it, maybe Metro's gotten it, I don't
24 know.

25 MR. WRIGHT: Okay.

1 THE COURT: Somehow it got distributed. I'm really
2 curious how it got distributed from --

3 MS. WECKERLY: He says his lawyer, his first lawyer
4 sent it.

5 THE COURT: Is that who gave it to Labus?

6 MS. WECKERLY: I think he gave it to other lawyers.

7 THE COURT: Other lawyers in the civil case? Because
8 what wound up happening, it looks like, is his criminal lawyer
9 is different than who's Ms. Johnson, who's ultimately
10 representing him civilly. And that's who starts asserting the
11 privilege, as I understand it. So.

12 MR. WRIGHT: More to put on the record, Your Honor.
13 On Shibonles Balducci [phonetic], that -- this redacted
14 document.

15 THE COURT: Correct. Right.

16 MR. WRIGHT: Margaret and Mr. Santacroce attested
17 they hadn't read it. I read it. I didn't realize this was
18 the same -- this -- when I went up there and stood and read
19 the whole thing --

20 THE COURT: Right.

21 MR. WRIGHT: -- I'm not going to use what was blacked
22 out. But I just wanted to tell you I did read it and that's
23 what I was talking about when I said, you know, this is where
24 she got all this stuff. So.

25 THE COURT: Okay. But it wasn't from the lawyer.

1 MR. WRIGHT: Correct. I was focused on this.
2 THE COURT: Right. Then --
3 MR. WRIGHT: But I did read that.
4 THE COURT: You read the memo --
5 MR. WRIGHT: Because I --
6 THE COURT: -- from the lawyer --
7 MR. WRIGHT: Right.
8 THE COURT: -- but --
9 MR. WRIGHT: I didn't know.
10 THE COURT: Okay. Well, that's fine.
11 MR. WRIGHT: Okay.
12 THE COURT: You can't unrace --
13 MR. WRIGHT: But I won't talk about it.
14 THE COURT: You can't unrace your memory, don't talk
15 about it, you've now got a redacted copy and suffice it to say
16 it wasn't the lawyer coaching her about her testimony or
17 anything like that.
18 MR. WRIGHT: Correct.
19 THE COURT: Correct? Okay.
20 MR. WRIGHT: Yes.
21 (Court recesses at 1:09 p.m., until 2:00 p.m.)
22 (Outside the presence of the jury.)
23 THE COURT: They'll be in in a minute.
24 MS. WECKERLY: Can I -- can you please read the
25 instruction you're going to --

1 THE COURT: I was just going to say something like,
2 Ladies and gentlemen, you must disregard any legal opinions
3 offered by this witness, as he is not an expert in legal
4 matters. Additionally, you must disregard any testimony as to
5 what this witness read on the CMS Web page or what he was told
6 at the annual billing classes.

7 MR. WRIGHT: Is it possible to add that you can
8 consider the balance of his testimony or -- you know, so it's
9 not they --

10 THE COURT: Right. Okay. You --

11 MS. WECKERLY: You can --

12 THE COURT: -- are free to consider the remainder of
13 his testimony and may give it the weight to which you deem
14 entitled.

15 MS. WECKERLY: Yes, please.

16 THE COURT: That's fine. I kind of ad-libbed that,
17 so I hope I remember.

18 MS. WECKERLY: It sounds right. I think I've heard
19 that somewhere.

20 MR. WRIGHT: Who is that? Is that your daughter?

21 THE COURT: Bring them in.

22 THE MARSHAL: Ladies and gentlemen, rise for the
23 presence of the jury.

24 (Jury reconvenes at 2:01 p.m.)

25 MR. STAUDAHER: Do you wish me to get the witness,

1 Your Honor?

2 THE COURT: I'm sorry?

3 MR. STAUDAHER: Do you wish me to get the witness?

4 THE COURT: Sure.

5 THE MARSHAL: Everybody may be seated.

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

7 Ladies and gentlemen, before we continue with the
8 testimony of the last witness, I have a -- an admonishment to
9 give you.

10 Ladies and gentlemen, you must disregard any legal
11 conclusions given by the last witness, as this witness is not
12 an expert in legal matters.

13 Come on back up.

14 You must also disregard any testimony regarding any
15 information the witness saw on the CMS Web page or what he was
16 told at the annual billing meetings. You are, however, free
17 to consider the remainder of his testimony and give it the
18 weight to which you deem it entitled.

19 All right. Sir, you are, of course, still under
20 oath.

21 And Mr. Staudaher, you may resume your questioning of
22 the witness.

23 MR. STAUDAHER: Thank you, Your Honor.

24 DIRECT EXAMINATION (Continued)

25 BY MR. STAUDAHER:

1 Q Just a couple of items. Showing you what has
2 been admitted as State's 82. And the highlighted portions of
3 this are mine, just so you know. But I want to go through
4 this with you a little bit. I'll represent to you that this
5 came from the clinic.

6 In reading the highlighted portion, can you do that,
7 or would you like me to bring the document up to you and make
8 it easier?

9 A Could I have the document?

10 Q Just take your time and [indiscernible]. Are
11 you done? Now, that passage there delineating some of the
12 things we've talked about, in comparison with your experience
13 and practice in anesthesia, how you calculate your times, you
14 know, and the like, is this the -- the formula, or is this how
15 you do it, essentially?

16 A Yes, sir.

17 Q To your knowledge, is this the way you've always
18 done it?

19 A Yes, sir.

20 Q I'm going to show you State's 86, and again, the
21 highlights are mine on this, this particular document.

22 MR. WRIGHT: What was that previous exhibit, Mr. --

23 MR. STAUDAHER: Previous -- previous one was 82.

24 MR. WRIGHT: Thank you.

25 MR. STAUDAHER: And this one is 86.

1 BY MR. STAUDAHER:

2 Q Now, also, as you can see, the title of this is
3 Gastroenterology Center of Nevada Instructions to
4 Post-Anesthesia Charges. It appears as though this is the way
5 that it -- this is what the document shows is how it was done,
6 at least at this center.

7 MR. SANTACROCE: I'm going to object to leading.

8 THE COURT: Overruled. It's kind of foundation.

9 BY MR. STAUDAHER:

10 Q With regard to where it's listed here where it's
11 talking about to figure units for time, calculate how many
12 15-minute increments there are, a portion should be rounded
13 off to the next 32 minutes, that would be -- it gives an
14 example of that being three units; do you see that, 32 minutes
15 would be three units?

16 A Yes, sir.

17 Q Now, if this was the -- if the practice of the
18 clinic was based on that, would that comport with the
19 15-minute billing that you're talking about, if the insurance
20 carriers accepted that, for example?

21 MR. SANTACROCE: I'm going to object.

22 THE COURT: Sustained.

23 BY MR. STAUDAHER:

24 Q Would it be three units of anesthesia as
25 depicted here in this record?

1 MR. SANTACROCE: Objection. Foundation.

2 THE COURT: I don't understand -- I don't understand
3 the question.

4 BY MR. STAUDAHER:

5 Q In the -- this is -- I'm -- I'm representing to
6 you that this came from the clinic. It's entitled -- it's
7 titled at the clinic; do you see that?

8 A Yes, sir.

9 Q And where it's talking about the figuring of
10 15-minute increments and what 32 minutes would be, would that,
11 based on this comport --

12 THE COURT: Is that how you did it? Is that your
13 question?

14 MR. STAUDAHER: I'm -- that's one of them. But I'll
15 -- we can ask that one first.

16 BY MR. STAUDAHER:

17 Q Is this how you would do it?

18 A No, sir.

19 Q Okay. How would you do it?

20 A Well, again, it was -- it strictly is the time.
21 In other words, the beginning and end time.

22 THE COURT: So you -- I'm sorry to interrupt. So you
23 didn't compute the units? You would just say I started the
24 patient at 10:00, I finished the patient at, say
25 hypothetically, 10:37, and you'd write on your chart, you

1 know, 10:00, 10:37; is that --

2 THE WITNESS: That's correct.

3 THE COURT: -- fair? Okay.

4 BY MR. STAUDAHER:

5 Q In doing your work, would you -- regardless of
6 procedure, would you just put down a -- a time? I mean, like
7 a set time like that?

8 MR. SANTACROCE: Objection. Vague, ambiguous.

9 THE COURT: Do you understand the question?

10 THE WITNESS: Would you repeat it again?

11 BY MR. STAUDAHER:

12 Q In doing your normal anesthetic times, and I'm
13 talking about for procedures like endoscopies or -- or
14 anything like that, when you -- when you put down your time,
15 is it the actual time or is it just some arbitrary number that
16 you just put down?

17 A It's the actual time.

18 MR. STAUDAHER: I pass the witness, Your Honor.

19 THE COURT: All right. Cross, who would like to go
20 first? Mr. Wright?

21 MR. WRIGHT: Yeah.

22 CROSS-EXAMINATION

23 BY MR. WRIGHT:

24 Q By the way, my name is Richard Wright. I didn't
25 introduce myself previously. I represent Dr. Desai.

1 Let's talk about your practice and experience in
2 California. Have you ever practiced in Nevada?

3 A No, sir.

4 Q Okay. And after Air Force, your specialization,
5 you end up -- I don't -- end up, I don't mean derogatorially,
6 you land at Cedars-Sinai in California and you've been there
7 about ever since?

8 A Yes, sir.

9 Q Okay. And you're an anesthesiologist and
10 specialize in what area?

11 A Well, most of the area has been in
12 cardiovascular anesthesia. It has been in critical care
13 medicine. But it also means taking patients who have
14 cardiovascular problems and doing anything on them. That can
15 be abdominal surgery, it can be a hip, it can be endoscopy, it
16 can be a catheterization. It's just taking a subset of
17 high-risk patient through any surgery or procedures at Cedars.

18 Q Okay. And so the vast majority of your
19 anesthesia practice is what -- and I don't use all the correct
20 medical terminology -- high-risk difficult procedures at --
21 no, patients?

22 A Not all of them. I -- before I -- as I said,
23 because I've been there a while and I've developed a
24 reputation, I have a lot of VIP patients who I take through
25 what most people would say is just ordinary surgery, who are

1 not high-risk --

2 Q Okay.

3 A -- but they want to have a safe anesthetic.

4 Q Okay.

5 THE COURT: So if Barbara Streisand calls you, that's

6 -- you would -- that --

7 THE WITNESS: I wouldn't say no.

8 THE COURT: Okay.

9 BY MR. WRIGHT:

10 Q Do anything with Michael Jackson?

11 A I do not -- corporate compliance --

12 THE COURT: He doesn't want to touch that.

13 THE WITNESS: -- does not allow me to discuss any of
14 these natures with the patients.

15 BY MR. WRIGHT:

16 Q So we don't have a yes or a no.

17 THE COURT: He isn't allowed to answer that question.

18 BY MR. WRIGHT:

19 Q The -- I -- I guess the endo center, what we
20 call the Gastroenterology Center here in Las Vegas that's the
21 subject of this criminal case, it was -- Dr. Desai was the
22 majority owner of --

23 THE COURT: Oh, keep your voice up.

24 BY MR. WRIGHT:

25 Q I guess -- I guess the gastro center here in Las

1 Vegas that Dr. Desai was a majority owner of in the Endoscopy
2 Clinic of Southern Nevada would -- would fall within the
3 ambulatory surgical center category of your classifications?

4 A Yes, sir.

5 Q Okay. And have you ever practiced anesthesia in
6 an ambulatory surgical center?

7 A No, sir.

8 Q Okay. And you have in what you call outpatient
9 clinics, correct?

10 A Yes, sir.

11 Q Okay. And -- and when's the last time you did a
12 endoscopic procedure, like in an outpatient clinic?

13 A Within 5 to 10 years.

14 Q Okay. Now, you have familiarity with this case,
15 correct?

16 A Yes, sir.

17 Q Okay. How -- how did you end up being here as a
18 witness?

19 A How? I assume, I don't know this for sure, but
20 I was involved in the trial with plaintiffs against Teva and
21 against Baxter and I got -- I got a phone call from one of the
22 lawyers whose patients I represented, and she told me that I
23 would get a call from the district attorney's office.

