issue about money at different times, and I wanted to ask you this. Based on your hearing and conversations directly with Dr. Desai, did you ever get the impression from him, either directly or just by his actions, that money was an issue to him?

A A big issue.

Q Did he ever say that?

A Yes.

Q What would he say?

A Well, I think he knew exactly what every item in the facility costs, and if somebody had to use one over or something like that, you were yelled at and told, you know, what that item costs and how much you were wasting and that type of thing.

Q Now, you mentioned propofol. You've don't anesthesia for 30 some odd years; correct?

A Correct.

Q These items here like this angiocath, you know the relative values of those various items, I assume?

A Yes.

Q And whether they're expensive or not expensive; correct?

A Yes.

Q Propofol in the mix, was that one of the more expensive or least expensive items in the mix?

A It would have been the most expensive item that we used as far as an anesthetic agent.

Q Now, you said that Dr. Desai was really fixated on propofol at one point.

A Yes, very much.

Q Can you tell us about that?

A I don't remember the year again, but it was -- came up when they felt -- or he felt that we using too much propofol, and that instead of injecting -- if we needed to give more propofol, we should just inject some saline to flush the -- the catheter, and what little bit would be in there would go into the patient.

Q So if I understand you correctly, and I'm showing, again, Exhibit 72B, that little tiny needle or -- or sheath over the needle would contain some propofol --

A Yes.

Q -- at the end --

A Yes.

Q -- when you injected it?

A Yes.

Q Instead of you giving more propofol to a patient, he instructed you to actually flush that out with saline?

A Yes.

Q He specifically said that?

A Yes.

Q With regard to propofol again, did you -- were you ever in a room with Dr. Desai when a patient was starting to wake up, move around during the procedure?

A Yes.

Q In normal situations that you had been in, what would you do in that instance?

A Give the patient more anesthetic, more propofol.

Q Would Desai allow you to do that?

A Most times, no, he would not.

Q So the patient is actually now writhing around or moving around on the table and you feel it's appropriate to give more anesthesia, and he won't let you do it?

A Yes.

Q What about the other end of the operation, before the patients -- and I say operation. It wasn't -- it was a colonoscopy or an upper endoscopy; correct?

A Correct.

Q Before the patients are anesthetized, you're back there you're either doing your form or you're getting ready to do it, are you with me?

A Yes.

Q You have not given anesthesia. Did Desai ever start procedures before a patient had anesthesia onboard?

A Yes, he did.

Q How did the patients react to that?

A Look at us for help.

Q And he would just continue?

A Continue and we'd try and give the anesthetic as fast as we could.

Q In those instances, is the patient moving around when you're trying to give the anesthetic?

A Yes.

Q Was it difficult for you to get the needle into the port on this -- and I'm showing 70I again, the port on this little hep-lock thing?

A Well, at times it would be, yes, because they'd be moving their arms and they'd be moving their body. It was -- you know, they were moving around on the gurney.

Q Did you ever stick yourself with a needle in those instances or some instances like that when it was occurring?

A I have been stuck three or four times, yes, over that.

Q Because of that very thing?

A Yes, moving around.

Q When -- is this something that he wasn't aware that the patient was awake still?

A He was very much aware.

Q Did you tell him that I haven't given anesthesia yet?

A That's right.

Q What would he do?

A Continue on. Just give it.

Q He would just tell you to give it?

A Yes.

Q And he would proceed?

A Yes.

Q Did he ever stop and wait until you had done that and then proceed?

A Not that I recall.

Q Now, the frequency of this happening, is this a one-time occurrence, or did this happen on a more frequent basis?

A It was not a one-time occurrence, and it didn't happen every time, but it happened quite frequently.

Q In a typical week, would it happen more than once?

A Yes.

Q Roughly in a typical week, how often would it occur when you were there?

A I'm just guessing. I would say maybe 10.

Q So a number of times during a week?

A Oh, yes. Many.

Q Now, the other end of the procedure, not -- and literally the other end, when the -- when the patient is about done with this procedure or near the end or at least he's moving around and Desai isn't done -- are you with me?

A Yes.

Q Did that happen? I'm talking about where you wanted to give more anesthesia and he ordered you not to do it?

A Yes.

Q In those instances, did that happen on a frequent, infrequent basis? What was the frequency?

A It was quite frequent.

Q So let's talk about the end of the procedure for a moment. And I'm not talking about a situation in which you need to give more anesthesia or whatever. Let's just assume for the moment that this is one where the patient is still under. Did you observe the scopes coming out of the patients, meaning out of their bottoms?

A Yes.

Q When the scopes came out of the bottoms, did Desai take the scope out differently than the other doctors did?

A At times, yes.

Q And what do you mean by that?

A Well, once in awhile we would get a patient

that, you know, wasn't doing that well and might have a slow pulse or bradycardia or something. He would whip it out just in a bit hurry.

Q So he would just yank the scope out?

A Yes.

Q When you yank the scope out of somebody, what would happen?

A Whatever was in there was flying around the room and on my and everyone else that was in the room.

Q So you actually got fecal material on you from him pulling and yanking a scope out of a person?

A Many times.

Q Did ever hit any other place in the room beside the people?

A Yeah, on the walls. I've seen it on the ceiling, floor.

Q Now, remember we talked awhile ago about the turnover time between patients?

A Yes.

Q You said it was really quick, between 30 -- well, less than a minute, I don't think you gave me seconds, but less than a minute up to just a few minutes.

A Correct.

Q In the instances where that kind of thing happened, was there enough time for somebody to come in and

clean the room?

A No.

Q Did you ever see anybody come in and clean the room during that time?

A No.

Q Let's talk about reuse of -- of -- you know, people wore gowns there. I'm talking about the coverings or the aprons or whatever it was --

A Right.

Q -- is that correct? Would Dr. Desai in your presence ever limit or give people a hard time about using too many of those?

A Yes. I didn't wear one. The doctors wore them and so did the techs. And they were a lot of times, you know, talked about it and said not to use that many and were allowed to have one sometimes for a whole week.

Q Now, the gowns are to protect -- to keep this stuff, this fecal material from getting on the person and the like; is that right?

A Correct.

Q Did -- when he wouldn't let them change the gowns or the -- or the -- or whatever, were they clean or was there any problem with that?

A They were dirty a lot of times.

Q When you say dirty, we're talking about fecal

material?

A Yes.

Q So they've got gowns with fecal material on them that they want to change and he won't let them do it, is that fair?

A That's correct.

Q Do you know what a sharps container is?

A Yes.

Q Did you have those in your rooms?

A We had one or two in each room. Uh-huh.

Q What are the -- what's the purpose of a sharps container?

A That's where the disposable items would go, especially the needles, syringes, that type of thing.

Q And I've just displayed again for the record, 72B, the angiocath that you described. The angiocath itself, is that considered as sharp?

A The metal portion coming out of it is, yes.

Q So after that would be used, where would that needle go?

A Into the sharp.

Q And what else would go into the sharps container?

A The portion, the plastic portion, or the outer shell, would go into the waste basket. But the propofol

bottle a lot of times or syringes that we had used with needles on them and that would all go into the sharps bottle -- or container. Sorry.

Q When Desai came into a room with you or if you saw this with somebody else, let's talk about you, first of all. Okay? When Desai came into a room, did he ever go over to the sharps container and look around inside the sharps container?

A Yes.

Q Do you know why he did that?

A Looking to see if we had thrown anything away that we shouldn't have.

Q You mean like what?

A Excessive propofol or something like that.

Q So if you had -- if you had discarded a partial bottle of propofol and he saw it in there, what would happen?

A I probably would have gotten fired.

Q Did he ever yell at you for doing that kind of thing?

A Yes.

Q Did you employ some mechanism when you actually wasted -- I mean, you didn't want to use the propofol on another patient -- so that he didn't see that?

A Yes, I usually tried to squirt it into a

wastebasket, just the liquid itself, you know, so that he wouldn't see that it was being wasted.

Q Did he ever watch what was in your syringes or in the bottles? Did he pay attention to what was going on over there with the propofol?

A All the time.

Q Now, did he ever yell at you about syringes that may have had propofol left in them that he saw in the sharps containers?

A Yes.

Q When he yelled at you what did he say?

A Look at how much you've wasted, what is that? He probably told me how much it costs.

Q Did he ever instruct you to use syringes with propofol remaining in them on another patient?

A No, I never heard that.

Q He never asked you to do that?

A No.

Q What about the bottles of propofol? If you hadn't used a whole bottle of propofol on one patient, did he ever tell you to save that and use it on the next patient?

A That was just common practice. That's the way it was done.

Q Okay. Everybody did it that way?

A That's what we were instructed to do, yes.

Q Instructed by whom?

A Dr. Desai.

Q When -- related to that -- that whole thing with the propofol, though, I want to get back to if you have ever observed others in the same situation that you were in when Dr. Desai came in and either rattled around the sharps container or reprimanded somebody because they were wasting propofol or the like, did you ever hear or see any of that?

A Yes.

Q In those instances, what would -- what would happen? What would he do?

A He would rant and rave about wasting -- wasting material, wasting propofol, and probably tell you how much it cost.

Q Now, sir, I want to ask you something about the syringes and all that stuff. Would you ever use a syringe that you had used on one patient on another patient?

A Never.

Q To your knowledge did you ever do that?

A No.

Q Same question, but now something else with bottles themselves. Did you ever have bottles of propofol that you had used on one patient that you then used on another patient?

A Yes.

Q And that was under the direction of Dr. Desai, if I think I understand you?

A Yes.

Q Now, third scenario, did you ever have a bottle of propofol that you had to reenter on the same patient? And what I mean by that, let me set it up so you understand what I'm talking about. You have a -- let's start off with a brand new bottle of propofol and you have a patient. You open the bottle of propofol, you draw out the medication, and you take that syringe needle combination and you go into the hep-lock and you administer medication to the patient. Are you following me so far?

A Yes.

Q You've done that, clearly.

A Yes.

Q Now, in that situation, if you needed to re-dose the patient with some additional propofol and you didn't have any remaining in your syringe that you had used, did you ever take that syringe and go back into the bottle of propofol?

A We would take the needle off and put on a new needles, and then reenter the -- with the same syringe into the bottle and draw up again, yes.

Q Was that common practice?

A That was common practice.

Q Were you instructed to do that?

A Yes.

Q By whom?

A Dr. Desai.

Q You've been doing this for 33 years before you came to Las Vegas?

A Yes.

Q Are you aware that there is at least a risk of potential contamination even changing out the needle in that situation?

A Yes, there is.

Q Did you ever express your concerns about doing this to Dr. Desai?

A Yes.

Q What was his response?

A It's to save money, just go ahead and do it.

Q So he instructed you to do it even though you made him aware of the risk?

A Yes.

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

THE COURT: That's fine.

BY MR. STAUDAHER:

Q Oh. Related -- I asked you some questions about putting in the IV and sometimes he would push you out of the way and leave blood dripping out or whatever. Do you

remember that?

A Yes.

Q That's a situation where he would kind of intervene in your area, is that fair?

A Correct.

Q Now, beside the other issues of him telling you what to do, did he ever at any point become frustrated because you weren't moving fast enough?

A Most of the time, yes.

Q In those situations where he became impatient or frustrated because you weren't moving fast enough and you had not given the anesthetic yet, do you recall any situations where he just came around, grabbed the anesthetic, and just pushed it in himself?

A Yes.

Q Did that happen more than a few times?

A When it happened frequently -- I mean, I shouldn't say frequently, but it has happened, I don't know, I can't tell you how many times.

Q But this is -- not just once or twice?

A No.

Q If you could describe for me what you felt the -- I mean, did you feel -- let me ask it a different way. I'm sorry. Withdrawn. The atmosphere within the clinic --

A Horrible. Everybody was under such pressure.

And when he would come around it was just like trying to walk on an eggshell because everybody was so cautious of what you were trying to do and being -- and doing the best that you could do. It was just a totally different atmosphere with him there or one of the other physicians.

Q So the staff was affected differently by who was there?

A Absolutely.

Q Again, I'm going to show you a series of documents, just portions of them, and again the highlighted portions were done by me.

A Okay.

Q They will not be on the original document that go back to the jury. 82. Sorry, it's not that very easy to read. I'll represent to you that these are items that were recovered when the police did the search warrants that were records of the clinic. Okay?

A Okay.

Q This document is entitled anesthesia, pain management services, and compensation schedule. Do you see that?

A Yes.

Q On this, and I know it's hard, can you read that at all, sir, or not?

A Yes, I can read it.

Q Okay. And down here, this talks about how anesthesia is billed at the clinic; correct?

A Correct.

Q That --

MR. STAUDAHER: And is it okay if I read this, Your Honor, because it's so small, to the jury?

MR. WRIGHT: Can we approach, again?

THE COURT: I'm sorry. Sure.

(Off-record bench conference.)

MR. STAUDAHER: May I proceed, Your Honor?

THE COURT: Please.

BY MR. STAUDAHER:

Q First of all, have you ever seen this document before yourself to the best of your knowledge?

THE COURT: Do you need to look at the whole document?

THE WITNESS: Yes, I'd like to see the top of it.

THE COURT: Why don't you show him the whole document.

BY MR. STAUDAHER:

Q This is 82, State's 82, just so it's on the record what we're looking at. Just flip through it and take as much time as you need. Just let me know when you're done.

A I don't recall it, no.

Q This does talk about, at least this document

talks about anesthesia billing; correct?

A Yes. Correct.

Q I'm going to read this to you and I want you to tell me if this is what the practice is -- if this practice is what you followed at the clinic. Okay?

A Okay.

MR. SANTACROCE: Can I just know what exhibit that is?

MR. STAUDAHER: This is Exhibit 82. It's Bates Number page 12 -- excuse me, 12101.

BY MR. STAUDAHER:

Q Let's read the highlighted portion that I highlighted. The base unit value and the sum of base units for the surgical procedure performed, time units and modifying units where appropriate. The source of anesthesia base units is primarily the American Association of Anesthesiologist, ASA, relative value guide.

THE COURT: It's says society.

MR. STAUDAHER: Excuse me. Society. I'm sorry.

BY MR. STAUDAHER:

Q Did you use that in your practice, that value guide when you were practicing?

A Yes.

Q Okay. And a thing called crosswalk, are you familiar with that?

A No, I'm not.

Q For all anesthesia services, anesthesia time begins when the anesthesiologist begins to prepare the patient for induction of anesthesia in the operating room, or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance. Is that what you did?

A Yes.

Q Okay. So just so we're clear on that before we go any further, your practice was that anesthesia time for you in the clinic was when the patient rolls into the room and you have contact with them and you're starting to do your work to when that patient leaves the room.

A Correct.

MR. SANTACROCE: Asked and answered.

THE COURT: Well, overruled.

BY MR. STAUDAHER:

Q Is that correct?

A Yes.

Q Okay. Standard time factor allowance is based on 15 minute increments, meaning on time unit equals 15 minutes. Do you see that?

A Yes.

Q Does that -- does that comport with your practice in the clinic?

A Yes.

Q Does that comport with your practice before you came to Las Vegas?

A Yes.

Q Now, this is also a document what seized, I'll represent to you, by the Metropolitan Police Department during execution of a search warrant. And it is a portion of a policy and procedure manual at the clinic. It says Endoscopy Center of Southern Nevada --

MR. SANTACROCE: Excuse me. Can I have the exhibit number?

MR. STAUDAHER: It's Exhibit No. 83, it's Bates No. 10264. And you see it says deep sedation policy.

BY MR. STAUDAHER:

Q Do you see that up there where it says --

A Oh, yes, I do. I'm sorry.

Q Have you seen this before?

A Not that I recall, no. I don't know. Is there a date on it?

Q Not on this page, but you were aware that there was a policy procedure manual in the clinic; correct?

A Yes.

Q Have you seen those before?

A Yes.

Q Have you read through them and -- and recognized certain parts of it?

A I'm sure I did, yes. Uh-huh.

Q Do you remember the procedure policy from the clinic back when you were working?

A Not really.

Q Okay.

A Sorry.

MR. SANTACROCE: I can't hear him.

THE COURT: I'm sorry?

MR. SANTACROCE: I could hear.

THE COURT: He said, no, sorry.

BY MR. STAUDAHER:

Q So under Section 2 labeled policy, Number A, did you see that?

A Yes.

Q I'm going to read this. It says, and it's talking about sedation; correct?

A Yes.

Q It says if administered by a CRNA, the attending physician will order and co-supervise with an anesthesiologist contracted with the Endoscopy Center of Southern Nevada II, LLC. All sedation practices in the Endoscopy Center of Southern Nevada II, LLC, shall be monitored for outcomes through quality improvement review. If a CRNA is utilized, it shall be under the provisions of Chapter 632 of NRS, an anesthesiologist contracted with the

Endoscopy Center of Southern Nevada II, LLC, will provide co-supervision for the CRNA while he/she is administering and caring for patients receiving sedation. The CRNA will report directly to both the supervising anesthesiologist and attending physician. Do you see that?

A I do.

Q Now, was it your testimony earlier that there was never an anesthesiologist that you worked with or there was a co-supervisor or anything like that at the clinic?

A Never.

MR. SANTACROCE: I'm going to object to foundation as to what deep sedation is.

MR. STAUDAHER: Okay. I'll ask him.

THE COURT: All right.

BY MR. STAUDAHER:

Q What is deep sedation?

A Deep sedation is where I would use propofol and there wouldn't have been a narcotic involved that -- you know, like I said, propofol is very short acting, and it would keep them quiet while a procedure was going on, but they would be awakened very momentarily after we were finished.

Q So that would cover the use of propofol?

A Yes.

Q Okay. Exhibit 84, Bates No. 10160. Have you ever seen this document related to anesthesia charting?

A No, I have not.

Q Do you see your name listed among other CRNAs on this document?

A I do.

Q Now, I had asked you before if you remember the procedure codes for a colon and an EGD and you said no; correct?

A Correct. I do not.

Q According to this record procedure code for a colon is 810 -- and I'm eliminating the first two zeros. It's 810 and an EGD is 740; is that correct?

A Correct.

Q The units here, are these the base units that we're talking about?

A Yes.

Q So five for each, and then it says plus and time, do you see that?

A Yes.

Q And up here it says one unit per 15 minutes.

A Correct.

Q And then it's just got some general information about the patient and so forth; correct?

A I think that's going into your ASA classification there.

Q Okay.

A One, two, and three, yes.

Q Exhibit 86, Bates No. 10158, entitled Gastroenterology Center of Southern Nevada, instructions to post anesthesia charges, do you see that?

A Yes.

Q Have you seen this document before?

A No, I haven't.

Q Do you see where it says up here using the information from the anesthesia record. Do you see that?

A Correct.

Q Now, that is the record that you would fill out in the endoscopy center?

A The clinic, yes.

Q Fill out the charge slip. So is there -- was there any -- I mean, clearly you know that when you fill out the anesthesia record to get paid, that record that you filled out is going to go to the insurance company eventually; correct?

A Correct.

Q It says the time -- here on the third one it says the time and physical status of the patient can be found on the record. To figure the units for time, calculate how many 15 minute increments there are. A portion should be rounded off to the next unit. And then it gives an example. 32 minutes would be three units. Do you see that?

A Yes, I do.

Q Exhibit No. 88, also from the procedure manual where it says cleaning procedure for rooms. Do you see that?

A Yes.

Q Have you ever seen or do you recall seeing this out of the procedure manual?

A Not -- not that I recall, no.

Q And this is, for the record Bates No. 9578. Starting on No. 3, each procedure gurney is to then be thoroughly -- this is after the procedure -- thoroughly washed or thoroughly washed down with cavicide solution or sani-cloths disinfectant wipes and allowed to dry. Do you see that?

A Yes.

Q After the area has dried, a fresh set of linen is put on the procedure gurney, along with the protective pad and made ready for the next patient. Do you see that?

A Yes.

Q Routine -- No. 5, routine terminal cleaning includes the above mentioned procedures and the following (a) wipe off all furniture and moveable equipment in the room with cavicide, to include canisters and return to its proper place. Do you see that?

A Yes.

Q Clean the gurney with cavicide, remove loose

pads, clean the area beneath. Do you see that?

A Yes.

Q Check the walls for soil and clean as needed, to include baseboards and air vents. Do you see that?

A Yes.

Q Spot clean the floor and remove blood and any other waste product. Do you see that?

A Yes.

Q After terminal cleaning, all personnel wash hands before leaving the area. Do you see that?

A Yes.

Q To your knowledge, did you ever see that kind of thing going on in the rooms between these patients?

A Never.

Q Exhibit No. 89, Bates No. 9570. Also from the policy and procedure manual from the Endoscopy Center of Southern Nevada entitled pre-surgical evaluation policy. Do you see that?

A Yes.

Q Under C -- first of all, have you ever seen this document to the best of your knowledge or remember it?

A Don't remember it.

Q Under C, all patients will have pre-surgical assessment and evaluation by the attending physician an CRNA or anesthesiologist immediately prior to the procedure. Did

that ever occur?

A Well, the CRNA, we would have done -- that's what I was explaining on the back of our anesthesia record. That's what we would have done.

Q But you saw that this was the CRNA or anesthesiologist and the physician. Do you see that?

A Well, I was -- the physician would probably have been on the history and physical done by them is what I'm thinking. But anesthesiologist, we never had anesthesiologists there.

Q But where it says immediately prior to the procedure, did you ever see the doctor come in and do any kind of evaluation on the patients before the procedures took place?

A If we had questions about things, they might put a stethoscope to their chest or something, but that would be it.

Q Was that a frequent occurrence?

A No.

Q Propofol, you said that you're familiar with that; correct?

A Yes.

Q Exhibit No. 90, Bates No. 9178. Have you ever seen this policy before?

A No.

Q Now, taking you down here to the highlighted section where it says single dose, unpreserved vials will be discarded at the end of the day or within 24 hours of opening with the exception of propofol, which is to be discarded in six hours from opening. Do you see that?

A I do.

Q Does that comport with the practice that you had?

A That's what -- yes. Uh-huh.

Q So why would there -- why would propofol have to be discarded within six hours?

A It does not contain a preservative in it.

Q What does that mean?

A It can grow bugs and bacteria inside of it if it's opened. Air gets to it.

Q So regardless of whether it moved from patient to patient or room to room or whatever, you would have to discard it after six hours at a minimum?

MR. SANTACROCE: I'm going to object and move to strike that propofol moving from room to room.

THE COURT: All right. The preface of the question is stricken.

So, Mr. Staudaher, just restate your question with the question part, which, I guess, would be --

MR. STAUDAHER: That's fine.

THE COURT: -- regardless of how it was used, was the propofol discarded six hours after opening?

THE WITNESS: Yes, it was -- it never lasted that long in the bottle. I mean, we were going through many, many bottles a day.

BY MR. STAUDAHER:

Q Well, let me ask you about that. At the end of the day did anything unusual happen with regard to propofol, unused bottles?

A If I was the last one there, I would always draw it up and squirt it into the bucket or, you know, into the red container or something. I never put the container in there with propofol itself.

Q Okay. Did you ever have people come around at the end of the day and give you partially used bottles of propofol to use on the last few patients so you wouldn't have to open up anymore?

A If someone was in the other room and that room had finished and we were still going in like the room I would be in, yes.

Q Okay. So would you use the propofol in that situation?

A Yes.

Q So that would be a situation where a bottle may have been opened up in another room and brought into your

room and you were supposed to use it and did, is that fair?

A Exactly.

MR. SANTACROCE: What did he say? I didn't hear.

THE WITNESS: Yes, we would use it.

BY MR. STAUDAHER:

Q No. 91, Exhibit 91, Bates No 9657. Have you ever seen this where it says anesthesia service certification?

A I don't recall it, no.

Q Also from the procedure that you see down here?

A Yes.

Q Highlighted portion, the contracted anesthesiologist and supervising physician will be responsible for that adequate supervision for anesthesia services performed. Do you see that?

A Yes.

Q And if you go down here, your name appears on No. 3?

A Right.

Q And then the anesthesiologist that's listed is Dr. Thomas Yee, co-supervising anesthesiologist. Do you see that?

A I do.

Q And ever know that he was even supposed to be your supervisor?

A I never saw the man.

Q Have you ever heard the term micromanager?

A Yes.

Q Would you classify Desai as a micromanager?

A Very much.

Q Did he know and was involved in every aspect of the practice?

MR. SANTACROCE: Your Honor, I'm sorry. I don't know what the term micromanagement means.

MR. STAUDAHER: Well, he does. That's why I'm asking him.

THE COURT: Well, wait a minute. When -- why don't we just ask him. When you say micromanager, what does that mean to you?

THE WITNESS: To me it means that he is involved in every portion of the practice and he knows exactly what's going on in every portion of the practice, the cost of everything that comes into the clinic, when it's used, how much it's used, how much it costs, and how much he's being reimbursed for it.

MR. STAUDAHER: Exhibit 85. This one has no highlighting on it at all, Your Honor.

THE COURT: Okay.

BY MR. STAUDAHER:

Q Have you ever seen a memo, and this is dated

January 11, 2007, ever seen a memo, and it looks like it is actually signed by Dr. Desai down here.

A Yes.

Q Ever seen a memo or any -- first of all, have you ever seen this memo before?

A No.

Q The things that are in this memo, have you had a chance to review it? Are those things that were told to you or that you practiced in the clinic?

MR. WRIGHT: What number is that?

MR. STAUDAHER: Oh, I'm sorry. That is Exhibit No. 85, Bates No. 10867.

THE WITNESS: I've never seen that before. It looks like it's something that, you know, has been written and wanting people to follow it. I mean, even reading number eight there, do you drink, do you smoke, and then saying you don't need to ask those questions?

BY MR. STAUDAHER:

Q Was that the practice? I mean, did you ever hear Dr. Desai say -- I mean, this is signed by him; correct?

A This was done in '07.

Q Correct.

A And I don't know as I was practicing at the clinic at that time, so --

Q Were you there when the Health District came

in?

A Yes.

Q Okay. So you were one of the ones that the Health District actually observed and you --

A Yes.

Q -- talked to them? So if they came in after the date of this or around the date of this memo, would you have been working there?

A Can you move it? I think it says January 11th. I -- I think I was gone. I was in California. And I think we came back around the middle of the month. So it would have been -- this, I did not see it.

Q Okay. I'm not saying did this get disseminated to you -- well, I did ask that, and you said no; correct?

A Right.

Q The information that's contained in here, did you ever have anybody talk to you about this, or was this a policy that was in place at the clinic to your knowledge?

A It's -- it's probably one that should have been, but I don't know as anyone every talked to me personally about it, no.

Q I'm just going to read it.

A Okay.

Q Reference: CRNA. Number one, please make sure

that CRNAs and RNAs will not take more time to start an IV access line than physician takes time to do the colonoscopy.

Two, please assign a specific RN to start the IV for the CRNA who may feel that they may need help to have somebody start IV.

Three, please have all the CRNAs sit together and figure out what pertinent minimum questionnaire they want to ask the patients.

Four, I have been observing with all the CRNAs, they ask all the different kinds of questions to the patients, but at the end of the day, they all give the same amount of medication irrespective of answer they might have received from the patients or any questionnaire.

Five, CRNA needs to understand that this is not a socializing time with the patients. They have to learn how to ask a pertinent relative question to the patients.

Six, CRNA needs to talk with the patient in a professional way and not in conversation, which looks childish and with any kind of -- and with any kind of sounds making. I think I read that right.

Seven, it is very important that CRNAs do not get into fight with the patients and trying to humiliate the patient by asking them stupid questions.

Eight, it is very important to ask the patient question whether they smoke or drink, but there is no need to

ask do you drink daily, weekly, monthly, or yearly. That is the most humiliating way of asking the question and needs to be stopped.

Nine, all CRNAs need to figure out with the patient who comes in for colonoscopy, do they need to have a question asked about the denture. Do you see that?

A Yeah.

Q So those are specifics about what you do during your evaluation process; right?

A Yes, they are.

Q Now, is -- is -- are questions about dentures, whether you wear them or not, important at all?

A Yes.

Q Why would that be?

A It depends on if they're tight or not. If they -- if they're not, they -- when they're under anesthetic or under sedation they could come loose, fall out, get broken or something like that.

Q And what might that compromise if that was the case?

A Their airway.

Q And what is the most important thing that an anesthesia person has to -- has to take care of during the procedure?

A Their airway.

Q So something that would directly impact the airway, he's directing you to, hey, don't ask patients about that?

A Yes.

Q Also on there specifically was questions about, well, yeah, ask if they drink and smoke, but don't ask them their history related to that. Is it important if they say they do to find out the extent?

A Absolutely.

Q Does that affect in some ways the medications that you give or how you treat a patient of what you have to look out for when you do your anesthetic?