24 Q Okay. And who -- who is that, first of all,
25 Teva, Baxter, who are they?

1 A They are the generic manufacturer and the
2 distributor -- and Baxter is the distributor of propofol, the
3 generic brand.

4 Q Okay. And you represented -- or not
5 represented. You were involved in the civil litigation on
6 behalf of plaintiffs in civil litigation arising out of these
7 circumstances of this case?

8 A Yes, sir.

9 Q Okay. And who was -- who was the lawyer who
10 contacted you?

11 A It was Nia Kellebrew.

12 Q Okay. And did -- did she -- you had been -- let
13 me back up on that.

14 You had been retained as an expert for how many of
15 these cases?

16 A Well, I can't -- I can't tell you the total
17 percentage, because it had settled out. I did represent the
18 -- any of the plaintiffs that were from the Bernstein law firm
19 and from the Gillock Law Firm, which was Ms. Kellebrew.

20 Q Okay. And by represent, you mean as an expert
21 witness?

22 A Yes, sir.

23 Q Okay. And did you have to get some -- some type
24 of waivers or something to be able to go to work for the
25 district attorney's office?

1 A No, sir.

2 Q Okay. I presume you -- are you being paid by
3 the district attorney's office?

4 A To be quite honest with you, I never discussed
5 the payment at all, so I have no knowledge of that.

6 Q Okay. Well, the -- how many cases -- so you're
7 doing it pro bono?

8 A I have no -- as I said, I don't know.

9 Q Okay. So when -- when Ms. Kellebrew called you
10 she asked you to help out the district attorney's office?

11 A No. She said you will be getting a call from
12 the district attorney's office about this case.

13 Q Okay. And did you say for what?

14 A Well, I said that and she just said that this is
15 for the trial for Dr. Desai. And that's all I discussed with
16 her. That was it.

17 Q Okay. Well, are those other law firms paying
18 you?

19 MR. STAUDAHER: Your Honor, I'm going to object this
20 point to --

21 THE COURT: Overruled.

22 THE WITNESS: No.

23 BY MR. WRIGHT:

24 Q Okay. Well, the -- I mean, you -- you charge a
25 lot, correct?

1 A I have in the previous cases, yes.

2 Q Okay. And, like, how much do you charge?

3 A Well, it depends what it is that I do. The
4 usual and customary for a malpractice case, which is what I'm
5 usually involved with, is \$400 an hour.

6 Q Okay.

7 A And that's to review the case. Then it depends
8 whether I go out of town or not.

9 Q What did -- what did you charge in these, I'll
10 call them the endoscopy Las Vegas cases?

11 A Well, that's what I charge. I charge \$400 an
12 hour.

13 Q Okay. And -- and you said that's your standard
14 and customary rate?

15 A Yes, sir.

16 Q Okay. Do you do this for a living?

17 A No, sir.

18 Q Okay. I mean, being an expert witness?

19 A No, sir.

20 Q Okay. So this is, like, your first occasion on
21 these cases?

22 A No, sir.

23 Q Okay. Second?

24 A No, sir.

25 Q Fifth?

1 A No, sir.

2 Q Tenth?

3 A No.

4 Q Twenty?

5 A No, sir.

6 Q Higher?

7 A Yes.

8 Q This is a hobby?

9 A No, sir.

10 THE COURT: What percentage of your income would you
11 attribute to expert fees, whether it's a file review or a
12 deposition or testifying at trial or doing a malpractice
13 affidavit or whatever?

14 THE WITNESS: Less than 1 percent.

15 THE COURT: Of your total income?

16 THE WITNESS: Yes.

17 THE COURT: Okay. And I'm assuming that's annual?

18 THE WITNESS: That's annual. Yes, ma'am.

19 THE COURT: Okay.

20 BY MR. WRIGHT:

21 Q Less than 1 percent of annual income. How much
22 did you make off the Las Vegas endoscopy cases?

23 A The total amount of that, I can't tell you
24 exactly, but I'll give you an approximation, at least \$50,000.

25 Q Total in all of them?

1 A Yes, sir.

2 Q Okay. So \$50,000 is 1 percent of what? Boy,
3 you're rich.

4 A No. I think the judge said when you allocate
5 this over a 30-year period, this was -- this was the most
6 amount of money by far.

7 Q I didn't hear her say anything about allocating
8 it over a 30-year period.

9 A She said annual --

10 THE COURT: Perhaps it was a poorly phrased question.

11 THE WITNESS: She said annual. So obviously, the one
12 year I got that amount of money was not 1 percent of my
13 salary. But if you go ahead and add 30 years of doing this,
14 it was less than 1 percent when you allocate it --

15 BY MR. WRIGHT:

16 Q Okay.

17 A -- over a 30-year period.

18 Q And you -- you've testified in many cases?

19 THE COURT: We can't hear --

20 BY MR. WRIGHT:

21 Q You've testified in many cases? Many, M-A-N-Y.

22 A No.

23 Q Not mini, M-I-N-I.

24 A No.

25 Q Many cases. No?

1 A No.

2 Q Okay. You examine the cases, do depositions,
3 and then they normally settle?

4 A That is correct.

5 Q Okay. So the cases actually going to, like, a
6 civil trial are a rarity?

7 A That is correct.

8 Q Now, the -- the theory, the lawyers who directed
9 you, the district attorney's office, the theory of their
10 civil --

11 MR. STAUDAHER: Objection. Directed him?

12 MS. WECKERLY: Can we approach?

13 THE COURT: All right.

14 MR. WRIGHT: The -- I'll rephrase it.

15 THE COURT: I mean, I think that's sustained. That's
16 the lawyer who contacted you and told you you would be
17 contacted by someone from the DA's office.

18 MR. WRIGHT: Correct. Well, it --

19 BY MR. WRIGHT:

20 Q Fair to say it appears some lawyers had a
21 conversation with the district attorney's office about --

22 MR. STAUDAHER: Objection. Hearsay, Your Honor.

23 THE COURT: Well, that would be speculation. I mean,
24 unless...

25 BY MR. WRIGHT::

1 Q Well, does Nina [sic] Kellebrew of the Bernstein
2 Law Firm --

3 MR. STAUDAHER: Objection. That's not her law firm.

4 THE COURT: That's correct.

5 MR. WRIGHT: Okay. Wrong --

6 THE COURT: It's -- it's Gillock Kellebrew, I think.

7 MR. WRIGHT: Okay.

8 BY MR. WRIGHT:

9 Q What firm is it? I misstated it.

10 A What is your question? Repeat your --

11 Q What law firm is --

12 THE COURT: Is Ms. Kellebrew with?

13 BY MR. WRIGHT:

14 Q -- Kellebrew with?

15 A Gillock.

16 Q Gillock. Gerold Gillock Law Firm.

17 A That's correct.

18 Q Ms. Kellebrew just called you and said expect a
19 call from the district attorney's office?

20 A That's correct.

21 Q Okay. Did that lead you to believe there had
22 been some discussions that took place --

23 MR. STAUDAHER: Objection. Speculation.

24 BY MR. WRIGHT:

25 Q -- with the district attorney's office?

1 A I have no --

2 MR. STAUDAHER: Objection. Speculation, Your Honor.

3 THE COURT: Well, were you then contacted by someone
4 from the district attorney's office?

5 THE WITNESS: Eventually, I did get an e-mail from
6 Mr. Staudaher.

7 THE COURT: Mr. Staudaher? How long after the
8 conversation with Ms. Kellebrew did you receive that e-mail?

9 THE WITNESS: Probably within a week.

10 THE COURT: Okay. And -- and you spoke
11 telephonically with Ms. Kellebrew?

12 THE WITNESS: She called me, yes.

13 THE COURT: Okay. Go on, Mr. Wright.

14 BY MR. WRIGHT:

15 Q Did -- did you talk to Ms. Kellebrew after you
16 got the call from the district attorney's office?

17 THE COURT: E-mail.

18 THE WITNESS: No.

19 BY MR. WRIGHT:

20 Q Okay. Now, the cases of the Rawlings Law Firm,
21 you were an expert in their cases?

22 A I'm not familiar with the Rawlings Law Firm.

23 Q Or, like, I keep -- I can't keep it --

24 THE COURT: Edward and Bernstein I think was the
25 firm. Did you deal with --

1 MR. WRIGHT: Gillock. Gillock.

2 THE COURT: Oh.

3 MR. WRIGHT: God. Jerry Gillock's law firm.

4 BY MR. WRIGHT:

5 Q Were you an expert in their cases?

6 A In the -- in -- if we're talking about the
7 propofol trial, yes.

8 Q Okay. Which -- who was the plaintiff in that?

9 A The -- well, the one -- the only jury trial that
10 I had was the Michael Washington case.

11 Q Okay. Michael Washington. And that was hand --
12 that's the Gillock Law Firm?

13 A No. That was the Bernstein.

14 Q Okay. Gillock Law Firm had some of the
15 plaintiffs arising out of this, right?

16 A That's correct.

17 Q You were an expert for them?

18 A That's correct.

19 Q Those cases settled as a result of trials?

20 A Well, they eventually settled, yes.

21 Q Okay. And the -- the ferry by which those cases
22 were going forward was what?

23 MR. STAUDAHER: Your Honor, at this point, legal
24 conclusion and relevance to this?

25 THE COURT: Well, if he -- if he knows or he can talk

1 about what he was assigned or asked to do as an expert.

2 MR. STAUDAHER: But that has nothing to do with the
3 theory that they had.

4 THE COURT: Well --

5 MR. STAUDAHER: It has to do with what he was asked
6 to review.

7 THE COURT: -- as it relates to his testimony, if he
8 knows.

9 THE WITNESS: Okay. Would you please rephrase the
10 question?

11 BY MR. WRIGHT:

12 Q What were the defendants being sued for?

13 A Product liability.

14 Q Based upon what?

15 A The way in which they had large vials and how it
16 might have led to the transmission of the virus, how they had
17 a mini spike that might have led to using the drug on multiple
18 patients, and the fact that a large vial is -- in an area such
19 as an ambulatory care center that does endoscopy which has
20 short procedures, a 50 cc vial should not be in that area.

21 Q Okay. We'll get back to all that. But is a --
22 a predicate, a basis for the lawsuit --

23 MR. STAUDAHER: Objection. Legal conclusion, Your
24 Honor.

25 THE COURT: Well, overruled. Again, he can -- you

1 know, don't give us any legal conclusions or speculate or
2 opine as to legal, you know, decisions that may have been made
3 by the lawyers. As it pertains to what you were asked to do
4 as an expert or your understanding of the, I guess, interface
5 between the claims made against the manufacturer, medical
6 claims that you were consulted on or opined on, you can
7 certainly testify as to that. Okay. I don't know if that
8 makes sense to you.

9 So, Mr. Wright, within that sort of parameter, he --
10 you can ask him the questions.

11 BY MR. WRIGHT:

12 Q A factual predicate, or a -- before the
13 manufacturers could be sued in the manner in which they were
14 sued for product liability, it was necessary that there be a
15 determination that the hepatitis C of Mr. Washington had been
16 transmitted by propofol use, correct?

17 A For inappropriate -- for unsafe injection
18 practices of propofol; that's correct.

19 Q Okay. So that -- that was a necessary basis,
20 meaning if -- if the hepatitis C transmission had been caused
21 by some other mechanism, like dirty scopes, whatever the
22 alternatives were, then you couldn't sue the manufacturers,
23 right?

24 MR. STAUDAHER: Objection. He doesn't -- he's not
25 the one suing the manufacturer. He's asked if he'd come in as

IN THE SUPREME COURT OF THE STATE OF NEVADA

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SEP 02 2014 09:15 a.m.
Tracie K. Lindeman
Clerk of Supreme Court

DIPAK KANTILAL DESAI,)
)
 Appellant,)
)
 vs.)
)
 THE STATE OF NEVADA,)
)
 Respondent.)
 _____)

CASE NO. 64591

APPELLANT’S APPENDIX VOLUME 31

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But I'm just saying we've heard what the issue is. We'll have the people bring in what they relied upon to make those assessments.

THE COURT: If it's not their memory.

MS. WECKERLY: Right. Right. Sure. And then there shouldn't be a problem.

MR. STAUDAHER: The Court is ordering those witnesses, in case there's some issue with them trying to find them, if they have to go up to corporate counsel or whatever, that the Court's ordering them to produce that stuff.

THE COURT: Yeah, whatever they're going to need to rely on to discuss the -- how much they paid out. And I mean, you know, the one where they were all lumped together, it's really not much of an issue, because you've got ten people there for your theft.

MS. WECKERLY: Right.

THE COURT: It's more the ones where they're separated. But even so, you got to get it over the 250 you've pled, and so yeah. You know, if they can't do it, if they need to rely on something to do it, then --

MS. WECKERLY: We'll inform them.

THE COURT: -- whatever it is they need to rely on they need to bring.

MS. WECKERLY: Okay. We'll do that, but they won't be tomorrow.

THE COURT: And that's --

MR. SANTACROCE: Can you just remind me who
tomorrow is?

THE COURT: Can I see counsel -- well, it's just us.
Off the record.

(Court recessed for the evening at 5:36 p.m.)

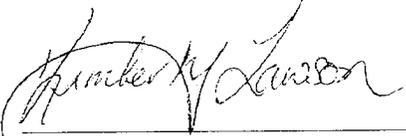
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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA,)
)
 Plaintiff,)
)
 vs.)
)
 DIPAK KANTILAL DESAI, RONALD)
 E. LAKEMAN,)
)
 Defendants.)
 _____)

CASE NO. C265107-1,2
CASE NO. C283381-1,2
DEPT NO. XXI

**TRANSCRIPT OF
PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 35

THURSDAY, JUNE 13, 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.

Also Present: Christian Balducci, Esq.

RECORDED BY JANIE OLSEN COURT RECORDER
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I N D E X

WITNESSES FOR THE STATE:

ARNOLD FRIEDMAN

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JOAEN SYLER

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1 LAS VEGAS, NEVADA, THURSDAY, JUNE 13, 2013, 10:56 A.M.

2 * * * * *

3 (Outside the presence of the jury.)

4 THE COURT: The jurors, some of them have little mini
5 vacations, so they wanted to know if they had to work on
6 the 5th. But, you know, we're hoping to be done before that,
7 so it won't even be an issue. We'll be done before the 5th.

8 Yeah. I mean, if they're deliberating, I don't care
9 when they deliberate, because, you know, if they want to be on
10 vacation on the 5th and come back, sure. If they -- you know,
11 I don't really care. I mean, you know, we're pretty flexible
12 with that.

13 All right. Apparently there is a lawyer here who
14 wishes to be heard on something. So sir, can you state your
15 name and your bar number for the record.

16 MR. BALDUCCI: Yeah. Christian Balducci. My bar
17 number is 12688.

18 THE COURT: All right. And you represent whom?

19 MR. BALDUCCI: I represent HealthCare Partners of
20 Nevada.

21 THE COURT: All right. That's one of the insurers in
22 this case; is that correct?

23 MR. BALDUCCI: Yes, Your Honor.

24 THE COURT: And my understanding is, pursuant to a
25 court order based on some testimony that came out yesterday

1 with a different insurer, Ms. Weckerly or Mr. Staudaher --

2 MS. WECKERLY: Well, it's the same insurer as --

3 THE COURT: Oh, it's the same insurer. Okay. We
4 asked that some documents be produced that apparently the
5 witness had viewed prior to her testimony; is that correct,
6 what you asked?

7 (No audible response.)

8 THE COURT: And we needed her to produce those
9 documents. Basically we told her when she got back from her
10 vacation to produce them to the State so that they could
11 produce them to the defense. So is there a concern or...

12 MR. BALDUCCI: I actually have two issues, Your
13 Honor.

14 THE COURT: All right.

15 MR. BALDUCCI: If you don't mind if I address those.

16 THE COURT: Go ahead.

17 MR. BALDUCCI: I'm sure I'm not the first attorney to
18 actually miss something in this trial, so.

19 THE COURT: Well, so far it's been the plaintiff's
20 lawyers.

21 MR. BALDUCCI: May I approach, or...

22 THE COURT: You may. You can just stand in the well
23 of the courtroom or stand at the podium, wherever you're
24 comfortable.

25 MR. BALDUCCI: The podium, please.

1 THE COURT: That's fine.

2 MR. BALDUCCI: It's come to my understanding that
3 yesterday during testimony, Patty Shibona, the director of
4 operations for HealthCare Partners of Nevada, I guess there
5 were some notes or something of that sort that she had with
6 her.

7 THE COURT: Right. Basically she had said, Can I
8 refer to my note -- I'll tell you exactly what happened. You
9 know, essentially she said, Can I refer to my notes, or
10 something, and she had a yellow folder with her and she opened
11 it up and she started reading something. And I said, For the
12 record, what is it that you're reading? And then the lawyers
13 said, can we just see what she's looking at, and I said fine.

14 And basically, the long and short of it is she had
15 made some notes. She had reviewed some documents. She had
16 written some things down, and she had reviewed some things
17 over the Internet in order to prepare for her testimony and
18 to, you know, I guess, record some -- I did not look at
19 whatever it was she was looking at. So that's essentially
20 what happened.

21 MR. BALDUCCI: And that exactly, that last part is my
22 concern. One of the things she had with her was it's actually
23 an email from me to her.

24 THE COURT: Okay. I don't believe the lawyers read
25 the email; is that true, Ms. Stanish?

1 MS. STANISH: That's correct, Your Honor. I was
2 only -- I only focused on her handwritten notes. I didn't
3 even know it was from a lawyer.

4 THE COURT: The handwritten notes concerned figures
5 and things she had referred to. I know one was the CMS rules
6 off the Internet, that specifically. And I don't remember the
7 other two things she had referred to.

8 MS. STANISH: Some numerical figures.

9 THE COURT: Yeah. They were figures that she had
10 needed to calculate how much the difference in the anesthesia
11 charges would have been. Mr. Santacroce, I believe you also
12 approached. Were you able to read that email?

13 MR. SANTACROCE: I saw it was an email and she had
14 handwritten notes on it, but I don't -- I didn't read the
15 content of it.

16 THE COURT: Okay. Well, I'm fine then if, you know,
17 she doesn't have to produce the email. We're fine with that.

18 MR. BALDUCCI: Okay.

19 THE COURT: All she has to do is produce the
20 documents that we said, which would be, you know, the contract
21 with the gastro center or the, you know, endo center, the
22 policy, what the chart was for in terms of reimbursement rates
23 and how that was calculated.

24 Was there anything else we needed from her?

25 MS. STANISH: The redacted --

1 MR. WRIGHT: I got a question.

2 MS. STANISH: -- email with the notes would be fine.

3 THE COURT: Yeah. Just she can cross out, you know,
4 in black marker the email, just so that we have her
5 handwritten notes that had those figures on it because she did
6 refer to those in her testimony.

7 MR. BALDUCCI: Certainly, and I actually do have a
8 copy of a redacted version here.

9 THE COURT: Okay.

10 MR. WRIGHT: I've got a question.

11 THE COURT: Mr. Wright.

12 MR. WRIGHT: I want to be sure your email to her was
13 simply legal advice and you didn't tell her any information,
14 facts that she --

15 MR. BALDUCCI: It was an attorney-client privilege
16 conversation.

17 MR. WRIGHT: No. My question is did you --

18 THE COURT: But you didn't say testify to this or
19 testify to that or --

20 MR. BALDUCCI: No.

21 MR. WRIGHT: Did you give her any factual
22 information?

23 MR. BALDUCCI: No.

24 THE COURT: Like the figures, numbers, anything like
25 that?

1 MR. BALDUCCI: No.

2 THE COURT: Okay. That's fine. You said you have a
3 redacted version?

4 MR. BALDUCCI: Yes. Would you like to --

5 THE COURT: Sure.

6 MR. BALDUCCI: -- review it, Your Honor?

7 THE COURT: Can you --

8 MR. BALDUCCI: If I may approach, please.

9 THE COURT: Sure, of course.

10 MR. BALDUCCI: Thank you.

11 THE COURT: Do you want to just leave that then? Is
12 this my copy?

13 MR. BALDUCCI: Yes, certainly.

14 THE COURT: Okay.

15 MR. BALDUCCI: And the other page behind it, the two
16 pages, one would be the -- it's on a loose-leaf paper.

17 THE COURT: Right. And that's her own handwritten --

18 MR. BALDUCCI: The other --

19 THE COURT: -- notes. All right. What we'll do then
20 is this will be a court's exhibit. I'll also make copies for
21 all of the attorneys, meaning the bailiff will make copies for
22 all of the attorneys. And is that all satisfactory with you?

23 MR. BALDUCCI: As for that, yes, but --

24 THE COURT: What's the other issue?

25 MR. BALDUCCI: The other issue was the contract or

1 the agreement. HealthCare Partners of Nevada today is
2 different --

3 THE COURT: Okay. We only care about what was in
4 place at the time the allegedly fraudulent charges were made.

5 MR. BALDUCCI: And that's the exact issue that we're
6 looking into. It's our understanding at the moment though,
7 we're looking at it further, that the Endoscopy Center's
8 contract was not with HealthCare Partners of Nevada at that
9 time. We're not entirely sure yet. We're still looking
10 into it. We think it may have been with an entity called
11 Pippa [phonetic], which is now bankrupt. So we don't know
12 what --

13 THE COURT: But she must have had something to figure
14 out, well, how much are we going to pay here, because
15 obviously there was some contract or you folks wouldn't have
16 been paying out on these claims, as I understand.

17 MR. BALDUCCI: What HealthCare Partners of Nevada
18 did, and of course the [inaudible] that we need a specific
19 time frame, because that's really going to help us. It's our
20 understanding the way it worked was we simply process on
21 behalf of PacifiCare. So whatever the start times or end
22 times of these things, they were a product of PacifiCare. We
23 were, I guess you could say, kind of in the middle.

24 THE COURT: Here's what I would ask then. If you
25 tell me, if you come back and you say we don't have the

1 agreement, what I need from you is whatever guidelines, forms,
2 policies your company used at that time to calculate
3 reimbursement. Is that -- that's essentially what we're
4 looking for. I mean --

5 MR. WRIGHT: And we want to know where it is, I mean
6 if PacifiCare has it or whatever.

7 THE COURT: Yeah. I mean, there may have been
8 another contract, but your company had to have had something,
9 some documents so that they would know how they're calculating
10 these charges. That's really what we're looking for, and what
11 the agreement was.

12 So there had to have been some guidelines. Whether
13 they had the full contract or not, you know, it has to go from
14 A to B so that B knows what it's supposed to be doing.
15 Whether that was a memorandum or some other kind of directive
16 from, you know, PacifiCare or whatever, whatever that was, we
17 need it.

18 MR. BALDUCCI: So I guess the thing that's most that
19 everyone is looking for is just that says how things get paid
20 out is really --

21 THE COURT: Well, whatever documents you have --
22 here's basically what we want. Whatever documents they have
23 relevant to any agreements with the gastro center or the endo
24 center at the time frame in question, any charts or schedules
25 or anything like that, that were utilized to pay claims and

1 reimbursements. Is that fair, Defense?