A Well, if they're an alcoholic, you certainly are going to be giving an anesthetic different to them than if they weren't. If they had a drink, you know, once a day or once a week or whatever.

Q Do you recall coming into the -- talk to the -- or when the Health District came in? When the Health District came in --

A Yes.

Q -- do you recall that? And when the Health District came into the practice, they -- they were there for a period of time and then came down and did some observations; is that right?

A That's my understanding. I never saw them

before they came into our room.

Q So the first time you saw them was when they came into your room?

A Yes.

Q Were you at least aware that they had been onsite for a couple of days before that?

A I was not aware, no.

Q You weren't. When they came in, they watched you do a procedure; is that right?

A Yes.

Q After you were done doing the procedure, did they question you about what had happened, what you did during the procedure?

A Well, you're talking Health District now. I never saw any Health District. I saw somebody from CDC.

Q I'm sorry. I misspoke. I'm talking -- that's what I'm referring to is the CDC. When I say Health District, I was using them --

A Okay.

Q -- combined with the CDC. But if it was the CDC, they came into your room?

A A physician from CDC came into my room, yes.

Q Now, after that procedure, for the procedures you were doing, were you talked to by the CDC personally?

A In general, yes. Uh-huh.

Q Did they ask you about the practices that you were -- that they observed you doing?

A I'm sure they did. You know, I don't really recall anything in particular, but I think they did, yes.

MR. STAUDAHER: Your Honor, may I approach?

THE COURT: Sure.

MR. STAUDAHER: I'm showing on Bates No. 4203 of the CDC trip report, which is Exhibit No. 92, page 5 of the exhibit itself, but that was the Bates number.

BY MR. STAUDAHER:

Q Now, I know that this is not something that you read. And this is a highlighted portion again that is something I put on there. But I wanted to direct you because it's a multi-page document. I want you to read that. It's not your statement like the transcript is over here, but it talks about what you told the CDC. Okay? I want you to read that and see if it doesn't refresh your memory on -- on what they observed and asked you about and how you answered.

THE COURT: Just read it quietly to yourself.

MR. STAUDAHER: Yes. Not out loud. Sorry.

THE WITNESS: Yes.

BY MR. STAUDAHER:

Q Does that refresh your memory?

A Yes.

Q Okay. Did you say those things?

A Yes.

MR. STAUDAHER: May I display, Your Honor?

MR. SANTACROCE: I'm going to objection.

THE COURT: Yeah.

MR. STAUDAHER: I can ask him.

THE COURT: Okay. Why don't you just ask him --

MR. STAUDAHER: Sure.

THE COURT: -- if that refreshes his memory as to what he told --

MR. STAUDAHER: That's fine.

THE COURT: -- the physician from the CDC

BY MR. STAUDAHER:

Q What did they ask you and what did you say?

A They asked specifically about the propofol, how it was used, and about reentering a bottle of propofol, never with the same -- on the same patient -- we always used a different syringe on the different patient, but using a different needle on there and that's what they were asking about.

Q So I have this clear, they were asking you about their observations of you reusing a syringe on the same bottle of propofol on the same patient?

A Yes.

Q So just that scenario we talked about before where you go into the bottle, then you go into the patient,

then you change out a needle and you go back into the bottle.

A Back into the bottle.

Q So they saw that and they asked you about it?

A Yes.

Q And you admitted that you did that?

A Yes.

Q And they asked you -- then they saw you take that bottle that you had done that with and go to the next patient to use that bottle?

A Yes, it was used until it was empty.

Q And you admitted that you would do that?

A Yes.

Q You know that that at least poses a potential risk to a patient?

A Yes, it did.

THE COURT: Was there just one person from the CDC there that talked to you, or was it just one?

THE WITNESS: There was only one that was -- I think she might have had another one with her, but I never saw,

THE COURT: Okay. So you only talked to one person.

THE WITNESS: One person period, yeah.

BY MR. STAUDAHER:

Q And going to Exhibit No. 87, Bates Numbers 10148 and 10149. Show you the document, and we'll see zoom out just a little bit and ask you if you've ever seen this

before.

MR. STAUDAHER: Well, let me approach, if I may, Your Honor, so he can --

THE COURT: That's fine.

MR. STAUDAHER: -- see the whole document.

BY MR. STAUDAHER:

Q Look at both pages. Look it over. Just take as much time as you need.

A I don't every recall seeing it, no.

Q This has to do with you being a CRNA --

A Correct.

Q -- and everybody else that was; right?

A Correct.

Q The document is entitled an affidavit. Do you see that?

A Yes.

Q So nobody ever came to you and had you try and swear this out as -- and it's even dated in March of 2008, do you see that?

A I see that. I don't recall it. I really don't.

Q It even has on here I make out this affidavit voluntarily on my own behalf and free will, all that. Do you see that?

A Yeah, and by a notary. I just don't recall

anything like that.

Q Clearly, the first line says I'm a Certified Registered Nurse Anesthetist, and it goes through and talks about -- has blanks for your schooling and --

MR. SANTACROCE: Your Honor, I'm going to object. He's never seen it before. What's the relevance?

MR. STAUDAHER: I'm getting to that point, Your Honor.

THE COURT: All right. Well, and there's water there.

THE WITNESS: Thank you.

THE COURT: I notice you're coughing.

Is this admitted?

MR. STAUDAHER: Yes, I believe so.

THE COURT: Okay.

BY MR. STAUDAHER:

Q As we move down the document, clearly talking about being a CRNA; correct?

A Yes.

Q And down here on No. 5, it says I understand that there are certain allegations about ESCN, is that the Endoscopy Center of Southern Nevada, the initials for it?

A I think so, yes.

THE COURT: Well, they're -- it's backwards.

MR. STAUDAHER: It's backwards?

THE COURT: I mean, it's ESCN.

MR. STAUDAHER: Yes.

THE COURT: It should be ECSN.

MR. WRIGHT: Can we approach, Judge?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: So you have never seen this affidavit before?

THE WITNESS: I don't recall ever seeing it, no.

THE COURT: Okay. And this isn't -- isn't similar or it's not an affidavit that you recall ever signing?

THE WITNESS: No.

THE COURT: All right. What's your question for Mr. Mathahs?

MR. STAUDAHER: It's going to be very simple.

BY MR. STAUDAHER:

Q I want you to look specifically at, actually, 6, 7, and 8, and 9, actually, if you can read that. Did you read those or can you see them all?

A No.

Q I'll zoom back out so you can see the whole thing. I'm sorry. 6, 7, 8, and 9.

A Okay.

Q Okay. Is that true?

A No. 7 certainly isn't, I never reused a

syringe on the same patient, which we did. Is that what you're --

Q Okay. Is No. 6 true?

A Correct. That is very true.

Q So 7 is not true. How about 8?

A I never reused a needle, no.

Q Okay. This one here where it says you never reused syringes on the same patient is not true?

A No, it's not true.

Q Could you come down here for one moment, please?

THE COURT: Sir, just go ahead and step down. That's fine.

BY MR. STAUDAHER:

Q This is -- you can stand right here. This is a summary chart. I know it's very difficult to see for the jury looking [inaudible]. But a summary chart of an incident day of September 21, 2007, one of the days that you worked. As a matter of fact, if you look in where it says -- this column here, you can see that you worked -- at least it's your name appears in all the record on the patients here on that day. Divided up into -- into two rooms because you were in one room and --

A Right.

Q -- other anesthesiologist -- or other

anesthesia person was in the other room.

A Right.

Q On this day it appears as though Ronald Lakeman was working as well. Do you see that?

A I do.

Q You start off over here where it says anesthesia time calculated for the records. You see those times?

A Yes.

Q Do those bear any reality? This is -- this would have been your calculated anesthesia time on the records. They're all above 30 minutes.

A Oh, I got you. Okay.

Q Okay.

THE RECORDER: I'm sorry. I didn't hear his answer.

MR. STAUDAHER: He said I got you.

THE WITNESS: I understand what he was saying that --

MR. STAUDAHER: Would it help to have this as we go through this?

THE RECORDER: Yeah.

BY MR. STAUDAHER:

Q Okay. I'll give that to you. Are these accurate times?

A No.

Q If we go across to the procedure log time, which is for the nurse's time that she puts down in the procedure room, and the stop time, which is supposedly based off of the tape read times from the machine that you're in the anesthesia room. Okay?

A Okay.

Q You see the times here are listed eleven minutes, four minutes, three minutes, nine minutes and the like for most of it?

A Correct.

Q Are those more similar to what you normally have in the procedure room?

A I am sure they would be more accurate, yes.

Q Now, you -- I had asked you a question earlier about moving from room to room. Do you remember that?

A Yes.

Q You said at lunch time you might relieve?

A Yes.

Q And you said there was also if there was a bathroom emergency or some reason why you might need to go over to the other room you might do that?

A Yes.

Q I'm showing you here on the times as we go down, and, again, these times are based on your record, so they can't be accurate; correct?

A Correct.

Q But if we look at the times over here during the day when things are happening, we know that around 9:49 there was a patient by the name of Kenneth Rubino who was treated, and you treated that patient.

A Okay.

Q And I've got the file over there. I can show you if you need it. All right?

A Okay.

Q Then that's that time. So at approximately 9:49 to 10:00. Do you see that?

A Yes.

Q Down here on Ron Lakeman's -- in Ron Lakeman's room, you'll notice that right here at about 10:13 according to the nurse record, which you said is more accurate, at about 10:13 it shows you in that room actually doing a procedure. Do you see that?

A Yes.

Q And that one is on page No. 18 in this particular case. So clearly you had to have gone from this room to this room to actually be on the anesthesia record here; is that correct?

A Yes.

Q Do you remember this day itself?

A No, not at all.

Q Okay. Do have any reason to dispute that based on what your testimony is that you might have gone across for some reason, bathroom break or the like?

A No.

Q So you appear in the record on this date at 10:13, which is after the close or finish of Kenneth Rubino's procedure; correct?

A Okay.

Q Does that look right?

A Yes.

Q 10:13. You end at 10:00 here. Now, it appears as though you come back to this room because at 10:05 it looks like you're in this room again. So some of these times don't necessarily match up, do they? 10:05 to 10:16, 10:13 to 10:25, 10:24 to 10:35. So clearly you go over, you're there for awhile, and then you come back; is that correct?

A Yes.

Q In this instance I will represent to you that the infected patients that we have from the -- Kenneth Rubino is the source patient of the infections.

A Okay.

Q And the ones in green are affected patients.

A Okay.

Q So we have infected patients in the room you

were in after the source patient following -- and you're the anesthesia person there except for around the lunch hour when Ronald Lakeman comes in the room.

A Okay.

Q And he's in the room on the record, and then following that you've got a patient and that patient becomes infected.

A Okay.

Q You come down here where you look at where you come into the room, and the patient just before you come into the room becomes infected, and then thereafter we have infections going on after you return back to your room. Do you see that?

A Yes.

Q Now, in this instance, obviously, you're on the record here on this particular patient, but we have --

MR. SANTACROCE: Can you specify which patient number that is?

MR. STAUDAHER: I'm sorry. This is Patient No. 18.

BY MR. STAUDAHER:

Q We have you on the record there. If it was a bathroom emergency or something where you had to just go across quickly, is it possible that you went over -- have you ever done it where you went over and just finished up the end of a procedure with somebody, and then did their patient until

they could get back?

A It's possible. I don't recall it.

Q Well, I know you don't recall this, but would that match up with the speed of what you're doing to try to relieve somebody?

MR. SANTACROCE: Objection. Leading.

THE COURT: That's sustained.

MR. STAUDAHER: All right.

THE COURT: Ask -- you need to ask that a different way.

BY MR. STAUDAHER:

Q If you were to go over, would it -- have you ever gone over and relieved somebody for the end of a procedure if they had an emergency for some reason, whatever reason?

A If they had an emergency. I don't recall any time that I did that, but it could have happened, yes.

Q Well, at least according to the records you're in both rooms around the same time?

A Yes.

Q The beginning of the day it looks like Clifford Carrol is there as the single doctor; correct?

A Yes.

Q And then later on Dipak Desai comes in, and then some of the other doctors, also.

A Correct.

Q At the beginnings of the day in some instances, or many instances, you tell me, did one doctor just do his procedures in the day, and then other doctors came in in the afternoon?

A Yes, some of them did. Dr. Carrol was [indecipherable] and was at the clinic all the time, so he would pop in and out at different times.

Q So if patients are going -- if doctors are going from room to room and you're staying in one room, are they just turning patients over as fast as they possibly can?

A Yes.

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

THE COURT: All right. Perhaps we should take a break.

May I see counsel at the bench, please?

(Off-record bench conference.)

THE COURT: Let's go ahead and take until 3:10 for our break. And during the break you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to reports of or commentaries on the case, person, or subject matter relating to the case. Don't do any independent research, please don't form or express an opinion on the trial. Notepads in your chairs, and follow Kenny through the

rear door.

(Jury recessed at 2:53 p.m.)

THE COURT: Mr. Mathahs, if you need a break, you know, we're just going to start back up at 3:10, so you're free to leave the courtroom.

And you wanted to put something on the record. And you -- are you requesting this be done out of the presence of the witness?

MR. WRIGHT: It doesn't matter.

THE COURT: Okay. Everybody can sit down. You don't all need to --

You're lawyer wants you, so --

MR. WRIGHT: Exhibit 87 is the --

THE COURT: Affidavit.

MR. WRIGHT: -- affidavit. And I -- I do withdraw, attempt to withdraw my agreement. When I viewed all the evidence, whenever, weeks ago, for stipulation, I did not see this document. I didn't see it on the table.

MR. STAUDAHER: It was in the file this morning. I tried to -- I tried to -- I don't dispute that you didn't see it.

MR. WRIGHT: I'm not talking about in the file this morning. I'm talking about when I went over with you all the evidence, looked at the logs, everything else, and said all of these hospital records, all of that stuff, we aren't going to

fight chain of custody or anything else. I did not know there was a March 2008 unsigned affidavit that was obviously prepared for something by counsel. I was not cognizant of this when I said I have no problem with those records going in.

MR. STAUDAHER: And just for -- to short circuit that, it's not in those records. Just so I know, the records you came over on Friday and looked, or whatever day it was you looked at, that record is not in there.

MR. WRIGHT: Okay.

MR. STAUDAHER: That is in the discovery --

THE COURT: Had Mr. Wright been given the records before? I mean, what led you to believe that it was a record that Mr. Wright was stipulating to?