2 MR. BALDUCCI: Yes. I under -- yes.

3 THE COURT: Defense, is that -- does that encompass
4 what we want?

5 MS. STANISH: The Court's indulgence.

6 (Pause in proceedings)

7 MR. WRIGHT: Right. We need the contract. I mean,
8 we need what you're asking for, but if they don't have it,
9 then they'll say PacifiCare has it.

10 THE COURT: Yeah. If they don't have it, you need to
11 tell us who does. But what I'm saying, Mr. Wright, is
12 whatever they have, then they have to have something. They
13 don't have the contract, then give us what you have
14 essentially.

15 And, you know, if you can make a representation as to
16 who, according to your understanding, would have the contract,
17 we'd appreciate that as well.

18 MR. BALDUCCI: Certainly, Your Honor.

19 THE COURT: Okay?

20 MR. BALDUCCI: All right. That really covers it all
21 for me. Sorry. I appreciate the time. Thank you.

22 THE COURT: No, no problem at all. This came up at
23 the last minute when she started looking at her notes.

24 MR. BALDUCCI: Yeah.

25 THE COURT: And then, you know, it's like, okay,

1 where'd this stuff come from. How long will it take you to
2 find all that, or have your company find all that?

3 MR. BALDUCCI: A little while.

4 THE COURT: All right. Here's what you're instructed
5 to do. Coordinate with whatever representative of the State
6 is going to handle this, whether that's Detective Whitely or
7 one of the lawyers or one of their investigators or whatever.
8 Okay?

9 MR. BALDUCCI: Okay. Great. Spoke with him in the
10 past, it's been a good relationship, so there won't be an
11 issue.

12 THE COURT: Okay. Good. Thank you.

13 MR. BALDUCCI: Thank you, Your Honor.

14 THE COURT: All right. Kenny, bring them in.

15 MS. WECKERLY: Your Honor, do you want us to try to
16 like get Scott Mitchell up here sometime today?

17 THE COURT: Between all the other stuff.

18 MS. WECKERLY: We can take care of a lot of it
19 though.

20 THE COURT: Yeah. I mean, he can maybe get right to
21 the heart of the matter.

22 MS. WECKERLY: Yeah. I'll send an email to try to
23 track him down.

24 (Pause in proceeding.)

25 (Jurors reconvene at 11:09 a.m.)

1 THE COURT: Court is now back in session. The record
2 should reflect the presence of the State, the defendants and
3 their counsel, the officers of the court, and the ladies and
4 gentlemen of the jury. And Mr. Staudaher, please call your
5 next witness.

6 MR. STAUDAHER: The State calls Arnold Friedman to
7 the stand, Your Honor.

8 ARNOLD FRIEDMAN, STATE'S WITNESS, SWORN

9 THE CLERK: Please state and spell your first and
10 last name.

11 THE WITNESS: Arnold Friedman, A-r-n-o-l-d,
12 F-r-i-e-d-m-a-n.

13 THE COURT: Thank you. Mr. Staudaher.

14 MR. STAUDAHER: Thank you, Your Honor.

15 DIRECT EXAMINATION

16 BY MR. STAUDAHER:

17 Q Dr. Friedman, what do you do for a living?

18 A I'm an anesthesiologist.

19 Q And how long have you done that?

20 A Since 1982.

21 Q Can you give us a little background about where
22 your training and experience have got you to the point where
23 you are today?

24 A Yes, sir. I started initially after finishing
25 at -- a BS degree at Indiana University, from there I ended up

1 getting accepted to medical school at the University of
2 Louisville. After that I did a year of internship at Cook
3 County Hospital in Chicago, Illinois. Went into the U.S. Air
4 Force. I was a flight surgeon for two years at Webb Air Force
5 Base. From there I worked in the emergency room in San
6 Francisco at one of the Kaiser facilities.

7 Then I started my training at the VA hospital in
8 Sepulveda, California. From there I went to Cedars-Sinai
9 Medical Center. I was chief medical resident. I started a
10 cardiology fellowship when they asked me to open up the first
11 medical intensive care unit at the hospital when it opened
12 in 1976.

13 After that for four years, I cross-trained into
14 anesthesia at UCLA and spent six months at Massachusetts
15 General Hospital. And from there, I then went into anesthesia
16 for open heart surgery and transplants, became the director of
17 the service. And after approximately 20, 25 years, I then
18 moved into the cardiac catheterization lab and
19 electrophysiology lab, as we were developing new heart valves
20 without opening people's chests, and I've done that for six
21 years.

22 I'm about ready to become the new director of the
23 [unintelligible] procedure, or the pre-anesthesia assessment
24 clinic in the new facility at Cedars-Sinai Medical Center.

25 Q Is it safe to say that you're familiar with

1 anesthesia and anesthesia practice?

2 A Yes, it is.

3 Q With regard to that, I --

4 THE COURT: Oh, and sir, we need you to speak up.
5 Some of the jurors can't hear you. See that black box there?

6 THE WITNESS: Yes, ma'am.

7 THE COURT: That's the microphone.

8 THE WITNESS: Okay.

9 THE COURT: That's better. Thank you.

10 And Mr. Staudaher, you need to keep your voice up as
11 well.

12 MR. STAUDAHER: I will try, Your Honor.

13 BY MR. STAUDAHER:

14 Q Go through -- I want to go through a couple of
15 things with you regarding anesthesia. Can you tell us what
16 kind of things you do as an anesthesiologist?

17 A Well, first and foremost, when we first meet the
18 patient, we obviously assess them for their medical problems
19 and do a risk stratification. We talk to them. We try to
20 allay any of their anxieties, answer any of their questions.
21 We start an intravenous under some kind of a local anesthetic
22 like Lidocaine, which is similar to Novocaine that you would
23 go to a dentist for when you are having a procedure.

24 Then we bring them into the operating room or into a
25 procedure area where we would go ahead and give them medicine

1 through an intravenous line and they would -- usually you go
2 to sleep. And during that period of time that you get
3 sedated, you have no memory or awareness of what's going on,
4 and the medicine that we use allays any of the pain that
5 occurs.

6 Afterwards we wake patients up. Obviously between
7 that we take care of any of the problems that occur that could
8 produce an adverse event, and we wake patients up, take care
9 of them either in the recovery room or the intensive care
10 afterwards.

11 Q So are there different types of anesthetics that
12 get used in different settings; meaning hospital, outpatient,
13 clinic, whatever?

14 A Yes, sir. In the operating room we tend to do a
15 general anesthetic or a regional anesthetic. A general
16 anesthetic usually requires a breathing tube, an endotracheal
17 tube that's put down into the tracheobronchial tree. Or we
18 can go ahead and do a regional anesthesia.

19 Let's say if you were coming for a hip replacement or
20 a knee replacement, and for that we would go ahead and put
21 some medicine either into the spinal canal or the area around
22 the spinal canal, in order to go ahead and numb the nerves
23 where the surgeon would be operating on. In the orthopedic
24 example that I gave you, that would be let's say the lower
25 extremities. We would also give you a little something just

1 to drift off to sleep. That would be a twilight sleep.

2 If we do something in the procedural areas which
3 would include the ambulatory surgical centers, most of the
4 times what we do is that we would use an -- just individual
5 drugs for sedation and a minimal amount of pain. Because a
6 lot of those procedures don't require an incision, so we're
7 not as concerned usually with extreme pain as we would be in
8 the general anesthetics in the operating room.

9 Q So let's not -- I want to move away from general
10 anesthetics and go to something short of that. Is there --
11 I've heard the terms "deep sedation, conscious sedation,"
12 things like that. Can you define those terms for us?

13 A Well, there's planes of anesthesia. If you want
14 to cover everything, it's usually monitored anesthesia care,
15 and monitored anesthesia care means taking you through the
16 simplest thing where a patient might be totally awake for
17 certain reasons to the fact that they would be under deep
18 sedation, which would be a general anesthetic. And between
19 that we have different gradations of sedation.

20 It depends strictly on what -- how sick the patient
21 is and what their body will tolerate in terms of drugs. It
22 depends upon obviously what kind of procedure you have. An
23 open heart procedure which is obviously going to be a higher
24 risk with a lot of other diseases that a patient has, and
25 they're going to have an incision usually in the sternum,

1 that's going to require a deep sedation that which includes no
2 awareness and no pain.

3 As opposed to let's say if we talked about an
4 ambulatory surgical center, the sedation is going to be much
5 lighter. And usually it's just required as a sedation that
6 would be mild sedation, so the patient isn't aware of what's
7 going on, but it doesn't necessarily require much in the way
8 of what we call analgesics or pain medicine.

9 Q Now, in the setting that you just mentioned, an
10 ambulatory care setting at that level of sedation, is that
11 something where the patient is awake or asleep?

12 A Most of the times the patients are awake --
13 they're asleep. It depends what procedure we're doing. If
14 we're doing let's say something in the GI lab, they would be
15 asleep. They would not be cognizant of what was going on
16 around them and they would be moderately sedated.

17 If we were talking about something where we're
18 looking at abnormal rhythms, which is an electrophysiology
19 lab, that we -- if we make patients too deep, then we can wipe
20 out the ability to go ahead and find what the rhythm
21 disturbance is and get rid of it by burning it. There's other
22 things like putting pacemakers in which is somewhere in
23 between.

24 So sometimes what we would do is we would do a local
25 anesthetic where the incision is, and then just do moderate

1 sedation, so a patient doesn't have any anxiety, they're
2 asleep and usually they don't know what is going on, so they
3 have no awareness of the procedure.

4 Q Are you familiar with the drug propofol?

5 A Yes, sir.

6 Q In the settings and the situations you've talked
7 about, when would you use or not use that drug?

8 A Well, it's used for two things. One is that it
9 can be used as what we call an induction agent, which means
10 you have an intravenous line in and a general anesthetic,
11 higher risk patient, and you want to get them to sleep quickly
12 so that we can then go ahead and put the breathing tube in.

13 We would give a certain dose of the propofol, and
14 that would be called a bolus, to get them to sleep so we could
15 then go ahead and give them the other things that we need to
16 in order to put the breathing tube in. As opposed to let's
17 say an ambulatory surgical center we would either give a
18 bolus, meaning one drug aliquot; in other words, a dose to get
19 the patient to sleep, and then we would re-bolus them
20 intermittently if we needed to.

21 We could also give an infusion, which is a constant
22 amount of drug, as opposed to a bolus that we just give at one
23 setting.

24 Q Now, you mentioned now patient settings. You've
25 also mentioned high risk or not high risk patients. Can you

1 tell us the types of patients that typically go to an
2 ambulatory care center?

3 A Well, they tend to be not as sick as the
4 patients that are in the operating room.

5 MR. SANTACROCE: Your Honor, can we approach?

6 THE COURT: Of course.

7 (Off-record bench conference.)

8 THE COURT: Mr. Staudaher, please proceed with your
9 questioning.

10 BY MR. STAUDAHER:

11 Q Have you worked in ambulatory care centers
12 before?

13 A Yes, sir.

14 Q Have you worked in hospital settings before?

15 A Yes, sir.

16 Q And you worked in this electrophysiology lab
17 that you talked about?

18 A Yes, sir.

19 Q So is it fair to say you've worked in different
20 settings giving anesthetic over the time period of your
21 career?

22 A That's correct.

23 Q Now, you said your career has lasted in
24 anesthesia for how long?

25 A Since 1982.

1 Q So 30-plus years; is that right?

2 A That's correct.

3 Q We're in a situation during that time where --
4 we're in a situation. You were in a situation during that
5 time, if you will tell us, was that pretty much continuous
6 work in anesthesia, or did you take a break and go to Hawaii
7 for years or...

8 A It was all in anesthesia.

9 Q In the various settings that we've talked about?

10 A Yes, sir.

11 Q Now, with regard to that, I want to go back to
12 the outpatient setting. You mentioned and I want to talk
13 about the types of patients that would go to an outpatient
14 setting; can you tell us that?

15 A The type of patients tend to be not as sick as
16 the ones that we would do as inpatients; in other words,
17 people who were morbidly obese, people who had sleep apnea,
18 people who had coronary artery disease, people who had poor
19 heart function or they were in heart failure, people who had
20 cardiac valvular diseases.

21 So again, patients who tended to have a lot of
22 stability and very little what we call co-morbidity or other
23 medical problems.

24 Q Is that what co-morbidity is?

25 A That is correct.

1 Q So a healthier population?

2 A A healthier population.

3 Q Now, with regard to those facilities -- and
4 we're not going to be really talking today much about the
5 hospital facilities. We're talking about outpatient level,
6 those types of patients. But before I get there, I want to
7 ask you one other question in general about anesthesia.

8 Depending if you're doing the same type of
9 anesthesia, general anesthetic, deep sedation, conscious
10 sedation, whatever it is, does it really vary depending on the
11 setting, or is it the same type of thing regardless of the
12 setting?

13 A Well, again, because of the fact that in the
14 ambulatory care center the patients tend not to be as sick and
15 the procedures are not like what we do in the operating room,
16 where there is a higher risk to the patient like open heart
17 surgery, like lung surgery, like abdominal surgery, the -- we
18 don't need the same degree of anesthetic or monitoring as we
19 would in an operating room setting.

20 Q Now, with regard to your -- do you use some sort
21 of record during any procedure that you do to document what
22 has happened to the patient and what you've done to the
23 patient?

24 A Yes. We have an anesthesia record that we fill
25 out during the operating room area. But before that, when

1 we're assessing the patient, we go ahead and we have a
2 documentation in terms of the preoperative workup, as well as
3 what the assessment is and the fact that we have discussed
4 risks, what some of the alternatives might be if patients want
5 to know.

6 And then we have at the end of the case, after we put
7 a patient into either the recovery room or into the intensive
8 care unit, we would write our postoperative note, which we
9 would then go ahead and put down the patients are stable,
10 their blood pressure, their heart rate, all their vital signs.
11 And we would do other exams, cardiac, lung exams,
12 neurologically, whether they were mentating okay and they were
13 moving all their extremities.

14 Q The assessment that you just mentioned, how
15 important is that in doing any anesthetic procedure?

16 A It's very important, because without an
17 assessment that is appropriate you may have patients who are
18 sent to you who need further workup, in order to go ahead and
19 minimize their risk. So what you're really doing is you're
20 doing initially a risk assessment, and then you're trying to
21 optimize the patient for the peri procedure, whether it's in
22 the operating room or in an ambulatory care center.

23 Q So describe for us what you do in a typical
24 assessment and does it vary depending on what setting you
25 might be in, say an outpatient setting to an operation in a

1 hospital?

2 A Well, most of the times it doesn't vary at all
3 because it's fairly standard. You do a regular history, find
4 out why the patient is there, what is the primary reason they
5 are there for, what is the surgery or procedure that is going
6 to be done, if there's a particular side, which side is it
7 going to be done so that wrong site surgery doesn't occur.

8 You then go ahead and find out what are the other
9 medical problems that they have that might put them at risk,
10 and whether they've been adequately treated or whether they
11 need to be delayed and worked up further. Like let's say a
12 patient with a heart problem who may have chest pain or
13 angina, that patient may have to be worked up to find out if
14 we need to go ahead and do something else to treat them before
15 we can go ahead and do the procedure or the operation.

16 After that we do a physical examination, including
17 the fact that we are very interested in the airway because we
18 are intimately involved in taking care of that, which means
19 putting the breathing tube down when you're doing a general
20 anesthetic. But even when you're doing sedation people can
21 lose their airways. So you have to find out whether these are
22 normal or abnormal.

23 You have to find out what kind of drugs they're on,
24 what kind of surgeries they've previously had, whether they've
25 had an anesthetic untoward event, or whether they've had any

1 untoward event during surgery. You have to know whether the
2 patients have allergies, because you are giving drugs and
3 you -- almost everything requires an antibiotic, and you want
4 to make sure that they don't have any kind of adverse event
5 there.

6 After that you have to take a look and see what kind
7 of labs that they have. You have to find out whether there's
8 anything that is abnormal and query the patient about that.
9 We want to make sure whether the drugs that the patients are
10 taking, what they have been given the morning of the procedure
11 or the operation.

12 And then we want to go ahead and put down what --
13 discuss with them what specifically is going to be done to
14 them, both from an anesthesia standpoint and at least find out
15 if they have an understanding of what the surgery is, and then
16 we talk about risks.

17 Q It seems like quite a bit of stuff.

18 A It is. And in 15 minutes, which is what you
19 usually have, you have to get -- you have to collect all the
20 data off of an electronic information system, and you have to
21 hope that your patient is a good historian.

22 Q So you have this window of time that you
23 actually spend with the patient before you go back and do
24 anything with them?

25 A Yes, sir.

1 Q Now, when you go through an assessment, you
2 mentioned a whole variety of things. I mean, if I understand
3 you correctly, the assessment is essentially you have to do it
4 regardless of whether it's a shorter procedure in an
5 ambulatory care facility or a longer procedure in a hospital;
6 is that fair?

7 A That's correct. It's just the fact that because
8 the patients will be sicker in the operating room area it will
9 take a little bit longer, because they will have more problems
10 than a person in an ambulatory care center. So statistically,
11 even though you go through the same thing, it just is going to
12 be shorter in an ambulatory care center.

13 Q When we say shorter, do you truncate it to a
14 degree where you just walk out and say hi to the patient and
15 you're done and you walk away?

16 A No. It's a matter of going through and asking
17 the same things. It's just the fact that most of the answers
18 will be no rather than yes in terms of the disease states that
19 they have, or whether they have chest pain, whether they've
20 had a heart attack, whether they have shortness of breath.

21 So when you go through a lot of noes pretty quickly,
22 it doesn't take long. And a lot of the time, since you
23 already have the medicines that they're taking in front of
24 you, you already have a little bit of an idea from that. And
25 also the surgeon or the interventionist is required to have a

1 history and physical on the chart already before you even get
2 there, and that gives you an idea that you can go through
3 things a little bit quicker.

4 Q Do you review that before you talk to the
5 patient?

6 A Yes, sir.

7 Q In the setting -- and I'm going to move to the
8 outpatient type ambulatory care sort of situation. In those
9 settings, the type of anesthetic, and we're -- and the
10 procedures that I'm going to ask you about primarily would be
11 like a colonoscopy, endoscopy, things like that, that type of
12 a procedure. What would be the anesthetics that would
13 typically be used with those?

14 A Well, for those you're usually talking about two
15 different types of anesthetic on average. One would be the
16 use of propofol, period. The other would be a narcotic and
17 what we call something to allay anxiety, which is a
18 benzodiazepine. We call it Versed or midazolam.

19 The narcotic which would be short acting would be
20 something like fentanyl, which is like morphine, but it's a
21 hundred times more potent and it's quick acting, and it's a
22 shorter time period so that the patients can go home earlier.

23 Q So those are the two sort of options you have?

24 A Well, you have more options, but those are the
25 two main options. The other option is that if you find that

1 you have a problem with an airway, you might have to go to
2 some other form. Like a person who has sleep apnea who is
3 overweight, that kind of a patient, you can lose an airway
4 very quickly. You may have to convert them to some other form
5 of an anesthetic.

6 And that would be something as opposed to putting a
7 breathing tube down, which is the ultimate in general
8 anesthesia, we have something that is called a laryngeal mask
9 airway. What it is, is that we put something that goes down,
10 and it ends just above what we call the larynx. It doesn't go
11 down into the tracheobronchial tree.

12 But by sliding it so that it slides along the tongue
13 and it stops, we can give a general anesthetic. And that can
14 be very, very effective more so with a colonoscopy than an
15 esophageal gastroscopy, because you're sharing an airway
16 there. That becomes a little bit different.

17 Q Okay. So but in the typical procedure of a
18 colonoscopy or upper endoscopy, do you typically have to put a
19 tube down somebody's throat?

20 A No.

21 Q So the anesthetic that you would use in those
22 situations would be what, if you had your choice?

23 A There have been studies to show that propofol is
24 much preferred to the narcotics and benzodiazepines by
25 patients. You get a much more complete sedation. You get

1 less awareness that occurs with it. And because of the fact
2 that the side effects are much less and it wears off very
3 quickly in terms of getting out of your system, your ability
4 to go home is much quicker.

5 The problem is, is that the narcotics can affect the
6 brain center and affect your ability to breathe well. You can
7 get nausea and vomiting to a much higher degree with a
8 narcotic than you could with propofol. The benzodiazepine
9 like Versed, the problem is, especially as you get older, you
10 can have a patient have a delirium just from a small amount,
11 especially if they're older or if they have central nervous
12 system problems.

13 Q So propofol, you said you were familiar with it?

14 A Very much so.

15 Q Have you used it much in your practice?

16 A I use it almost every day.

17 Q Is this over the time period that it's been in
18 existence essentially?

19 A Yes.

20 Q Now, before propofol was around what did you
21 typically use?

22 A Well, you would -- initially what we would have
23 to do is we would use the other alternative agents. At
24 that -- before propofol, we certainly had the fentanyl or we
25 had morphine, some kind of narcotic, and we had some form of a

1 benzodiazepine which could have been Versed or midazolam. It
2 could have been Ativan.

3 They're all related to the drug that people were
4 taking orally which was Valium, which we could give. Each one
5 of them have a different footprint. But you would have to
6 give a much higher dose and it would stay in your body much
7 longer.

8 Q With regard to propofol, you said every day. I
9 mean, does that equate with -- I mean, can you give us a
10 general estimate in a year how many times you use that drug?

11 A Well, again, I told you that it can be used
12 either for complete sedation or just to get the patient to
13 sleep. I would say on an average, I probably do a thousand
14 cases a year where propofol is involved in some fashion.

15 Q So you've done a lot of them?

16 A A lot.

17 Q Now, with regard to an in and out patient sort
18 of setting with a procedure like a colonoscopy or so forth
19 that's relatively short in duration, did you mention that you
20 could just use propofol alone as the anesthetic agent?

21 A Yes.

22 Q In the situations where that would be the case,
23 how would you use it, in your experience?

24 A Well, in my experience we would usually give a
25 bolus, meaning we would give a certain amount of drug based

1 usually on body weight, and the patient would go ahead and
2 approximately within 30 to 45 seconds the patient would drift
3 off to sleep. Most of the time their airway, they would
4 spontaneously breathe once we had a little distribution of the
5 drug, and you could go ahead let's say in a colonoscopy or
6 what we call an EGD, the esophagogastrosocopy, the patients
7 could go ahead and tolerate that.

8 There are only usually two discomforting things on
9 average with those problems. With the colonoscopy the problem
10 is, is that in order to get good visualization there's a lot
11 of air, to go ahead and inflate the bowel so you can go ahead
12 and take a look and see if there's any lesions or not. That
13 distension can be very discomforting. That's for a
14 colonoscopy.

15 For the esophagogastrosocopy, it's just the initial
16 insertion, because of the fact that you have to get past the
17 airway you would gag. So you need to go ahead and actually
18 need initially to get a little bit more sedation to put the
19 esophagogastrosocopy in as opposed to the colonoscopy. Whereas
20 the colonoscopy -- in other words, once that's down for an
21 esophagogastrosocopy, there's not a lot of discomfort, so you
22 just want to go ahead and have a sedation so the patient isn't
23 aware of what's going on.

24 As opposed to with a colonoscopy, as you get further
25 into the procedure, you get more dilatation of your bowel, so

1 there's more discomfort. So you may actually need a little
2 bit more at the end of the case, and you may have to
3 supplement that in the postoperative arena, meaning the
4 recovery room.

5 Q So would it be unusual to have to give some
6 additional medication, propofol, near the end of a colonoscopy
7 case because of those issues?