MR. STAUDAHER: Because this morning I brought over the records specifically that I was going to go over with this individual, which included additional things that aren't contained over there.

MR. WRIGHT: I didn't know that. I mean, I literally thought these -- I thought -- and I'm not saying --

MR. STAUDAHER: Okay.

MR. WRIGHT: I mean, this is my miscommunication. I thought all this stuff was simply out of there, you know, and it was already in. And I didn't know there were new things sitting here. And I even had copies made of this so that I

could view the exhibits that he just utilized --

THE COURT: Okay.

MR. WRIGHT: -- this morning.

MR. STAUDAHER: The only thing that was --

MR. WRIGHT: Because I --

MR. STAUDAHER: Right. And the only thing was --

MR. WRIGHT: -- I said, I don't have, you know, like my copies or anything.

THE COURT: Right.

MR. WRIGHT: But I did not look at them. I mean, I looked at some. I mean, I flipped through them, saw the FEA, you know, and things. But I'm --

MR. STAUDAHER: Right.

MR. WRIGHT: -- I'm just telling you, until it occurred here in the courtroom, I hadn't even been cognizant of that.

MR. STAUDAHER: With the exception of the FEA document that he saw and agreed to before, the rest of it was in a folder that I brought over this morning to --

THE COURT: Okay. I don't believe that it was a deliberate attempt of Mr. Staudaher to sneak in an exhibit. I know you're not suggesting that, but just so it's clear when somebody down the road who may be handling this doesn't say, oh, you know, looks like Mr. Staudaher snuck something in.

I think, you know, it was just a misunderstanding

between the two of you. Going forward I would ask if there are different exhibits or new exhibits that you're going to be introducing that day, just make sure opposing -- I just noticed we're missing half the -- half the group here.

MR. WRIGHT: I thought he was here.

THE COURT: Well, maybe he'd like to be here. I'm going to take a really quick break. It's not his objection, but going forward, Mr. Staudaher, just make sure if there's something new that you tell them. My understanding from the conversation at the bench is that that was an item that was seized that was on the computer and it was seized as part of the search warrant; correct?

MR. STAUDAHER: It was seized in the search warrant. I'd have to double check to make sure it was on a computer.

THE COURT: Okay. Well, wherever.

MR. STAUDAHER: Okay.

THE COURT: Because I'm sure you had a separate search warrant for the computer --

MR. STAUDAHER: Yes.

THE COURT: -- or that was part of the search warrant. So it's admissible as an item that was seized pursuant to a search warrant executed on the premises. Obviously, if it's not stipulated to, you have to get it in through the police officer who actually found it or was overseeing the search. But this one, it's a done deal. I

find that there's really no prejudice because it would have come in anyway through the police officer.

I understand, Mr. Wright, you're objecting because you don't think it's relevant it was unsigned --

MR. WRIGHT: No.

THE COURT: -- and it's clearly written by a lawyer. I asked at the bench, this wasn't attached to an email from a lawyer that you somehow downloaded, in which case we've got a real problem, we have a problem here. Mr. Staudaher said, no, he didn't think so because obviously if this is part of a communication from a lawyer or something like that you shouldn't be opening those and reading them and downloading stuff.

So I would have an issue with that if his lawyer that sent that to him. I think it's evident, no disrespect to anybody, but looking at the items that were actually authored by Dr. Desai and comparing it to that, I think it's pretty clear Dr. Desai did not write that because it doesn't appear he has the, at least written English skills to do so.

Having said that, it is an item in the possession of the office that was seized pursuant to a lawfully, you know, executed search warrant. So to me it would be admissible. You know, to me, that relevancy is that they're making, you know, kind of a knowledge of guilt idea, that you've got assertions in this affidavit that are contradicted,

apparently, if you believe the testimony, by what was actually going on.

So to me, the fact that you're -- that there's something here, you know, who sent it, who wrote it, where he got it, all that stuff, I think that's cross-examination and that goes to the weight of the exhibit, not its admissibility. But, again, you know, I think the relevance is it was in their possession and it's assertions that are different from what the practice was.

And even though that was never signed by Mr. Mathahs, it's sort of, if you look at the whole affidavit, it's the total thing like this is what the practice was, not just this one, you know, isolated thing. So I think it's relevant for those reasons.

MR. WRIGHT: But who wrote it and what was the context? It's March 2008.

THE COURT: Well, we don't know that's -- that's --

MR. WRIGHT: Well, then that's what --

THE COURT: If it wasn't stipulated to, he wouldn't --

MR. WRIGHT: I'm not. I'm withdrawing my stipulation.

THE COURT: Okay.

MR. WRIGHT: I did not know it. This wasn't -- I stipulated to documents I went over and looked at --

follow the patients out?

A More -- staying in the room more than we left.

Q Was it more rare occurrence or a more common occurrence for you to leave the room and follow out to the recovery area to deal with a patient?

A It would have been a more rare occurrence to go out.

Q So you're in the room when the patient comes in and you're in the room when the patient goes out, fair?

A Yes.

Q Could you describe for us the -- what happens in between. I mean, we've got -- and I'm talking about from the point the patient exits the room until the next patient actually physically rolls in. What goes on?

A The nurse would try and set the computer up for the next patient coming in. And when the patient got in the room, we would be hooking them up to the electrocardiogram monitor, pulse oximeter, make sure the IV is functioning if there was an IV in. Otherwise, we'd have to start the IV as well.

Q Okay. Now, I'm talking about -- I know that's when the patient actually gets in the room because you're talking about doing things to the patient; correct?

A Yes.

Q But as -- what I'm talking about is what I'm

going to term turnover time. I don't know what you would call it, but that's what I'm going to use for the moment. Meaning the patient actually physically exits room, and before the next patient physically breaches, comes right through the doorway into the room, what goes on in that room?

A Nothing that I am aware of. I mean, they're probably changing the scope out is all.

Q Any cleaning of the room?

A Not that I ever was aware of.

Q Okay. Any -- so no cleaning to your knowledge? They just rolled the next patient in?

A Yes.

Q What was the time frame between the time one patient leaves and the next patient rolls in, typically on one of these days that you described?

A It could have been a minute, it could have been less, it could have been two minutes. Somewhere in that area.

Q You think it could have been less than a minute?

A It could have been. I'm not sure.

Q I mean, if we sat here and ticked off a minute, I mean, there is a physical amount of maneuvering that has to happen, correct, for a patient, one patient --

A Correct.

Q -- to the next? Is it fair to say that it was a relatively short window of time?

A Short, yes.

Q In the minutes or even less, possibly?

A Yes.

Q So if that's happening, if that's the kind of turnover that we're talking about, do you really ever have a chance to walk out and deal with a patient if they're bringing the next one in within a patient of the first one leaving the room?

A The only thing you're going to be dealing with a patient is when they arrive in the room. Really you don't have time to go out and talk to them in the room -- or, I mean, in the recover area.

Q When you're back there inside the room and the new patient rolls in, what is -- tell me what you actually do to the patient at that point.

A Well, I want to start interviewing them. Usually -- I mean, if there was a tech available, they would hook up the monitors for us. And, I mean, I would have to -- if there wasn't an IV, I would be responsible getting the IV started and -- and trying to interview the patient, get a history and physical, you know, for my satisfaction. Sometimes there was, sometimes there wasn't one on the chart so that we would have some idea why the patient was there, why

-- why they came for a procedure, and that type of thing.

Q Okay. Were you ever pressured in any way to move that along?

A All the time.

Q By whom?

A Well, the physician.

Q A particular physician or more than one?

A Well, Dr. Desai was usually the one that would be pushing us to move along faster.

Q Do you see him in court today?

A Yes, I do.

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

A Right there at the end of the defendant's table.

MR. STAUDAHER: Will the record reflect the identify of Dr. Desai, Your Honor?

THE COURT: It will.

BY MR. STAUDAHER:

Q On the back end, once the patient leaves the room, I know that you said you didn't see anybody doing anything in the room, but you -- you is who I'm asking -- what did you do before the next patient came in to hook up to have a procedure done?

A Finish my chart from probably the last

patient, get that ready to be, you know, submitted to the patient and the recovery room nurse, and then make sure that I had propofol and things drawn up ready to -- or even if I had to start an IV, I would have everything ready that I needed to get going before we would be able to do the procedure.

Q Now, isn't it true that the -- the chart left with the patient, typically?

A But the anesthesia record is separate. We kept that, you know, until we were finished with it, and then it would go out. We'd give it to either the nurse in the room or the recovery room nurse to go with the chart, then.

Q So they would, then, take that record, even though the patient is gone, they would take that record out to wherever the patient was?

A To the recovery area, yeah. Uh-huh.

Q And that's typically where the patient went was out into the recovery area?

A Yes.

Q In the times that you went out to the recovery area, how did the patients get positioned in those sort of -- we understand there were four stalls of -- of patients, beds or gurneys or whatever you call it. How would they be positioned? A Well, usually there was one -- one or two ready to come into a room, and so then there would be an empty bed -- or, I mean, not an empty bed, but an empty

stall where the patient coming out of the room would go into and then get hooked up to the monitors again.

Q When they wheeled the patients from the room that you were in doing the procedure to the recovery room, in those instances where you observed it, did the patient go in head first into the stall or feet first into the stall? If you recall.

A I don't recall.

Q Now, I want to step back from that. We're going to come back to it in a moment, but I want to go back in time a little bit. When you were first coming into the clinic in 2003, up to the time that you left, was there ever to your knowledge any kind of supervising anesthesia MD person there?

A If there was, I never saw anyone.

Q Do you know who Thomas Yee is?

A I've heard the name, but I don't know him at all, no.

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

A No, I don't.

Q Ever seen either of those people around in the clinic to the best of your knowledge?

A No, I haven't.

Q Did anybody every tell you at any point that they were your supervising anesthesiologist?

A I heard the word Yee mentioned, and that was only because Anne, I think, worked with him down at a hospital in North Las Vegas.

Q Did you ever supervise anybody? I mean, what was your role as far as a CRNA at the clinic?

A Just a CRNA. I had no supervisory position at all.

Q Are you familiar with the drug propofol?

A Yes.

Q Can you tell us what it is?

A It's a complete anesthetic agent. It can be used as sedation as well, but it's -- we use it as a complete anesthetic agent.

Q Was that a drug that was always used at the clinic during the time that you were there?

A No.

Q Can you describe when that came in and how -- came into use and how?

A Well, when I first started in '03 they were using versed or valium. I don't recall, Demerol or fentanyl sort of as an amnesia type medications and the patients were taking a longer time to recover from that. And that's when I suggested that we bring in propofol because it is such a short acting medication.

Q When you say short acting, what are you

talking about?

A Well, depending on the amount given, but usually they're awake within five minutes after the last injection would be given. They would be totally awake and recall where they're at and that type of thing.

Q So it would be something they could recover from very quickly as well?

A Yes.

Q And so the onset, how quickly did it act?

A Very rapidly.

Q So if there was a situation in a patient's room, and I'm going to ask you first of all if -- well, if this ever happened where you were in a patient's room where the patient was starting to wake up, and in your opinion may have needed some additional medication, is that something you could have given a small dose and the patient would have gone under for a very short period of time?

A Yes.

Q Did you have situations like that where patients began to wake up and move and you felt that they needed, as a clinician, additional medication to put them under?

A Yes, I did.

Q In those situations, were you ever told not to give any medication?

A Yes, I was.

Q Who told you not to do that in those instances?

A Dr. Desai would have been the one.

Q Did that happen on a regular basis?

A I would say yes it did, yes.

Q So a patient -- just so we've got a clear picture of this. A patient, in your opinion, needs additional medication to have a safe comfortable procedure.

A It wouldn't happen every time, but it would happen quite regularly, yes.

Q But in your opinion was that something that was, as the person doing the anesthesia, something you would have normally given to the patient?

A Yes, I might have -- should have done it, and a lot of times I did give it without him knowing it, yes, just to keep the patient, you know, in sedated stated.

Q Did he ever see you doing that and then yelling at you for doing it?

A Yes.

Q Was that also something that happened fairly often?

A It could happen frequently, yes.

Q I mean, we're not talking about isolated events, are we?

A No.

Q With regard to -- getting back to the anesthesia, the propofol part of this, once propofol was introduced into the practice, was it used fairly regularly thereafter?

A It became the agent of choice, yes. Uh-huh.

Q Did every anesthesia person use propofol after that?

A Pretty regularly unless there was someone that might have been -- had an allergy, you know, that would have been related to it, then we would switch over to valium and Demerol or fentanyl or something like that.

Q How often did that kind of a thing happen?

A Very rarely. I mean, maybe once -- once a week, maybe once every other week, something like that.

Q How many times would you say you've used propofol over the years?

A Thousands.

Q Thousands?

A Thousands.

Q Did you use it back in California during the 33 years you worked there?

A Yes, I did.

Q Is it fair to say that you're familiar with that drug?

A Very familiar.

Q How it's used, what it's indications are, and contraindications?

A Yes.

Q And what, to you, is an indication for use of a drug like that?

A Well, if it's going to be a regular surgery, it's known as an induction like sodium pentothal used to be used, and it would be an induction agent, then you would switch over to your anesthesia agents, gas, nitrous oxide, oxygen, and an agent that you'd be vaporizing in the machine, and that's how it would have been used. But here in the clinics when you're doing short procedures, it's used as the total agent because it's such short acting, you know, the patient awake shortly after your finished.

Q Because it's so short acting, does that require you to give multiple doses of the medication during the procedure?

A Yes.

Q Even for short procedures lasting ten minute or less sometimes?

A Depending on the patient's, you know, stability and weight and that type of thing. You might get away with, you know, one injection for ten minutes, but probably not. It probably would require more.

Q Now, during the time that you're -- you're there, what kinds of procedures are taking place back in the procedure room? And I'm talking about the whole time. What do they do at the clinic?

A You're talking about here in Vegas?

Q Yes, in Vegas.

A Well, upper endoscopies and colonoscopies and we would put in the tubes, feeding tubes, that type of thing.

Q So the main predominant procedures were what?

A I would say colonoscopies and upper endoscopies.

Q In those types of procedures, did they take the same length of time to do typically?

A Depended on the physician who was, you know, doing the procedure and what -- you know, it varied from time to time.

Q Let's talk about Dr. Desai for a moment. On average, and I know it can vary depending on what was going on, but on average you saw him do thousands of these things over the years?

A I'm sure it was.

Q How long did it take him to do an upper endoscopy, or an EGD, I think, is what it's called.

A EGD, yeah.

Q Correct.