8 A It could. It strictly depends on how quick the
9 endoscopist is; in other words, the gastroenterologist. If it
10 is somebody -- and we see a bell shaped curve in terms of how
11 long it takes a gastroenterologist to do the procedure, just
12 like it would any surgeon. Sometimes it's short and sometimes
13 it can be very long.

14 Q And what factors play into that?

15 A Well, again, again, some people are more facile
16 doing things than others are. The other thing is that all the
17 sudden they may see that there are problems that occur. They
18 may see polyps where they're going to have to biopsy. They
19 may have a problem where the patient isn't cleaned well
20 enough. Then it becomes very, very difficult for them to do
21 that.

22 Q Sometimes there may be certain angulations that don't
23 allow you to get to the places that you want to. It depends
24 on the pathology that they find. So part of it is the
25 operator themselves, and part of it is either the preparation

1 or the disease state that the patient has.

2 Q So in those types of procedure -- procedures
3 rather, what is your role?

4 A Our role is, well, we first of all monitors --
5 after we go through the assessment, we bring them in. They go
6 into position. We want to make sure that the intravenous line
7 is working well and we put monitors on for safekeeping. Those
8 monitors include a continuous electrocardiogram which
9 determines what the rhythm is and whether it's normal, whether
10 it's fast, whether it's slow.

11 We go ahead and put a blood pressure cuff on and we
12 have a baseline blood pressure. And then we would get another
13 blood pressure certainly after the propofol, because the
14 patients are sedated and that tends to cause the blood
15 pressure to go down. We want to make sure the patient is
16 breathing adequately, so we have a monitor where we can
17 actually see carbon dioxide that's being exhaled from the
18 lungs and we know the patient is not obstructed.

19 We have a monitor on the finger that is called a
20 pulse oximeter that measures the oxygen that you have in your
21 body, so a patient doesn't get to a dangerously low level of
22 oxygenation. And so these are the primary monitors that we
23 use.

24 Q Now, as far as decisions on that type of care,
25 including either withholding or giving additional medication

1 anesthetic, who makes those decisions in that situation?

2 A Well, at our hospital where we have
3 anesthesiologists, it's the anesthesiologist that makes that
4 decision. There may be times when the surgeon or the
5 operator, in this case it would be the gastroenterologist,
6 where he might need a little bit more sedation because of the
7 fact that something painful is going to happen, or when
8 patients have the ability to move and they're not paralyzed
9 from neuromuscular blockers that we do so a patient doesn't
10 move, like in an open heart surgery, we might have to give
11 more.

12 And patients vary. It isn't only their body weight.
13 Part of it is genetically determined in terms of how sensitive
14 they're going to be to the medicine, and that is something we
15 don't know until we take care of the patient and see how they
16 respond to the anesthetic.

17 Q When you're doing a procedure and you're
18 assessing those things as you go, I mean, are you making
19 adjustments to how much medication you give?

20 A Yes.

21 Q Who makes the decision on how much medication to
22 give?

23 A The anesthesiologist, or in this case it would
24 be the nurse anesthetist would, because that is their scope of
25 practice.

1 Q So with regard to the surgeon though, or the
2 operator, would they ever enter into the realm with you and
3 start dictating to you how things should be done or not done?

4 A It would be very, very rare that that would
5 happen.

6 Q Is there an issue of sort of a person in the
7 room that has to take care of the safety of the patient? I
8 mean, where do you fall into that?

9 A We are responsible for the safety of the
10 patient, because the surgeon usually is operating room --
11 operating, and so that's his focus, to do whatever he can and
12 take care of that. We are responsible for everything else in
13 terms of the patient's safety.

14 Q If you had a situation where a surgeon told you
15 not to give anymore medication and you felt that it was
16 appropriate to do so, what would you do?

17 A I would do what would be in the best interest of
18 the patient, which is my determination.

19 Q Now, as far as the -- well, let me ask you a
20 different area. Are you familiar with aseptic technique and
21 safe injection practices, things like that?

22 A Yes.

23 Q Is that something that you've been familiar with
24 throughout your career?

25 A Yes.

1 Q Has that changed at all for you during your
2 career?

3 A Very little, except for the fact that we are
4 seeing more and more write-ups in the medical literature about
5 this problem occurring in the medical profession.

6 Q And you're talking about the problem you're here
7 to testify about today?

8 A Yes.

9 Q Now, with regard to -- well, walk us through.
10 What is considered aseptic technique and a safe injection
11 practice in the setting of an ambulatory care facility, a
12 colonoscopy, upper endoscopy, that kind of thing?

13 A Aseptic technique means that it is a technique
14 in which you want to make sure that there is no microbes that
15 essentially are involved in transmitting to the patient. That
16 microbe can be a bacteria, it can be a virus. And how -- what
17 are those techniques? That includes any of the handling or
18 storage of any of the drugs. It could be the intravenous
19 bags. It can be the equipment, meaning the injection
20 equipment.

21 It's also the fact that we wear masks, we glove, that
22 we wash our hands for a period of time, that we go ahead and
23 we use alcohol to make sure that nothing enters the system
24 that shouldn't be entering the system and be contaminated.
25 Aseptic technique in some ways includes part of safe injection

1 practices, which is a much more specific area.

2 Aseptic technique also includes the fact that when
3 you come for a surgery, obviously we have to go ahead and put
4 something that's going to kill organisms on your body. We put
5 drapes around. So it's the maintenance of an environment that
6 literally has no bacteria or no virus that can go ahead and
7 invade the patient.

8 The other aspect is safe injection practices, and
9 those are those practices that allow you to give a safe
10 injection of a drug or a solution of without -- and that can
11 be both to the patient and the healthcare provider, like
12 having a needle that is uncapped and sticking yourself, being
13 the healthcare provider, to the fact of the transmission of
14 either bacteria or viruses because of the fact that you
15 haven't used appropriate techniques to prevent that from
16 happening.

17 Q Can you describe what safe injection practices
18 actually are?

19 A It's -- safe injection practices can be anywhere
20 from the fact that you don't go ahead and put let's say
21 alcohol over a rubber stopper when you go ahead and you
22 aspirate. It can be the fact that when you inject a drug and
23 the port that you inject it in the intravenous, you don't go
24 ahead and use alcohol. It can be the fact that you take a
25 syringe, let's say from a vial of medication, and you don't --

1 you don't wear gloves.

2 It can be the fact that when you take a syringe full
3 of it and you give it to the patient, and then you go ahead
4 and you go back into that vial and reuse the syringe, that can
5 be a problem. You can go ahead and never get rid of the
6 syringe and even use it on the next patient.

7 You can go ahead and because of the fact that you
8 have gone a second time into the vial with the same syringe,
9 you can go ahead and actually get contamination that can then
10 be transmitted to whatever the remaining contents are in the
11 vial. If you then go ahead, even if you go ahead and use a
12 new needle and a new syringe, and you don't waste any of that
13 medication and you use it on the next patient, you now have a
14 contaminated vial, and then you can go ahead and give that
15 problem, meaning a virus or a bacteria, to the second patient.

16 So in other words, the thing that you don't want to
17 do is that when you have something where it is a single use
18 vial or a single patient use vial, you never want to use it on
19 more than one patient.

20 Q Now, in reality, does that happen? I mean, do
21 single use containers of medication get used on multiple
22 patients?

23 A There is a single -- a single use vial can only
24 be used on multiple patients under only one circumstance
25 according to the CDC and the U.S. Pharmacopeia, who makes all

1 the suggestions of what is a safe injection practice.

2 And that is a situation where you have to by law, you
3 have to do it in a sterile area outside of the operating room.
4 There has to be a certain number of air exchanges. You have
5 to be gloved. You have to wear masks so that you aren't going
6 to go ahead and contaminate what it is you're about to do.
7 And these substances are very specific.

8 They would be like what we call radiation or
9 radiopharmaceutical drugs that are used in radiation. Whether
10 it's primarily let's say for stress tests for your heart where
11 we're using radiopharmaceuticals, it is very expensive. It
12 has a certain expiration date. And so what you might do is
13 that you might take it in this area and you might take three
14 aliquots so that three studies can be done if there's X
15 amount in.

16 There are certain drugs that we use for oncology,
17 cancer, that are very, very expensive. And the way in which
18 you did it may allow you to go ahead and divide it into three
19 areas. But again, it has to be under certain areas not in the
20 operating room.

21 They're done in pharmacy under very strict codes,
22 where you have to have certain amount of air turnovers and you
23 are checked by the joint commission to make sure that you
24 are -- and the standards of let's say the state, that you
25 abide by that. Those are the only things that you can do it.

1 There are certain biologicals, Botox being one of
2 them in the past, where that was another thing where because
3 of the cost of the drug and how much was given by either the
4 plastic surgeon or a dermatologist, which allowed under the
5 circumstances I told you to divide it into certain different
6 syringes. But that is the only time that is allowed, that you
7 can take a single use vial and use it on more than one
8 patient.

9 Q Now, we know that that's the way it's supposed
10 to be done, correct?

11 A That is the way it's supposed to be done.

12 Q In reality, do some practitioners use a single
13 use vial or a single patient use vial on multiple patients in
14 some settings? I mean, in reality does that happen?

15 A In reality the answer is yes.

16 Q Now, in a situation where you do what you
17 describe, you take the vial of medication and you draw it up
18 into say three separate aliquots -- or is that -- what is an
19 aliquot?

20 A An aliquot is a certain dose. So in other
21 words, let's say we just had something -- for ease, let's say
22 we have something where there is 20 milliliters of drug and we
23 want to give 5 milliliters to one drug [sic], and it's
24 obviously a certain concentration, 5 milliliters to another
25 patient, and 10 milliliters to another, that is an aliquot.

1 And the dose like in propofol is it would be 10
2 milligrams per ml, milliliter, or 10 milligrams per cc. So if
3 it was giving 10 ml to one patient, that would be 100
4 milligrams. And that would be what we would use possibly to
5 get the patient to sleep. We might use the 5 milliliters or
6 50 milligrams as a touch-up, or we might go ahead and give it
7 to a small person. It depends.

8 In this case we also have 50 cc of 50 milliliters,
9 meaning large vials, so we have much more medicine to go
10 around. So we had a larger number of ability to go ahead and
11 do multiple draws for multiple patients.

12 Q So if you did that though, if you had a vial and
13 you extracted from the vial with a clean syringe, sterile,
14 hadn't been used on another patient, you did let's say a 50 cc
15 bottle and you had 10 cc syringes, I mean, you could draw five
16 different syringes full, correct?

17 A That is correct.

18 Q And then if you kept those separate and sterile
19 and not used by any other patient, theoretically could you use
20 those aseptically on subsequent patients?

21 A You could do it theoretically. The problem
22 comes in is because, as you alluded to before, there is a
23 significant number of unsafe practices that are occurring. So
24 what you end up doing is, is that you start getting vials that
25 are partially mixed and matched where people go in, they take

1 out. There's confusion, and so they have the ability to go
2 ahead and infect a second patient, who the first patient was
3 already infected.

4 So that what's happened is, is that the nature
5 organizations, meaning the CDC, the Centers for Disease
6 Control, the FDA, the Food and Drug Administration, the
7 American Society of Anesthesiology, the American Association
8 for Nurse Anesthetists all believe in one easy standard
9 approach, and that is you have one vial, you have one syringe,
10 you have one needle for one patient.

11 So the ideal thing would be to take whatever the vial
12 size is and empty all of it into one syringe, throw away the
13 vial. At the end of the case, if you have any left in the
14 syringe that has to be wasted, you throw away the syringe and
15 you throw away the needle and you start all over with the
16 second case. That is the only way you can be assured of safe
17 injection practices.

18 Q Getting back to reality though with certain
19 practitioners, if you did as I described and you ended up with
20 these five syringes that had not been used on patients before,
21 theoretically, if I understand you, you could use those on
22 five patients? I know it's not the guideline and what's
23 recommended, but you could use those, if you were very
24 careful, safely on five successive patients?