A It would take, I would say, a maximum of five, maybe, you know, two to three minutes.

Q So two to three minutes, maybe up to a maximum of five minutes?

A Yes.

Q The colonoscopies, how long would those take?

A I would say that could be from five minutes, up to a maximum of ten.

Q Okay. So we're talking about relatively short windows of time, is that fair?

A Correct.

Q Now, during that time did you ever hear -- and I'm talking about any time during this window that you worked there, did you hear Dr. Desai bragging about how fast he could do procedures?

A Yes.

Q Did he do that -- and what would he say typically?

A Just that he was able to do them in a very short period of time. I don't recall the exact words, but I know I heard it different times.

Q So you said different times, so that's more than once?

A Yes.

Q A lot more than once?

A I don't know how many, but it was more than once.

Q Did he ever give any of the other clinicians, other physicians, a hard time about maybe taking more time?

A One in particular that I recall. There were a couple of them, maybe. Yes. Uh-huh.

Q Okay. And who was that that he gave a hard time to?

A Dr. Carrera and Dr. Faris.

Q Felt that they -- their procedures were longer than they should have been?

A Yes.

Q What kinds of things would he say when he was discussing them?

A Well, sometimes I wasn't aware of it, you know. I mean, he would call them into their office -- his office, but I've heard him talk very abusive to Dr. Carrera about the procedures and, you know, that he needed to hurry up and get things going and that type of thing.

MR. STAUDAHER: I'm referring now to State's Exhibit 4, and Bates Numbers DA Endoscopy 261 and 26 -- excuse me, 2601 and 2602, for the record and for counsel.

BY MR. STAUDAHER:

Q I'm going to show you a document that I want you to tell me some information about as we go. And first of

all, let's get down the very bottom. Do you see the signature down here?

A Yes, that's mine.

Q You recognize that?

A Yes.

Q And as we go through some of the documents that we're going to go through, you can draw on the screen with your nail, fingernail.

A Oh, okay.

Q And you can just tap it down there to make it go away if we need to.

A Okay.

MR. WRIGHT: Is that Exhibit 4?

MR. STAUDAHER: I'm sorry?

MR. WRIGHT: Is that Exhibit 4

MR. STAUDAHER: Exhibit 4, Bates Numbers 2602 and 2601.

MR. WRIGHT: Bates Numbers don't do anything for me.

MR. STAUDAHER: Well, for the record.

BY MR. STAUDAHER:

Q So in this particular case, I just in general want to ask you some things. This area up here, this multi box area at the top where I see some checkmarks and other marks, what is that area used for in your experience or in this case? This is your record, is it not?

A It's a graph that we use for recording our blood pressure, our pulse.

Q And across the top do you see that there are times listed here as well?

A Yes, and every -- well, let's see. Wherever the dark line comes down to the bottom, we counted it as a 15-minute increment.

Q Okay. And I actually have the original records of these if you need to look one, if something is a little faint for you. But these are --

A No, I can see this.

Q -- a redacted copy to remove certain information from it. Okay? Now, as far as the records here of the blood pressure, heart rate, and the like that you mentioned on the small box area of this, is there a specific -- any significance, rather, to the actual different boxes? I mean, what do these represent as we go across the page?

A Well, starting out the blood pressure would have been somewhere around 130 over, it looks like 80, maybe 82, somewhere in that area.

Q Let me stop you there. That's not what I was asking. Just in general, without the hash mark or the different markings there, what do these boxes represent as they go across?

A Oh. Time segments.

Q What is the time typically?

A Between the ones where they come down through the bottom, it would be -- each one of the little lines would be five minutes.

Q So each one of --

A So I took --

Q -- each one of these is five minutes?

A Correct.

Q And then this one here is 15?

A Correct.

Q So these are 15s, and these individual ones are five; is that --

A Yes.

Q -- correct?

MR. STAUDAHER: And I was referring to the middle portion of the document, Your Honor, of 2601 for the record.

THE COURT: All right.

BY MR. STAUDAHER:

Q When we get down here to this portion, and I see some numbers listed here. Do you see those?

A Yes.

Q And we're referring to an area that says SaO2. What is that?

A That's the oxygen saturation levels.

Q So you're measuring those --

A Yep.

Q -- along the same time range of, it looks like every 15 minutes you're doing that; is that correct?

A Correct. That was the pulse oximeter that would be on their finger.

Q Okay. And then where it says EKG, what is that marking there?

A Just, yes, that it was on -- on the patient.

Q And where it says oxygen or O2 per minute, it looks like liters per minute --

A Two.

Q -- what is that?

A Just the line that the oxygen was on the patient.

Q Now, the next line says actually the words propofol on it. Do you see that?

A Right.

Q Is that the anesthetic agent that you talked about earlier?

A Yes, it is.

Q When I look over here and I see these different numbers of 50, 50, 60, 60, what are those?

A Those are the amount of propofol that was given in increments. 50 milligrams and then 50, and then 60 milligrams and then 40.

Q So at the very end over here it's got a total and it says what?

A 200 milligrams.

Q Now, propofol that came in bottles that you used, how many milligrams of propofol were in a single milliliter within the bottle?

A 10.

Q So it was a ten to one ratio?

A Yes.

Q So a 20 cc bottle of propofol, then, would have 200 milligrams of the drug in it?

A Yes.

Q So is it fair to say that at least this corresponds to 20 cc or 20 milliliters of the drug?

A It absolutely is.

Q Now, over here there's also an indication that there was actually a procedure done. What is that?

A That's where it was a colonoscopy, but there was a polyp and they took out the polyp, a polypectomy.

Q Now, on the right hand side of the screen there is some printed material here. Do you see that?

A Yes.

Q And the first thing says -- and I'm doing this for the record because just to know where we are on the diagram. It says anesthesia and monitoring equipment checked

before induction, and there's a mark. What is the mark?

A That it was checked and that it was working.

Q Okay. H&P reviewed.

A Yes.

Q And is that a history and physical?

A That would have been their history and physical, yes.

Q Patient identified.

A We always ask the patient, you know, and the procedure that they were going to be having, yes.

Q Patient evaluated immediately prior to induction.

A That would have been our H&P that we did, and it's usually on the back of our anesthesia record.

Q And that would be, as you testified, in the procedure room, typically?

A Yes.

Q And then the next one is patient positioned self lateral, left lateral position prior to procedure, and it's marked yes; is that correct?

A Yes.

Q Now, this next one here it says cath size, and it's got a circled thing here. What is this?

A That's the angiocath. The size is 22 gauge. GA means gauge. And --

Q Now, you said angiocath. Does angio mean blood vessel --

A Yeah.

Q -- or vein?

A Yes.

Q And cath means what?

A Well, it's actually a little -- the angiocath itself is actually two parts. There's a metal needle that you use to put into the patient, and then you slide off a little plastic tube into the vein, and the metal part comes out. So that's -- that's what that all pertains to.

Q So you're designating which type and which size of that particular item was in the patient; is that correct?

A Exactly.

Q Is there any indication on this form as to whether or not you put that device in or not? And there may not be. I'm just asking.

A I don't -- I don't see that there is, no. It says it's in the right hand.

Q So is this -- this is right and this is hand down here under IV site?

A Right. Correct.

Q IV fluids down below. It says -- what is that?

A None.

Q Did you in your experience ever use bags of IV fluids in patients for these types of procedures?

A At the clinic, no, unless it would be a real exception of something that we might had to have started an IV on someone.

Q And then at the very right hand corner of this we have the date, obviously, and then what is -- what is depicted here in this spot?

A The 9:45 is the -- in the morning, that's the time we started, and then 10:17 is when patient was turned over to recovery.

Q Okay. We're going to talk about that in just a minute. Let's go to the back of the sheet.

A Okay.

Q Now, there's -- there are various things listed here on the record. Do you see that?

A I do.

Q And you said that it's your experience to actually go through this with the patient once they get into the room?

A Yes.

Q Is that right?

A Yes.

Q Now, just so I'm clear on this, we -- you said

that the turnover time could be anywhere from less than a minute to just a few minutes, meaning one patient exiting and the next patient entering.

A Correct.

Q Once the patient actually gets into the room, it's your job to hook them up to the devices, I mean, the monitors and so forth?

A It could be, but usually we try to have a tech do that because we were busy trying to, you know, get our -- this pre-op evaluation done.

Q Did you try every time to at least review the history and physical that was on the charts so you were aware of what medical issues the patient may have?

A I tried all the time, but wasn't always successful, yes.

Q Okay. When you say you weren't always successful, what do you mean?

A It was a hurry that we wouldn't be pushed not to have to finish it. I mean, you know, just get going.

Q And who would be pushing you to do that?

A The physician, the doctor.

Q Which doctor?

A Dr. D.

Q Okay. When --

A Desai.

Q -- you say Dr. D, you mean --

A Desai.

Q -- Dr. who?

A Desai.

Q Okay. So just so we're clear on this, the anesthesia record that you're filling out to do your little sort of evaluation of the patient, he would push you to start before you were done doing it?

A Yes.

Q Did you feel that that was appropriate?

A No.

Q Did you feel comfortable with that?

A No.

Q Did you feel that that in any way compromised the patient potentially?

A Yes.

Q Let me go back to the first page.

MR. STAUDAHER: And for the record, we were just looking at States Bates No. 2602. We're back to 2601.

BY MR. STAUDAHER:

Q I want to ask you about -- well, let's -- let's talk about the time down here, first of all. And we've got a lot of records we can look at, but we're not going to look at everything. Those times down there, what does that add up to in this case?

A A little over 30 minutes.

Q In fact, if it's 9:45 to 10:17, that would be 32 minutes, would it not?

A Yes.

Q Is there any significance to 32 minutes of time on an anesthesia record working at the endoscopy center?

A It's something that was instructed to us that that was what it had to be, that they had to be 30 minutes or longer, the time -- time factors.

Q Now, you worked 33 years in California.

A Yes.

Q In 33 years in California, did you ever put down time on an anesthesia record that wasn't accurate?

A No.

Q You come to Las Vegas, and if they're telling you a time before you've even done this patient that this needs to be, would that -- I mean, it certainly could be accurate if the patient had actually taken that long; is that correct?

A That's correct.

Q But you're pre told that this record and all others you do needs to be greater than 30 minutes?

A Yes.

Q Who told you that?

A When I started it was Ann Lobiondo and Dr. D.

both emphatically made clear that that's what had to be done.

Q Now, specifically, Dr. Desai, after you started, did this ever come up again where he reiterated that in any way?

A Many times. If we would have messed up on the records, they would be evaluated somewhere along the line and they'd come back to us and tell us to make sure it was done properly.

Q But specifically, Dr. Desai, did he tell you over the time repeatedly to do this?

A At times, yes.

Q Now, I'm going to look over here to the area where that 32-minute time period is on this particular patient. And on this particular patient we also have a whole listing of sort of these checkmarks for blood pressure, respiration, O2 sats, all that stuff that you mentioned; right?

A Correct.

Q Those markings go out for the full time, the full 30 -- 30 plus minutes; correct?

A Correct.

Q Now, we -- we'll go over to the chart in a minute, but I'll represent to you this is Rodolfo Meana's chart. And we have a big board that has the summary information on it that we'll --

A Okay.

Q -- I'm going to bring you down to it in just a bit. But suffice it to say that the procedures didn't last that long, did they?

A Ordinarily, no.

Q So we've got Dr. Carrol on this one, though; correct?

A Yes.

Q And you said he was one of the faster ones, too?

A He used to brag about how fast he could do it, yes.

Q So if this is not an accurate time, it's far less -- and what was the average time that they're doing these procedures? I mean, you said Dr. Desai was five to ten minutes for a colonoscopy. Dr. Carrol, where was he in the ballpark range?

A Tried to be about the same somewhere.

Q So if we're doing a procedure that's five to ten minutes and we've got 32 minutes of anesthesia time and 32 minute of vital signs and the like marked down here, is that accurate?

A No, it isn't.

Q Okay. And is this something you put down on this record?

A Yes, I did.

Q Why did you do that?

A Because that's what I was told it had to be.

Q By who?

A Dr. D.

Q Did he explain to you why he wanted it that way?

A I -- I was told all along that there was a global fee for anesthesia and that time didn't make any difference. So I guess I was told different things, but I don't remember how many times I was told.

Q But you knew that this was false information; correct?

A Yes.

Q And you knew that was a patient record that somebody down the road might rely on, like yourself.

A Yes.

Q But you agreed to put down this false information?

A Yes, we did.

Q Now, even though Dr. Desai told you that there was a global fee for anesthesia, did you ever question him or refuse to do this?

A I don't remember about refusing, no. I mean, I was just told that's what we had to do.

Q If you didn't do it, what happened?

A I probably wouldn't have been working there.

Q But would Dr. Desai do or say anything to you if you didn't do it right?

A It would -- I don't know if it would be him, but it would come back through the upper office. We used to say, you know, that the record would come -- go up to Tony or somewhere, and then they would come back down maybe a day or two later or a week later and tell us to correct the, you know, the times and all that type -- type of things that needed to be corrected. So I don't know if it was Dr. D. telling her what had to be or, you know, us directly. But, I mean, we knew it. It was an implied -- an implied order.

Q But did he follow up on that to make sure -- I mean, was it coming from him basically where he's told you this before and yelled at you for that?

A He would check the charts at different times, yes.

Q Now, let's go back to California. Let's take a break and go back to California for just a minute. You were doing 33 years of anesthesia work in your own group as by your testimony.

A Correct.

Q Who billed for you?

A We had a billing service.

Q Now, the billing service that you used, what basis did they use to bill the patients?

A Are you talking about the anesthesia -- I mean, the ASA codes you're talking about?

Q Both, but I'm saying how would -- how would they know what to bill for your services first?

A Well, we -- we would have to look and see what the procedure was, if it was an appendectomy or gall bladder or whatever, there would be a certain code number that would be put down for that, and then the billing company would go according to that, you know, and know that. But then our time would be on the record as well so that they would be billing the time, plus whatever the code gave them.

Q So the code would give a base amount; is that right?

A Yes. Uh-huh.

Q And then how much time you were in the room would be added to that?

A Correct.

Q So is it fair to say that time is money in anesthesia billing?

A Yes, it can be. Sure.

Q Okay. And in your 33 years of experience in California, you put down these same types of hash marks on records; right?

A Yes.

Q And when you got to the end you had a time that was listed for the procedure?

A Right.

Q Did you ever fabricate any records over in California?

A No, I didn't.

Q And is it fair to say that you were aware that this record would be used to go to an insurance company to eventually get reimbursement for your services?

A Looking back, yes. But at the time, you know, it was -- we had no idea what was going on as far as billing. I mean, it was a very secretive type thing. Money was -- was not talked about. I was not aware that there was a billing service and that going on.

Q Well, let's talk about your experience in California. You were aware when these forms were submitted that they were sent to the insurance company for reimbursement, clearly.

A Correct.

Q And that the amount of time you put down would depend on -- would actually correlate with how much money you got back; correct?

A Yes.

Q So in those instances would you ever fabricate

any of the information on these forms?

A You're talking about here or there?

Q In California.

A No, absolutely not.

Q So when you came out here and Dr. Desai said, you know what, global fee doesn't matter. Just put this down as 32 minutes. I mean, clearly you're putting information down that isn't accurate.

A That's right.

MR. SANTACROCE: I'm going to object as it was asked and answered.

THE COURT: Well, overruled.

Go on.

BY MR. STAUDAHER:

Q So why was it, even though he's telling you -- and why does it matter what you put down if there's just a global time for anesthesia. You could have put down one box.

A It was so the record would look proper, I guess, again --

Q There we go.

A -- going to the insurance company. Yes.

Q That's what I'm talking about.

A Yeah.

Q So you knew it was --

MR. WRIGHT: Objecting to --

BY MR. STAUDAHER:

Q -- going to go to the insurance --

MR. WRIGHT: -- the guess.

THE COURT: Yeah.

MR. STAUDAHER: Well, we can -- I'll go back, Your Honor. That's okay.

THE COURT: Don't -- don't speculate. So ask the question. You can ask it a different way.

BY MR. STAUDAHER:

Q 33 years of experience doing this; correct?

A Yes.

Q You know these records go to the insurance company; correct?

A Yes.

Q When these records go to the insurance company you get reimbursed for them; correct?

A Correct.

Q So you know that this -- what you're putting down here is going to go to the insurance company.

A Correct.

Q So when Dr. Desai tells you global fee, put this down, why don't you not just do it? Excuse me. That was a bad way to ask that. Why do you do this even though you know it doesn't matter, or at least he's telling you it doesn't matter?

A I can't answer you, truthfully. I don't know why we did it. I don't know why I did it. I don't know. Because of that we -- that's what we were told we had to do, I guess.

Q What is a billing unit? In time, what is a billing unit?

A 15 minutes of -- of time.

Q Is that pretty standard across every place you've ever worked?

A Yes, as far as I recall.

Q Does it matter whether you're an anesthesiologist, an MD, or a nurse anesthetist?

A No.

Q So the time is the time.

A Time is time.

Q Do you know if there's a difference in the amount of -- if the amount of reimbursement for a CRNA for 15 minutes of time versus an MD for 15 minutes of time?

A I think some of the plans have a different -- like Medicare probably would be a difference.

Q But in the instances that you worked, I mean, you worked in those facilities, you did your own work, was there a difference between like if you went in for a -- in California, if you went in for a colonoscopy procedure and did it versus an MD doing it, do you know if there would be a

difference in reimbursement?

A I don't know.

Q Okay. But in your experience it was a fixed amount of money?

A Correct.

Q For upper endoscopies, do you remember what the code was that was used?

A I do not.

Q Do you remember what the base units that were given for those procedures?

A I do not.

MR. SANTACROCE: Can I ask you to have him speak up, please.

THE COURT: All right. You said I do not, was that --

THE WITNESS: Yeah.

THE COURT: And then just -- that black box there is the microphone.

THE WITNESS: Thanks.

THE COURT: Just be mindful. It's kind of hard to hear in here.

BY MR. STAUDAHER:

Q When you did these procedures, I mean, and you write down these forms, if you were -- let's go back to California where you were [inaudible] for sure. If you get

into another increment, meaning you're past the 15 minutes and you're into the next 15 minutes, can you bill and would you bill for that time?

A If it was up to 10 minutes, we would bill. Otherwise, we did not bill.

Q So if you went 15 minutes and -- let's say, actually, 17 minutes, you wouldn't bill for the other unit?

A No, I would not.

Q That's what you did in California?

A Correct.

Q Okay. And yet you're told that you have to bill for more than 30 minutes, 31 or 32 minutes here; is that correct?

A Correct.

MR. STAUDAHER: Court's indulgence, please.

THE COURT: That's fine.

MR. STAUDAHER: Your Honor, could we approach for a moment?

THE COURT: Sure.

(Off-record bench conference.)

BY MR. STAUDAHER:

Q Let's talk about the records, too. This is your record, the one that you -- I mean, this is actually your record on this particular patient; right?

A Correct.

Q Did you see other records that were done at the clinic, the nursing records on the charts and things like that during the time that you were there?

A You're referring to patients that I had or other CRNAs?

Q Well, let's talk about ones for you, first of all. Did you see other -- and I'm not talking about the CRNA records like this at this point. I'm talking about the other -- you know, there was a pre-op procedure form, there was a post-op procedure form, there was a procedure form, that kind of thing. Did you see those kinds of records?

A Most of the time, yes.

Q Do you know what the term precharting means?

A Yes.

Q What does that mean?

A It's where something is put on the chart before it actually happened.

Q Did you see that going on at the clinic?

A Yes.

Q On a regular basis?

A Yes.

Q Daily basis?

A Yes.

Q Lots of charts?

A I think probably most of them.

Q Why was that, do you know?

A Because the nurses would tell us they just didn't have time to do it all when the patients were out there and the -- the rapidity of things that were going on.

Q So if I understand you correctly, you've seen records filled out before the patient's even gotten a procedure done?

A Certain parts of it, yes.

Q I mean, parts that you would have to have the procedure done to fill out, correct, if you did it legitimately?

A Correct.

Q Now, in fact, I mean, you said that at some point if -- I want to make sure I'm clear on this. Before the patient actually gets into your room, the record that you receive with the patient would have information filled out by the nurse in advance for things that had not yet happened?

A Yes.

Q The general atmosphere that was in there, I know you've talked about the issue of having your foot rot and so forth, but as far as the -- the speed and the pressure and so forth, I mean, what was the general atmosphere around, not just the procedure room that you were in, but around the staff? How did the staff react to this time -- time crunch?

A Very stressful. I mean, it was just speed,

speed, speed, speed, come on, let's go faster, and that type of thing.

Q And did it give you concern about not just what you were doing, but other people were rushed so much that they might cause trouble, cause mistakes?

A Yes, I did.

Q Why did you all do it?

MR. WRIGHT: Speak for himself.

BY MR. STAUDAHER:

Q Okay. Why did you do it?

A Looking back, I don't know why. I purchased a house here, I guess, and maybe that was the reason. We moved here, you know, and if I had known things beforehand I would have never come. That's the way it would have been.

Q When you came here, what was your -- what was your starting salary back in 2003?

A I think it was 120,000 a year.

Q Were you given any kind of bonuses as things -- as time went on during the year?

A We were to get a $5,000 bonus, I think, every four months.

Q So another 20,000. So about 140,000 is what you started with?

A Yes.

Q Is that what you were making back in

California?

A No.

Q Or is that better?

A Less.

Q Less? So you were making more in California?

A Oh, yes.

Q Now, you -- were you still actively working in California or had you stopped working? What was the --

A No, I had retired in June or July of '02.

Q And I know we're going to take a break in about five minute for lunch, but I want to cover one area before we -- we do that.

MR. STAUDAHER: And I need one document before we do that, Your Honor.

THE COURT: That's fine.

Did you have the job prior to moving from California to Las Vegas?

THE WITNESS: I worked for myself.

THE COURT: Okay. So you hadn't been hired yet, or had you -- was the job in place before you moved?

THE WITNESS: The job was in place. I was hired in like in November of December something like that of '02. Yeah. I didn't move up here until sometime in January.

THE COURT: Okay.

MR. STAUDAHER: They're looking at the document,

Your Honor.

BY MR. STAUDAHER:

Q PacifiCare.

A Yes.

Q One insurance company specifically. The -- the insurance company PacifiCare, was it treated differently than some of the other insurance companies, at least the patients that came in?

A Are you talking --

MR. SANTACROCE: I didn't hear your question. I'm sorry.

BY MR. STAUDAHER:

Q I said was PacifiCare -- were PacifiCare patients treated differently than other patients of other insurance companies?

A Some were. I don't remember if it was '03 or '04. It must have been '04 that there was -- they were treated differently. I mean, before that I don't think they were.

Q Okay. So what happened after '04? How were they treated differently?

A We were given the directive that we could not do PacifiCare patients simultaneously or one right after the other. There would have to be another patient or two patients in between the patients. You know, if there were two

PacifiCares, there'd have to be two patients or one patient in between them.

Q So there had to be interruption --

A Uh-huh.

Q -- and you could never have two together?

A That's what we were told, yes.

Q Okay. Why was that?

A Why was it? I was because I think there was a phone call somewhere along the line that came to my attention, but I -- I never --

MR. SANTACROCE: I'm going to objection to foundation, how he knows this.

THE COURT: Well, all right. Lay a foundation.

MR. STAUDAHER: What is the problem? You've seen these in advance.

MR. WRIGHT: We object to the highlight.

MR. STAUDAHER: Okay. I'm going to show him and ask him specifics.

MR. WRIGHT: Okay. Is this the exhibit?

MR. STAUDAHER: Yeah, this is the exhibit.

MR. WRIGHT: Okay. Well, why did we highlight it?

MR. STAUDAHER: You saw the exhibits are highlighted because I want a specific [inaudible].

MR. WRIGHT: Can we approach, Your Honor?

THE COURT: Well, let's -- I don't know about you,

but I could use lunch. Why don't we go ahead and take our lunch break now. We'll have an hour for lunch. So that's -- basically we'll be back from the lunch break at 1:15.

And, ladies and gentlemen, during the lunch break you're of course reminded again that you are not to discuss the case or anything relating to the case with each or with anyone else. You're not to read, watch, or listen to any reports of or commentaries in this case, any person or subject matter relating to the case by any medium of information. Don't do any independent research by way of the Internet or any other medium, and please do not form or express an opinion on the trial.

Would you all please place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 12:10 p.m.)

THE COURT: And, Mr. Mathahs, you're excused for the lunch recess. I don't know if they want you to hang around or not. But --

MR. STAUDAHER: No.

THE COURT: -- as far as the Court's concerned, you're excused to go to lunch. And the only thing I would tell you is the admonition not to discuss your testimony with anybody who may be a witness in this case. Obviously, you can talk to your lawyers --

THE WITNESS: Okay.

THE COURT: -- about it if you want to. Okay. Sir, thank you, you are excused.

Everyone can be seated. All right. Since the jury has been excused, Mr. Wright, you had wanted to approach the bench but we don't need to --

MR. WRIGHT: Okay.

THE COURT: -- have a bench conversation, apparently, about the exhibits. I'm assuming that's what you wanted to approach the bench about?

MR. WRIGHT: Yes.

THE COURT: Okay.

MR. WRIGHT: The exhibits are all highlighted. These are the Court's exhibits.

THE COURT: Okay.

MR. WRIGHT: And they're -- this isn't the way they were. I mean --

THE COURT: Right.

MR. WRIGHT: -- they've been highlighted by the State. I simply never experienced where we highlight the exhibits and then they go to the jury room and it was placed on there by the prosecutor. I never have.

THE COURT: Mr. Staudaher.

MR. WRIGHT: So I object to that.

MR. STAUDAHER: They are the actual words. Whether they're -- it does no difference to me pointing to a specific

place on the record, but it shows the -- it shows the jury where I want them to look --

THE COURT: Okay.

MR. STAUDAHER: -- when I'm talking to the person --

THE COURT: Here's the thing.

MR. STAUDAHER: -- when we have a document.

THE COURT: You can use the highlighted exhibits, but we can also admit non-highlighted exhibits.

MR. STAUDAHER: I don't have any problem with that.

THE COURT: And you have to explain that this was done by you and it's not the condition of the exhibit at all.

MR. STAUDAHER: That's fine. I don't have an issue with that.

THE COURT: And then, you know, we'll have non-highlighted exhibits to show that this is really the condition, and then when you put the exhibit up just make it very clear that these highlights -- highlights were added by you so you could direct the witness or something like that.

MR. STAUDAHER: Fair enough.

THE COURT: And as long as it's clear on the record who did the highlighting and for what purpose, I'm fine with that.

Would you be fine with that, Mr. Wright?

MR. WRIGHT: Yes, Your Honor.

THE COURT: Okay.

MR. WRIGHT: The exhibits and the one that go to the jury don't have any highlight.

THE COURT: Right.

MR. STAUDAHER: That's fine.

MR. WRIGHT: Okay.

MR. STAUDAHER: I don't have a problem with that.

THE COURT: Okay.

MR. STAUDAHER: I just want to --

THE COURT: But he could publish, clearly, the highlighted exhibit so the jurors can, you know, follow along with that. All right. Anything else we need to do?

MR. SANTACROCE: My last objection you didn't rule on that about foundation.

THE COURT: I said Mr. Staudaher, lay a foundation.

MR. SANTACROCE: Oh, I didn't hear you.

THE COURT: Because it wasn't --

MR. STAUDAHER: Oh, I don't even remember what the --

THE COURT: -- clear to me how he knew about that, so you need -- and then he said he'd overheard a telephone call, so I think that's how he knows, but --

MR. SANTACROCE: Okay. Who, what, when, and where.

THE COURT: Well, I know. I said he can -- at first I was concerned was he speculating that he said he overhead it on a telephone call.

So maybe, Mr. Staudaher, you can make that clearer --

MR. STAUDAHER: Certainly, Your Honor.

THE COURT: -- how he learned about this. He overheard a telephone call, where was the phone call, etcetera.

MR. STAUDAHER: Yes. And then later on you'll hear other -- well, I'll get it in, Your Honor.

THE COURT: Anywho, or how. So I did -- I did tell him that, Mr. Staudaher, but he and Mr. Wright were conferring over the exhibits, so I don't think Mr. Staudaher heard, and then we took our break. So the witness --

MR. STAUDAHER: Thank you, Your Honor.

THE COURT: You can kind of --

MR. WRIGHT: Thank you.

THE COURT: -- back up a little bit, Mr. Staudaher, with the witness.

MR. STAUDAHER: I'll just start -- I just started the PacifiCare thing.

THE COURT: Right. Okay.

(Court recessed at 12:14 p.m., until 1:19 p.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session. Everyone may be seated.

And, Mr. Mathahs, you are still under oath.