25 A Theoretically, yes.

1 Q Now, same situation where -- or a different
2 situation rather, where you've got a vial of medication and
3 you don't pre-draw, but you just as you need it draw with a
4 clean syringe, clean needle and so forth, you are able to draw
5 out 10 cc at a time for this patient.

6 Then you were careful. The next patient rolls in,
7 new syringe, new needle, same medication. You draw the same
8 10 cc out and use it for the next patient, and so on until
9 it's gone, you could do that theoretically?

10 A Okay. That's if -- let's go over this again.
11 You only use the 10 cc syringe on the first patient.

12 Q Yes. Never re-enter the vial. Never re-enter
13 the vial.

14 A And then that's it. And then you go to the
15 second patient and you put a new syringe and a needle on; is
16 that correct?

17 Q Correct.

18 A Theoretically that is correct.

19 Q Now, if you didn't quite do it that way, where
20 you took that syringe and you took your medication out of it
21 and you gave it to a patient, and let's say you even changed
22 the needle and you put a brand new needle but it's the same
23 syringe that actually came in contact with the patient, go
24 back into that vial of medication, could you then use that
25 vial of medication on a next -- on the next patient?

1 A Absolutely not.

2 Q And why not? What would be the problem?

3 A The reason is, is that because they have shown
4 that even though you may think that you may not be -- you may
5 not have blood on your syringe, the closer first of all you
6 are to a patient's bloodstream, the higher probability that
7 you will end up with blood on the needle and in the syringe,
8 the closer you are to the port where you're giving your
9 medication to the bloodstream.

10 And if you have a patient like we have here who could
11 have hepatitis C, which is a blood-borne virus, a certain
12 percent of cases, that syringe now will be contaminated. Even
13 if you throw away the needle and you then put a new needle on
14 and you go into that vial the second time, that then will
15 contaminate the contents in the vial.

16 Q What about if you went into that vial of
17 medication with a syringe, maybe even change out the needle,
18 and I'm talking about one that you used on a patient and you
19 did something with the plunger, where you were either holding
20 the plunger from moving or you were putting negative pressure
21 on it or something of that nature, would that be okay?

22 A No.

23 Q Why not?

24 A Because the same thing can happen. You still
25 have come in contact with potentially a patient who has a

1 blood-borne virus that will then still, regardless of what you
2 do with the syringe and the plunger, the -- still comes in
3 contact with the syringe.

4 Q So let's move to a different area. I want to
5 ask you about anesthesia billing and the like. The sheet that
6 you put together, the anesthesia record, what's the purpose of
7 that?

8 A Well, it's multiple things. You go ahead and
9 you put a patient's height and weight. You put their
10 allergies on. You put that you have identified the patient,
11 that you've looked over their chart and the patient is ready
12 to go. You put down any of the monitors you're going to put
13 on them. Usually it's circled or it's check-marked.

14 It has a place where we can use all the vital signs,
15 usually meaning the blood pressure, what the heart rate is,
16 what the oxygen level is that we're monitoring, their
17 end-tidal carbon dioxide, so that we know that they're
18 breathing. We can put an arterial line in the artery so that
19 we can have a more exact idea of what the blood pressure is.

20 We have an area where you can see where the
21 inhalational agents have been given, whether it's a general
22 anesthetic or whether it's a drug like propofol, or it's
23 something else where we paralyzed a patient so that they don't
24 move, so the surgeon doesn't have a problem with a moving
25 target.

1 It also shows the fact of how much fluid we give
2 them. It's a place where we can go ahead and show where the
3 blood products are, if the patient bleeds because they have a
4 problem with coagulation. So it gives us really all the
5 information in a very short window, and it's obviously a time
6 lapse.

7 Q A time -- a time lapse?

8 A A time lapse. So in other words, we have
9 something where we can record literally every five minutes.
10 Now, with electronic systems, you can even do it more than
11 that if you wish.

12 Q So you keep track of all those parameters that
13 you talked about. Are those called vital signs?

14 A That is correct.

15 Q Is that something that you track as the
16 patient's under anesthesia?

17 A Yes, sir.

18 Q And what's the purpose of even doing that? Why
19 is that important?

20 A Because you obviously need to have some
21 documentation of not only what it is that's going on with the
22 patient, but what it is that you did to prevent adverse events
23 from occurring. You need the documentation. That's a
24 standard in medicine. We can also use it to go ahead and
25 accumulate research data. But the primary reason is to go

1 ahead and have something that spells out what occurs to the
2 patient during a time that potentially is risky.

3 Q Is that important for maybe future practitioners
4 who may want to review how somebody did?

5 A It can do -- it can -- well, you can see what
6 that practitioner has done so that if there's something bad
7 that happened you can stay away from that. What are those
8 things? Like an allergic reaction, like something that you
9 put on a face to go ahead and protect the eyes, that they have
10 an adverse event, a difficult airway. There's a lot of things
11 that it gives you in terms of that kind of an information.

12 Q Is that document considered part of the medical
13 record?

14 A Yes, sir.

15 Q Is it important that you as the person who --
16 and I assume. I didn't ask you that, but are you the one that
17 would fill that information out?

18 A Yes.

19 Q I mean as the anesthesia person during the
20 procedure?

21 A That's correct.

22 Q Is it important that the information that you
23 put in there be accurate?

24 A Yes.

25 Q Is there any wiggle room on that at all; meaning

1 could you fabricate vital signs or anything like that?

2 A No.

3 Q Would you ever do that?

4 A No.

5 Q Would that ever be acceptable in any situation
6 that you've ever come in contact with?

7 A It would not be acceptable. It would be below
8 the standard of care.

9 Q Now, with regard to you mentioned a time, that
10 this records time; is that right?

11 A Yes.

12 Q Why do you even -- why are you even concerned
13 about time on a procedure?

14 A Well, I mean, since you have different data
15 points obviously you go on in terms of the procedure, so you
16 need that in order to go ahead and say when you gave certain
17 medicines, when you reversed them. If a patient's blood
18 pressure went down, you have to know what time that happened,
19 what you did. That's not only for this patient, but anybody
20 else who may take care of that patient.

21 It could even be for afterwards in terms of the
22 postoperative care, whether they go to the recovery room or
23 whether you go to an intensive care unit. It gives you an
24 idea. It gives you a footplate of that real time what goes on
25 to a -- what goes on with a patient.

1 Q Does the time have anything to do with your
2 reimbursement?

3 A Yes.

4 Q Is that important for you to get paid for what
5 you do is document that time?

6 A Yes.

7 Q Now, is that a big secret?

8 A No.

9 Q As far as the anesthesia time, can you tell us,
10 define for us how anesthesia time is calculated?

11 A The anesthesia time starts from the minute you
12 see a patient and you remain in attendance to that patient
13 until you turn them over to another healthcare provider. That
14 can be another physician let's say in an intensive care unit.
15 In the recovery room you're usually handing it over to a
16 postoperative nurse.

17 When you finish telling her about the patient, you
18 give the information as to the history, the physical exam,
19 what went on, what to look for postoperatively, what we've
20 given let's say in the number of transfused units, what drugs,
21 if it's a continuous drip. After that and we are finished
22 being at the bedside with that patient, our anesthesia time
23 ends.

24 Q You said personal attendance. Is that -- do you
25 have to actually be physically with the patient?

1 A You have to be physically with the patient. You
2 cannot go ahead and be doing something else and billing at the
3 same time. That's concurrency. In other words, you can only
4 bill when you are right there with the patient.

5 Q Now, with regard to that, what about if you're
6 in a procedure room, you've done an anesthetic procedure on a
7 patient. The patient has left the room. Maybe you've even
8 gone out and passed the patient off to the nurse like you
9 described. When you come back into the room --

10 You leave that patient. You come back into the room
11 and you actually are engaged on the anesthetic procedure of
12 another patient. You're just a few feet away if anybody needs
13 to call you to ask a question. Can you still bill for that
14 patient?

15 A No.

16 Q Would you ever be able to bill for that patient
17 in that scenario?

18 A No.

19 Q Now let's say you finish your procedure and they
20 call you over to do something with that patient, airway issue
21 or whatever, could you then bill for that time?

22 A Yes.

23 Q How would that work?

24 A Well, it works where let's say an emergency
25 comes up and you are no longer in attendance with another

1 patient. The nurse calls you because the blood pressure is
2 down, there are problems, having trouble breathing. You can
3 then go ahead and you can take care of that problem, but you
4 have to document in the record that you spent time with the
5 patient in attendance.

6 And so you put the beginning and you put the end in
7 terms of the time, and you put what happened, why you were
8 needed and what you did. And if you then have to go ahead and
9 turn the care over to another provider, healthcare provider,
10 like another physician, another specialist, you document all
11 that. But you can only -- it's that time that you spend with
12 the patient can you bill.

13 Q Your liability may be larger than that time
14 window though.

15 A And that's not infrequent with surgeons and
16 anesthesiologists. What can happen is, is that we might be
17 finished with the first case. Our anesthesia record stops
18 because we no longer are with them, we've turned it over to
19 another healthcare provider. We start the next case, and then
20 all of the sudden, you know, 30 minutes later there's
21 something that's going wrong with the patient that we just
22 finished.

23 You then have to tell the nurse to do A, B or C. You
24 have to tell her to try to find if you need another physician,
25 it might be a respiratory therapist. But you have to go ahead

1 and take care of them, but you are not allowed to bill. That
2 is not -- if you take a look at CMS, which is the Center for
3 Medicare and Medicaid Services, they do not allow you to bill
4 for doing that.

5 Q Now, along those lines, just so we're clear,
6 you're in a room, and let's say the procedure hasn't started
7 on a new patient and you don't go out and do any personal
8 attendance, but somebody just comes in and asks you a
9 question. You've already released the first patient to the
10 care provider, gone in and you're preparing to do another
11 patient, even though you're being asked a question about that
12 patient, you're no longer in personal attendance?

13 A And you cannot bill. It would be the same thing
14 like if you go ahead and you call your private physician and
15 you just want some information about medication, you know,
16 he's not going to go ahead and bill you for that. But for
17 anesthesia it's different. It's the sense that we have to be
18 there taking care of a patient face to face without not taking
19 care of another patient for us to be able to bill.

20 There is no exception that we can be taking care of
21 two patients simultaneously and bill them both for extra time;
22 in other words, that's what concurrency is. So if we -- let
23 me just be very specific. Let's say we finished a case and we
24 turn it over to the nurse in the recovery room at 12:00
25 o'clock. We bill for whenever we started to that 12:00

1 o'clock. We cannot then --

2 We're seeing our next patient. We can't -- we can't
3 bill. We obviously can't see that patient until it -- at
4 least a minute later, which we can then start billing for the
5 next patient. We cannot bill patient number one anything
6 more. We are now dealing with patient number two.

7 Q Could you ever overlap?

8 A Never. Not according to the billing -- the
9 billing guide by the CMS.

10 Q Now, and do -- I mean, does -- are there other
11 guides that deal with how anesthesia time is calculated, or is
12 this pretty much across the board?

13 A Well, I think most of the other providers,
14 because of the fact that it's the federal government and
15 they're the biggest payer, they usually set the guidelines for
16 what is acceptable and what isn't acceptable. And the
17 providers, the other private health insurance providers follow
18 the rules and regulations --

19 MR. SANTACROCE: Your Honor, I'd object to him
20 testifying as to what other providers do unless there's a
21 foundation as to how he has this knowledge.

22 THE COURT: All right.

23 MR. STAUDAHER: Fair enough. Let's not talk about
24 other providers. Let's just talk about your experience and
25 your familiarity with the actual regulations.

1 BY MR. STAUDAHER:

2 Q As far as the -- I mean, have you ever in your
3 experience, ever seen a situation where it was acceptable to
4 overlap billing?