Mr. Staudaher, you may resume your direct examination.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q We were just starting to talk about PacifiCare, but I want to ask you two questions kind of back on the pre-charting issue before we get to that. One of the things that you had talked about a moment earlier when you were on the stand was the fact that some of these charts would be brought into the room before patients -- and filled out to some degree before the patients were even brought in, is that fair?

A Yes.

Q Okay. In fact, at some point did you ever see any records that were -- that essentially had the patient discharged from the facility before they even came into the room for the procedure?

A It's possible. I can't recall right at the moment, but it's possible.

Q Okay. I have left up there, I just put up there a moment ago a copy of a statement that you gave during -- or prior to your pleading guilty in this particular case. So if you need to refer to that, I might refer you to some specific pages. Okay?

A Okay.

MR. STAUDAHER: For counsel, I'm referring specifically to page 7 of the document.

BY MR. STAUDAHER:

Q And you can grab that. I'd like you to look at it and refresh your memory. It's near the bottom of the page, the last couple questions and answers at the bottom of the page. Read that to yourself and then put it aside when you're done and tell me if that doesn't refresh your memory as to that issue.

A Okay.

Q Does that refresh your memory?

A Yes.

Q Okay. So as far as the chart, any indication that at times at least the charts were filled out completely before they were brought into the room, patients, that is.

A They could have been, yes, absolutely.

Q Is that what you said in your -- in your statement?

A I'm talking about -- you're talking about the nurse's charts?

Q Yes, nurse's charts. I'm not talking about your charts.

A Right. I said yes, the entire chart could have been filled out except for times, I guess.

Q In fact, if you go to the, I think it's the

one, two, three, four, the second answer to the bottom, do you indicate in there that they would even have the patients discharged from the facility before they even came into your room?

A Correct.

Q I'd like to move to the PacifiCare. You can set that aside, if you would. If you need to refer to it later on, we'll do that. Okay?

A Okay.

Q I want to ask you about the PacifiCare issue. Now, you said before the break that you couldn't have PacifiCare patients back to back. Do you recall that?

A I recall when the directive came down. Yes. Uh-huh.

Q And was that the way it was until you stopped working?

A Yes.

Q I'm going to direct your attention to Exhibit 81. I'm going to display that in a moment, but before I do so there is some highlighting that is on this document. And I will represent to you and to the jury that that is something that was not contained in the original document and something that I have done so that I can direct you to the areas of the document that I want to ask you questions about. Okay?

A Okay.

Q And there will be a succession of document I show you thereafter that are in the same way. The highlighting is something I put on there to -- to facilitate us getting to the information that I want to ask you about. Okay?

A Okay.

Q It will not be something that will be contained on the exhibits when they go back to the jury room. A clean copy will be provided. Okay?

A Okay.

MR. STAUDAHER: May I display, Your Honor?

THE COURT: Yes.

BY MR. STAUDAHER:

Q Now, you had mentioned the time period that you believe that this information was disseminated to you was in 2004; is that correct?

A As far as I can remember back. I think it was '04, yes.

Q And as you can see, even the date of this particular memo is January 23, 2004. Do you see that?

A Yes, I do.

Q In here is some discretion -- or some discussion about the fact that there are to be 42 patients scheduled in Endo 1 in time slot allotted. Do you remember me asking you questions about double booking and the like?

A Yes.

Q And you said that that did occur?

A Yes.

Q Actually, this memo talks about that directly, does it not? That fill up all the time slots before any double booking?

A Correct.

Q And then it actually gives an example of what double booking is. Do you see that?

MR. WRIGHT: I'm going to object to the summarization and leading.

THE COURT: Well, go on. Try not -- just be mindful, Mr. Staudaher.

MR. STAUDAHER: Yes.

BY MR. STAUDAHER:

Q I want to -- so there's discussion there about the double booking; correct?

A I see that, yes.

Q Now, I want to refer to No. 3, this area here. Does this comport -- does this match up with the things that you were told about not having PacifiCare patients back to back?

A Yes.

Q So in this particular example, there is actually an example given of how to schedule patients with

different insurance companies, do you see that?

A I do.

Q So HPN, as an example, then PacifiCare, then Aetna, then PacifiCare?

A Correct.

Q Okay. Is that the way that you did things, not just you, but the whole clinic did things when you worked there after 2004?

A Yes.

Q Do you know why that was done?

A It was because of the -- evidently the --

MR. WRIGHT: Objection.

THE WITNESS: -- insurance company --

MR. WRIGHT: Foundation.

THE COURT: All right. Lay a foundation.

BY MR. STAUDAHER:

Q Do you know why? Let's -- let me see, were you ever --

THE COURT: Well, he can answer yes or no --

MR. STAUDAHER: Okay.

THE COURT: -- and then how do you know -- how do you know, you know, did someone tell you, did you overhear a conversation, etcetera?

BY MR. STAUDAHER:

Q Do you know why this was done?

A Yes.

Q Why?

MR. WRIGHT: Well --

THE COURT: How do you --

MR. WRIGHT: -- how?

THE COURT: -- know -- how is it that you --

MR. STAUDAHER: I'll go through --

THE COURT: -- learned why --

MR. STAUDAHER: -- the steps, Your Honor.

THE COURT: -- this was done?

BY MR. STAUDAHER:

Q How did you learn this?

A That this memo came out, you mean? It was because of the fact that a phone call had come from an insurance company.

MR. WRIGHT: Foundation.

THE COURT: Did you overhear the phone call or did someone tell you about the phone call or how did you learn of the phone call?

THE WITNESS: Someone came and told me that I had a phone call from an insurance company and Dr. Desai was doing the procedure and he stopped the procedure and said I will take it.

THE COURT: All right. Go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q Okay. So this is -- actually Dr. Desai is present when all of this is going on?

A Yes.

Q So tell us what happened.

A Well, he -- after he came back, that's when the decision was told to me that we are not to do back to back patients. I just thought it was PacifiCare. I didn't realize that there were other insurance companies. At least I don't recall that.

Q So this is something Desai comes back and tells you?

A Yes.

Q Okay. So Desai tells you specifically, you personally, that you're not to have PacifiCare patients back to back, you're supposed to separate them?

A Correct.

Q And in that example, so we're clear, going back to 81, it's talking about PacifiCare, not other insurance companies being separated, and then it gives an example of how to separate them; correct?

A Correct.

Q So after that conversation with Desai, is that what you would all do thereafter?

A I know I did, and I'm sure the rest of them were instructed. I know Ann was instructed because she had

told me the same thing, you know, that's the way it had to be done.

Q Okay. So this is something that clearly --

MR. WRIGHT: I object to --

BY MR. STAUDAHER:

Q -- Dr. Desai is --

MR. WRIGHT: -- hearsay. I mean, we can ask him proper questions where he won't elicit that.

MR. SANTACROCE: And I'm going to object as to speculation as to the other ones. He only said one.

THE COURT: It's sustained as to speculation. It's overruled as to what he personally knew and what was told to him by other people in the clinic who were doing the same thing.

Go on.

BY MR. STAUDAHER:

Q But let's be clear on this. Dr. Desai was the one who at least at one point told you this specifically?

A Yes.

MR. WRIGHT: Asked and answered.

MR. STAUDAHER: Well, we're --

MR. WRIGHT: That's --

MR. STAUDAHER: -- going back to make sure.

THE COURT: Okay. Just overruled.

MR. WRIGHT: I object.

BY MR. STAUDAHER:

Q Is that correct?

MR. WRIGHT: I object, Your Honor. I don't know --

MR. STAUDAHER: Your objection is on the record, sir.

MR. WRIGHT: My objection is we don't need to go back to make sure on every question.

THE COURT: That's correct. I mean, we had an interruption, so I allowed Mr. Staudaher to go back to where he was prior to the objection and the Court's sustaining part of the objection and overruling part of the objection. So now we know where we are and please proceed.

BY MR. STAUDAHER:

Q With regard to the reason that Desai wanted you to do that, did he ever tell you specifically as to why that should be done?

A I recall that it was because of the fact that the insurance companies were getting bills, you know, consecutively, you know.

MR. WRIGHT: Can we have a foundation.

MR. STAUDAHER: This is discussion with Dr. Desai.

MR. WRIGHT: I'd like a foundation as to when and where.

THE COURT: All right. When did you -- Mr. -- can you lay a foundation. When did this conversation occur, was

it in the clinic, etcetera.

BY MR. STAUDAHER:

Q And we'll go to that in a minute. You have the conversation after the phone call with Dr. Desai; correct?

MR. WRIGHT: Objection.

MR. STAUDAHER: I'm just bringing --

THE COURT: Overruled.

MR. STAUDAHER: -- us back.

THE COURT: I mean, again, we're getting back to where we were before the discussion on the objection.

So go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q So in relation to Dr. Desai telling you this should be done, the part about why it should be done, was that in the same conversation or was that later?

A As far as I recall it would have been at the same time because of the back to back patients.

Q And so what was the explanation, then?

A That we couldn't do them back to back because of the times, the time factor and the insurance company was questioning, which I didn't know. But, I mean, that's what they called about was they were questioning why the times were overlapping, I'm sure.

Q But that's what he's telling you?

A Yes.

Q The insurance company is calling, we can't do them back to back because of the time?

A Yes.

Q Now, you had mentioned -- you had mentioned that there were some items that were actually utilized for doing your anesthesia work; correct?

A Correct.

MR. STAUDAHER: As a matter of fact, may I just approach, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q Showing you what has been -- this is Exhibit -- let's see, Exhibit 70I, 72A, 72B, 70H, and 70G.

MR. STAUDAHER: I believe these were all stipulated to admission, if I understand.

THE COURT: Is that correct?

MR. WRIGHT: Yes.

THE COURT: All right. Those are all admitted, then.

(State's Exhibit 70I, 72A, 72B, 70H and 70G admitted.)

BY MR. STAUDAHER:

Q Do you recognize these various items?

A Absolutely, yes.

Q Are they things you used in your practice?

A Every day.

Q Every day.

MR. STAUDAHER: May I publish, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q When I was talking to you before, you mentioned a device called an angiocath, do you recall that?

A Yes.

Q And showing you --

MR. STAUDAHER: I'm going to have to actually take it out of the package. I'll put it back in, Madam Clerk.

MR. SANTACROCE: Can you tell me what exhibit that is?

MR. STAUDAHER: This is 72B.

BY MR. STAUDAHER:

Q So what are we looking at here?

A That's the angiocath with a sterile tube that slides off of it right in the package itself the way it would come from the factory.

Q So there's -- inside this container -- we won't undo it, you can look through it, it's semi-transparent down at this end over here --

A Right.

Q -- is that correct?

A Correct.

Q And in there it appears to be a needle with

some sort of white plastic sheathing over the top of it.

A Yes.

Q What is the difference -- what is what white plastic sheathing?

A That was the tube, the little plastic tube that would have been inserted into the vein after you punctured the vein with the metal portion of the needle.

Q So if I understand correctly, the needle with the sheath goes into the vein, then the needle is withdrawn and the sheath remains?

A Correct.

Q Is that what allows you to get access to the person's blood system?

A Correct.

Q So you can administer medication?

A Correct.

Q Is that what you used to do that?

A Yes. Uh-huh.

Q So this is one device. We have another one, which is Exhibit 72A. The first one was yellow. This one is blue in nature, but it looks very similar. What is the different between the two?

A This one says 22 gauge, which would be a little larger. And the yellow one is a 24, which would be a little smaller.

Q So they were just different sizes?

A Just different sizes.

Q Length or width?

A I'm sorry?

Q Length or width, the diameter of the needle?

A Oh, the diameter. You would evaluate it when you're looking at a vein. Smaller veins you'd use the smaller.

Q Showing you what has been marked and admitted as 70I. Can you tell us what that item is?

A That's just the port that you would put on the IV. I mean, after the needle was in the person, and then it would be so you could use it on the end where it's --

Q Use your fingernail.

THE COURT: If you touch it --

THE WITNESS: Oh, your nail?

THE COURT: -- that'll make a mark.

THE WITNESS: Okay. There. That, there's a port there, that's where actually the needle would go in. It's silicon or rubber or something that you can push a needle into it and give the medication, and the medication would go this way into the patient.

BY MR. STAUDAHER:

Q Okay. So on this end over here, does this -- is this the part that screws into the angiocath that you would

put into the patient?

A Yes.

Q And this part on the end here is where the needle would go into, and then into the patient?

A That's -- yes, that's the port end. Uh-huh.

Q Okay. And is this the type of device that you would use at the clinic?

A Yes.

Q Is this also known as what's called a hep-lock?

A Yes.

Q And why is it called that, do you know?

A Because sometimes a patient would have had a catheter left in, an angiocath left in, and they would have been given heparin so that you wouldn't have -- have any clotting or something like that. It would prevent clotting of the blood in the -- in the IV itself around the angiocath.

Q Do you all use heparin in that capacity at the clinic?

A No.

Q So that's just the name for what it's used for?

A Yes.

Q Okay. And I'll show you this -- this last item here which is 70 -- wow, it's hard to see unless I can

turn off the light -- 70H. Do you see that?

A No, I can't really see what it is.

Q It's really tough, isn't it? Is that better?

A I can see a little port on top, but I can't see if it's a --

Q Let me bring it up to you so you can look at it and tell us what this is.

A Oh, okay. I see now what it is.

Q What is it?

A That is a port that could have been placed into a propofol bottle. A propofol bottle has a rubber stopper on it, and that could be placed into that stopper, and then you could use this port for drawing your propofol out into a syringe.

Q Would that be used on the smaller bottles or the larger bottles, or does it matter?

A It wouldn't matter. You could use it on either one.

Q Okay. So in this particular instance, this -- and I know it's very difficult to see unless you're right down on top of it.

A Right.

Q There's sort of a plastic sheath over this end; is that correct?

A Correct.

Q And that looks to come to a real point inside.
A That's the --
Q Is that the part that pierces that rubber stopper?
A Yes, that's the one that pierces into the bottle.
Q And then it looks like there's also another place on the other end where you can screw on a syringe of some nature?
A Yes. Uh-huh.
Q And is that how you would draw the medication out?
A Yes. Uh-huh.
Q The one last item, I think I said that was the last, but this is the last. 70G, what are we looking at here?
A It's a Becton Dickinson 10 milliliter syringe.
Q Now, are these the -- I mean, are you familiar with the use of these in the clinic?
A Yes.
Q Where were they used?
A That's not -- we used for anesthesia, we would draw up our propofol, and those or any other mediation that you might need to give would all be drawn up in this type of a syringe.
Q So you didn't have larger ones for that

purpose, 20 cc syringes, anything like that?