5 A No. And we are very careful about that with our
6 anesthesia department and group.

7 Q So you could --

8 A We never --

9 Q I'm sorry.

10 A We never have this occur.

11 Q So you could never have five patients in the
12 recovery room, even though you're still liable for those
13 patients, that you would be continually able to bill for when
14 you're in attendance of say a different patient?

15 A That is correct.

16 Q Now, with regard to billing time, how is billing
17 time essentially determined?

18 A In anesthesia it's different than any other
19 specialty. For the procedure you get a base unit. And let's
20 say the procedures that we're talking about today,
21 colonoscopies, the esophagogastrosopies, we're talking about
22 five units for the procedure. Anesthesia gets an
23 additional -- for every 15 minutes they get one additional
24 unit.

25 And the reason is, is that because you have slow

1 endoscopists. You have slow surgeons and you have fast
2 endoscopists and fast surgeons, so your time is still with the
3 patient. And the belief is that you should not be penalized
4 if you work with a slow surgeon or a slow endoscopist. So for
5 every 15 minutes you get an additional unit.

6 Once you get past a 15-minute mark, it depends on
7 what the insurer is as to what it is that you can then bill
8 for that last allotment of time over 15 minutes. So in other
9 words, 15 minutes, it's the 16th minute, what happens. If
10 it's 30 minutes, what happens when you go 31 minutes. And
11 it's different between Medicare. It's different between
12 Medicaid. It's different with different insurers, private
13 insurers, and it differs from state to state.

14 Q Now, the part that's different is what? I mean,
15 is the 15 minute increment pretty much the same, those are the
16 windows?

17 A The 15 minute is the same. The five -- in other
18 words, for one unit. The five units for the procedure is the
19 same. What is different is that each one of them does
20 something a little different in terms of how they reimburse
21 you.

22 Let me just go back a little. Each unit translates
23 into a dollar amount that is paid by the insurer, and that's
24 how you then get --

25 MR. WRIGHT: A foundation as to this, or knowledge

1 of it.

2 THE COURT: All right. How is it that you're
3 familiar with the --

4 MR. WRIGHT: I can take him on voir dire a moment.

5 VOIR DIRE EXAMINATION

6 BY MR. WRIGHT:

7 Q Do you do the billing for your practice?

8 A When we first started, we --

9 Q Do you do the billing for your practice --

10 A Just a minute.

11 Q -- presently?

12 A Presently, no.

13 Q Okay. When's the last time you did billing for
14 an ASC practice where anesthesia was being done?

15 A Me personally?

16 Q Yes.

17 A I haven't because we have a billing service.

18 Q Okay. And you have a billing department where
19 you are?

20 A We have a billing service as part of the
21 corporate entity that is with our department; in other words,
22 we have a billing service.

23 Q Okay. What is "our department"?

24 A The department of anesthesiology at Cedars-Sinai
25 Medical Center.

1 Q Okay. So is that a hospital? I'm a layman.

2 A Okay. Cedars-Sinai Medical Center is a
3 hospital, yes.

4 Q Okay. So you do -- you do an anesthesia
5 practice in a hospital, right?

6 A Not just in a hospital. We do anesthesia --

7 Q Not we. You.

8 A Oh, me.

9 Q You.

10 A I do it just in the hospital, that is correct.

11 Q So when's the last time you ever even did a
12 ambulatory surgical center gastroenterology, you performed the
13 anesthesia in it?

14 A Several years ago.

15 Q How many?

16 A Well, my practice is a little --

17 Q How many?

18 A Okay. I can't tell you when the last one was,
19 but it would be more than ten years ago.

20 Q More than ten years ago is the last time you've
21 ever done a procedure for a gas -- a colonoscopy or upper
22 endo --

23 A No.

24 Q -- in a outpatient clinic?

25 A Out in --

1 Q In an outpatient clinic, correct?

2 A No. Wait, wait.

3 Q Correct?

4 A Wait.

5 Q Yes or no?

6 A That's -- it can -- you're asking me yes or no.

7 In the outpatient -- okay. Outpatient, the answer is yes.

8 Q Okay. You did one?

9 A No. I've done more than one.

10 Q More than ten years ago, correct?

11 A Even more recent than that. Okay. Because you
12 are asking --

13 Q Did you bill it?

14 A Excuse me.

15 MR. STAUDAHER: Your Honor, I'm going to ask that he
16 be allowed to answer his question.

17 THE WITNESS: Just --

18 THE COURT: Sir. Sir, sir. Both of you.

19 THE WITNESS: Yes.

20 THE COURT: Please, if Mr. Wright asks you a yes or
21 no question, then answer it yes or no. Mr. Staudaher will
22 have an opportunity, as I'm sure you know --

23 THE WITNESS: I do.

24 THE COURT: -- to come back over and ask you to
25 clarify your answers. If it is a question and you cannot

1 answer it as a yes or no question, then say I cannot answer
2 that as a yes or no question. Then Mr. Wright will determine
3 whether or not he wants to ask you a different question or
4 rephrase his question.

5 Okay. If you don't understand Mr. Wright's question,
6 then say, you know, I don't understand the question, or if you
7 don't know, then just simply say I don't know as opposed to
8 offering an explanation. If you don't feel that honestly you
9 can say yes or no, then the appropriate response in my view is
10 I cannot answer that as stated. And then Mr. Wright, as I
11 said, has the option, does he want to ask you a different
12 question, does he want to try to rephrase his question or
13 whatever.

14 So Mr. Wright, state your question.

15 Can you try to do that, Doctor?

16 THE WITNESS: I can. But, Your Honor, let me just
17 explain one little --

18 THE COURT: No, no.

19 THE WITNESS: No?

20 THE COURT: No. The way it works is you can only
21 provide answers to questions. Now, if Mr. Staudaher thinks
22 that your answer was incomplete in some way, it's
23 Mr. Staudaher's duty to come back over the testimony and ask
24 you for clarification or explanation, okay?

25 THE WITNESS: Okay.

1 THE COURT: So Mr. Wright, go ahead.

2 MR. WRIGHT: The last time you performed your
3 services providing anesthesia --

4 THE COURT: Mr. Wright.

5 MR. WRIGHT: Yes.

6 THE COURT: You need to keep your voice up.

7 MR. WRIGHT: Okay. The last time --

8 THE COURT: The only person that can always be heard
9 in this room is apparently me --

10 MR. WRIGHT: The last time --

11 THE COURT: -- and Mr. Santacroce. Something we have
12 in common.

13 BY MR. WRIGHT:

14 Q The last time you performed an outpatient
15 surgery center colonoscopy or endoscopy, by you performing it
16 I mean you gave the anesthesia services, okay, whenever it
17 was, whether it was more than ten years ago or recently, did
18 you do the billing on it?

19 A No, sir.

20 Q Okay. And in -- are you a billing expert?

21 A No, sir.

22 Q In order to have this information that you're
23 telling the jury here when you have nothing to do with your
24 own billing for your services, what did you do, research it
25 and read up on it?

1 A No, sir.

2 Q Okay. You knew all that you're testifying to,
3 CMS, the documents, all of that you had already known,
4 correct? And you did no research, correct, sir?

5 A Yes, sir. I -- okay. You asked two things.
6 Rephrase the question again.

7 Q Okay. Did you do any research?

8 A Yes.

9 Q Because you're not an expert you needed to read
10 up on it --

11 A No.

12 Q -- correct?

13 A I am not an expert, but --

14 Q Okay.

15 A -- I'm not a billing agent.

16 MR. WRIGHT: No further questions. Can we approach
17 the bench?

18 THE COURT: Well, actually, I was about ready to take
19 our break.

20 MR. WRIGHT: Okay.

21 THE COURT: Well, do approach the bench regarding
22 scheduling issues.

23 (Off-record bench conference.)

24 THE COURT: I'm going to go a few more minutes before
25 we take our lunch break. Unfortunately, we won't finish with

1 this witness at any reasonable time for the lunch break. So
2 Mr. Staudaher's got a few more questions and then we'll be
3 taking a lunch break around 12:30 or so.

4 DIRECT EXAMINATION (Continued)

5 BY MR. STAUDAHER:

6 Q When defense counsel was asking you some
7 questions, you wanted to expound on some of those things. Can
8 you tell us some of the things you're talking -- what you
9 wanted to say in relation to those questions?

10 A Well, he was asking me two separate things in
11 terms of when I did anesthesia or an endoscopic procedure, and
12 he was talking about the billing. But what was confusing me
13 is that, and maybe I misunderstood it, he said three different
14 things. One was an ambulatory surgical center, one is an
15 outpatient facility, and one is an inpatient facility. And
16 you can do endoscopy in any of the three areas.

17 Q Okay. So go on.

18 A And I have done those more as an inpatient and
19 in an outpatient facility, because at our facility we do all
20 three. I do not do them in the standalone ambulatory surgical
21 center that is at a distance from our campus. So that's what
22 the confusion was.

23 THE COURT: Can you tell us, in case it's not clear,
24 the difference between an ambulatory surgical center and an
25 outpatient facility? I think we all know what an inpatient

1 facility --

2 THE WITNESS: Right.

3 THE COURT: -- that's in the hospital.

4 THE WITNESS: Usually an outpatient facility is
5 attached to a parent hospital or a medical center, whereas a
6 standalone unit is a standalone unit. They don't do anything
7 else except whatever that procedure is, and that is usually
8 somebody that -- it tends to be more people in private
9 practice.

10 It's usually surgical centers where the surgeon or
11 the endoscopist or whoever is doing that frequently owns the
12 facility per se, and has his or her people there doing
13 procedures and doing anesthesia if they need, and it's just a
14 different setting.

15 THE COURT: Okay. So an outpatient would be somebody
16 who's not admitted to the hospital, but the facility is right
17 next to the hospital?

18 THE WITNESS: That is correct, Your Honor.

19 BY MR. STAUDAHER:

20 Q So you've done work in -- you've done endoscopy
21 work in all three facilities, but most recently in the
22 inpatient and outpatient facilities, right?

23 A That is correct.

24 Q And although you don't do the actual physical
25 submission of the bill itself to anesthesia, do you provide

1 the information by which that bill is generated?

2 A We not only provide the information, is that --
3 because of this corporate compliance issue that we've talked
4 about, at least once a year our billing service comes and
5 gives us a talk of about what we can do and what we can't do
6 so that we remain in compliance to what it is that they do,
7 which is the billing.

8 And that frequently is the times that we're talking
9 about, and that's one of the reasons why I'm very well aware
10 of that. And the reason I looked it up was just to
11 substantiate that this is exactly what CMS says. But it's
12 what we do from our billing agents to make sure that we, that
13 the group stays within the letter of the law.

14 Q So you used that as just to make sure what you
15 were being told was accurate?

16 A Yes.

17 Q Okay. So you go through this compliance thing
18 every year?

19 A Every year it's required.

20 Q And is that part of -- so you submit the right
21 things to the billing people so that then they can send it off
22 to the insurance company?

23 A That's correct.

24 Q So as part of that, you said that this class
25 that you go to where they talk to you about this and provide

1 this information to you, do issues like we've discussed come
2 up?

3 A Yes, sir.

4 Q Okay. And as far as your knowledge, do the
5 different carriers have different -- within the 15 minute
6 increment, do they have different issues of what portion of
7 that they will pay for the whole increment, for example?

8 A Yes, sir.

9 Q Is that what we were talking about?

10 A Yes, sir.

11 Q And what I'm specifically asking is, is there a
12 difference between going over one minute into the next
13 increment for some insurers versus going over eight or ten
14 minutes into the next increment for some insurers?

15 A Yes, sir.

16 Q And as part of the classes or the information
17 that you get from your billing people so that you can comply,
18 do you have those kinds of discussions?

19 A Yes, sir.

20 Q Did you then use that information to look into
21 your research to confirm that what they were telling you was
22 actually accurate?

23 A Yes, sir.

24 MR. STAUDAHER: At least on that issue, Your Honor.

25 THE COURT: Let me ask you this. Do you -- when you