A No, we never had any.

Q Did you ever request any?

A Yes.

Q Who did you request those to?

A Probably our supervisors and were turned down.

Q Do you know why?

A I'm sure it was cost factoring.

Q Do you know -- did you ever talk to Dr. Desai about this specifically?

A I probably did. I don't recall, you know, specifically, but I probably did because it just made more sense to use the 20 milliliter than this one.

Q Okay. Now, I want to talk to you now that we've been looking at different supply issue about supplies. Was there an issue about no wasting supplies in the clinic?

A Absolutely.

Q When you say absolutely, can you tell us some of the things that you're referring to?

A Well, the propofol, for one of the things, was absolutely something that was forbidden to waste. Syringes, I mean, angiocaths, anything like that. If we had to restick someone because we missed the vein or somebody had missed the vein, you know, or something like that, that would be considered a waste and we would be talked to about it.

Q Who would talk to you about it?

A Well, if Dr. D. Was there and saw, he would be talking to us about it.

Q What would his tone be when he was talking to you about it?

A Angry.

Q So -- and, again, I'm putting up on the screen an angiocath which was from 72B. It's the yellow one. Is this a device you can use more than one time?

A No.

Q Single use device?

A Single use.

Q If you used this device to try and puncture a vein on a patient and Dr. Desai was there, did you ever get reprimanded about having to use another one, or anything like that?

A Yes, I did.

Q What would he want you to do?

A Well, if -- you couldn't use this one over. I mean, you'd have to use a new one. That would be it, you know.

Q Would he want you to use this one over again if you could?

A If you could.

Q Is that something you would normally do in

your practice in the 33 years you were -- before you came here?

A No, I was not limited to that type of thing.

Q So even something like this you were -- you were having trouble with as far as him giving you a hard time about using it?

A Yes.

Q When it came time to using these devices, were you ever in a situation where you were having a hard time starting an IV or it was taking too long and Dr. Desai was there?

A Yes.

Q Can you describe for me any instances that you had where Dr. Desai may have intervened in that situation?

A Yes, he would give you about one chance to do it, and if you didn't do it he would grab the needle and try and do it himself or proceed to do it himself and then just leave the blood running out while we'd try and get the port on so we could go ahead and tape it and get the patient sedated.

Q So you're telling me he would insert the device into the vein, and then just walk away?

A Yes.

Q And when this has been inserted into the patient, now that's in communication with the blood stream; correct?

A That's right.

Q So what is happening to the patient's blood during this time?

A Running on the arm and running on us trying to get the port on to get it stopped.

Q Beside that item, were there other items that you couldn't -- couldn't use any more of or you tried to limit the amount of use that there was or waste associated with those items?

A Tape was a big -- big item. I mean, if we -- if there was too much tape on an angiocath or something like that, we'd -- we'd hear about it.

Q So he would give you a hard time about using too much -- you're talking about this plastic tape that you put down?

A Yes. Uh-huh.

Q About too much of that?

A Yes.

Q Anything else beside tape?

A You're talking now about anesthesia, or in general of the clinic.

Q General in the clinic where you were and could observe that kind of thing going on.

A Well, I heard many times about too much K-Y.

Q When you say heard, I want to at this point

tell you that I'm talking about either Dr. Desai saying it directly to you, or you overhearing him saying it to somebody else when you are in his presence, essentially. Okay?

A Well, this would -- I would have overhead him telling the technicians about using too much K-Y jelly or whatever, you know, for doing the scopes and having the doctors use less because of the cost factor.

Q So K-Y jelly, let's talk about that stuff. What is it used for?

A Lubricant on the scope.

Q Is it necessary to have that stuff on the scope to use it?

A It certainly makes the scope slide a lot easier.

Q And one of the issues when the scopes are going in, you're trying not to perforate an intestine or something; correct?

A Correct.

Q So -- and also patient comfort, I would imagine?

A Yes.

Q So when the situation is that he's giving the techs a hard time about using too much K-Y jelly, what is he talking about? Don't squirt as much on, or what was he doing?

A They would place it on a 4x4 and he would

watch how much was placed on the 4x4, yes.

Q He would actually watch that and comment about how much was on the 4x4?

A Oh, yes. If there was too much, they would know very much about it.

Q What about things like the 4x4s themselves that you're talking about. Those are little gauze 4x4 pads?

A Correct.

Q What about those? Would he give anybody a hard time about using too many of those?

A Well, I'm not sure. I'm sure it was probably brought up. I don't recall hearing it, but, I mean, it could have been.

Q Okay. What about during the procedure, are you aware that there is a larger syringe, 50 or 60 cc syringe that's used to flush the scopes?

A Yes.

Q Did you see those used in the clinic in the rooms where you were working?

A In the room, yes.

Q When Desai was there, was there any issue about those being reused or not reused?

A Well, they were always reused over and over in the room, yes, same syringe.

Q Over and over again, patient to patient?

A Yes.

Q Did you hear him ever yell at anybody about that issue, about not reusing them or trying to open up a new one, anything like that?

A I don't specifically, but I'm sure it was brought up, you know, because it was just an item that was to be reused over and over.

Q So your observation was that it was reused over and over?

A Oh, yes. I saw it used many times.

Q As a matter of fact, did you ever see him open up new ones throughout the day at all?

A First case of the day would have been when it was -- the new one would have been opened.

Q So when we've got 60 plus patients rolling through there, we're talking about one syringe for all of those patients?

A Well, for each room there would have been a syringe --

Q Well, two syringes for all of the patients?

A Correct.

Q Okay. Do you know what a bite block is?

A I do.

Q What is it if you can tell us?

A When you're going to do an EGD or an upper

endoscopy, it's a bite block that goes in there between their teeth so they don't bite the scope. And there's a hole on it, and there's a ridge on each side of it, and it goes under their teeth on the bottom and the top, and then the scope can slide through the bite block so that they don't bite the scope.

Q Okay. Were those reused?

A Yes.

Q On a regular basis?

A Yes.

Q And these are ones that -- I know -- did you know anything about how they were cleaned or anything like that?

A No, I don't.

Q You just know that they weren't opening up new ones for --

A Right.

Q -- new patients? What about snares and forceps, anything like that?

A They were reused over and over and over until they were broken.

Q And these are items that would go in to take biopsies and the like?

A Yes.

Q What about the -- was there anything like a

bowl that was used for irrigation fluid to go into the scopes?

A That's the bowl where the 50 cc syringe would have been in, yes. There was a bowl there with clean water and one for dirty water, but --

Q And were those changed out?

A No.

Q Did you ever hear him yell at anybody in your presence about actual costs of the items themselves? You know, that's three cents, that's one cent, anything like that?

A Yes, many times.

Q Can you tell us about that?

A Well, sheets for instance. If a patient would be cold, you know, one of the nurses would put a sheet on somebody. He would take it off and fold it up and put it back in the cupboard, and it would be three cents to clean that sheet or something like that. That's what the nurses would be -- they would all -- he would holler at the nurses about that, not to use them.

Q Okay. So it was going to cost him three cents to clean a sheet, so he would -- the doctor would actually take it off the patient, fold it up and put it back on a shelf for use on another patient?

A Yes.

Q Anything else like that that any of the cost of some of these items -- did he ever say that that cost me so

much or that cost me so much when he would see it not used in the way he wanted?

A Yes, we would hear it quite frequently on different subjects, different objects that were being used.

Q What about -- any comments about alcohol pads used, anything like that?

A I don't think we had alcohol pads. I think we were using just cotton balls and then, you know, putting alcohol on them.

Q What about the chucks? You know what those are; correct?

A Those were always cut in two and used.

Q And the chucks are what, exactly?

A I don't know exactly. I think they're 17 inches or something.

Q No, no, no. Not the size, but just want are they?

A Oh, it just goes under the patient when they're having a colonoscopy, under the rear of a patient so when the procedure is going on.

Q Now, I know you mentioned a few things, and so these are the things that collect the fluids that might spill out of a patient kind of thing?

A Correct.

Q You had mentioned that at least the whole

worked, the people would be accompanied by their escorts coming in and going out --

A Yes.

Q -- normally?

MS. STANISH: Nothing further.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: Nothing.

THE COURT: Ms. Weckerly?

MS. WECKERLY: Nothing, Your Honor.

THE COURT: All right. I'll see counsel up here at the bench, please.

(Off-record bench conference.)

THE COURT: Ma'am, we have some juror questions here. And in no particular order I'm just going to ask these.

How many discharges did you do in a typical day, in a typical, you know, eight-hour work period?

THE WITNESS: Me, myself, or -- or like for the day?

THE COURT: Just yourself.

THE WITNESS: I have no idea. It was quite a few.

THE COURT: You know, more than 10?

THE WITNESS: Definitely more than 10.

THE COURT: More than 20?

THE WITNESS: Probably, yes.

THE COURT: Okay. What was the average time from start to finish that it took you to discharge someone,

including the paperwork --

THE WITNESS: And scheduling the appointment.

THE COURT: -- and all of that, talking to them?

THE WITNESS: Uh-huh. Maybe 10 minutes.

THE COURT: About ten minutes?

THE WITNESS: Uh-huh.

THE COURT: Okay. Were the follow up visits scheduled with the same doctor who had performed the procedure?

THE WITNESS: Not always, no.

THE COURT: Not always. Was there some method to who the follow up visits were scheduled with? How did you -- how did you do that?

THE WITNESS: Actually, a lot of the patients would -- a different doctor would do the procedure on a patient than who they saw in the office prior to the procedure most of the time. And I believe then we would schedule the follow up with the doctor who actually had seen them originally.

THE COURT: Okay. And was every patient scheduled for a follow up appointment?

THE WITNESS: Yes.

THE COURT: Okay. Are you -- were you pressured to discharge the patient quickly?

THE WITNESS: If we had patients waiting, yes.

THE COURT: Okay.

THE WITNESS: Because sometimes we'd be in with one, and there might be two or three more patients waiting to be discharged to go over their instructions.

THE COURT: Okay. Was it -- was somebody, you know, in the clinic pressuring you, or did you just feel pressured yourself because, you know, patients are backing up and sitting there and --

THE WITNESS: Yeah, I was pressured myself probably.

THE COURT: Okay. Can you give examples of unsafe practices or conditions that you observed?

THE WITNESS: I didn't actually observe any procedures, so just to me and my experience it felt like that procedures were being done very quickly.

THE COURT: All right. Was there -- you said four patients per 15 minutes. Was that regardless of whether, you know, somebody had a tumor that was, you know, observed in the colonoscopy or, you know, a hemorrhoid or whatever?

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: And the computer system that we used, you would open it up and there would be like four spots for every 15 minutes to fill a patient in for discharge -- I mean, for a follow up visit.

THE COURT: Okay. And that was universal?

THE WITNESS: Uh-huh.

THE COURT: Is that yes --

THE WITNESS: Yes.

THE COURT: -- for the record?

THE WITNESS: Yes.

THE COURT: This lady right here --

THE WITNESS: I'm sorry.

THE COURT: -- is our court recorder and there's a tape. That's why they make you say yes or no and have to establish what the distances are and things like that because we can't see hand gestures.

All right. Ms. Weckerly, do you have any follow up to those last questions, those juror questions?

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

THE COURT: Does the defense have any follow up?

MS. STANISH: Briefly.

THE COURT: Okay.

BY MS. STANISH:

Q As part of the instructions would the patients or their escorts receive written instructions?

A Yes, we would have the family member sign them, I believe, and they would get a copy.

Q Thank you.

THE COURT: Mr. Santacroce?

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q You said that it seemed unsafe because it seemed quickly to you; correct?

A Yes, and sometimes patients were still staggering a little bit when they were brought to my room.

Q You -- prior to working for the endoscopy center, you had never worked for an endoscopy or gastro center before; correct?

A No.

Q And you haven't worked for one since; correct?

A Correct.

Q So you weren't familiar with the procedures or the times that were involved; correct?

A Not working at one, but I had been to a few with family members as the family person with them, and it -- whenever I have been to one it was run totally different.

Q I'm talking about in your professional career.

A Not in my professional.

MR. SANTACROCE: Thank you.

THE COURT: Ms. Weckerly, any other follow up?

MS. WECKERLY: No, Thank you.

THE COURT: Any additional juror questions for this witness? Nothing?

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

THE WITNESS: Yes, ma'am.

THE COURT: All right. Thank you, ma'am. You are excused at this time.

Ladies and gentlemen, we're going to just take a quick recess until 10:30. During the recess, once again, you're admonished that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on the case, any person or subject matter relating to the case, by any medium of information. Don't do any independent research, and please don't form or express an opinion on the trial. If you'd all please place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 10:19 a.m.)

THE COURT: May I see counsel at the bench.

(Off-record bench conference.)

THE COURT: And just -- well, I also just want to put on the record that Mr. Mack Brown, as you'll recall during jury selection I asked him, Ms. Stanish asked him, are you sure your employer pays, and he said, oh, no, it's no trouble with serving. And I think we'd even said, well, what a good corporate citizen the Venetian is and blah blah blah. It turns out --

MR. STAUDAHER: They're not a good corporate citizen?

THE COURT: I don't want to say --

MR. WRIGHT: Sheldon isn't as rich as we thought.

THE COURT: I don't want to say that. They do pay for jury service, but only ten days. And so he brought in a letter from someone at the Venetian, basically. It's really to him, it's not to me, but saying that they only pay for ten days of jury service.

Now, obviously, he didn't ask anybody, he just assumed they would pay him. He didn't bother to ask anybody until Monday, after Monday, when, oh, he's actually already serving. So he does work Saturdays and Sundays, so he's paid for those days. So really it's three days a week that he's missing. As of right now, this week, it would be five days because I'm counting the three days that he would work this week.

I'm counting the day -- well, I don't even know what day they came in to fill out the form and what day he came in for questioning. So he may only be three days out, or it could be five days depending on what -- so we'll have to talk to him again. So, you know, he's still within the 10 days.

MS. WECKERLY: We're probably not going to finish in that.

THE COURT: No, well, except, it's 3, 6, 9, that's three weeks.

MS. WECKERLY: Right.

THE COURT: So then really, you're only looking at another three weeks. So let's keep him in the back of our minds. I don't know that we need to talk to him today, but he is talking to the bailiff and concerned about it. You know, again, he assured us, and I remember even I think Ms. Stanish was very thorough with all of the jurors about, you know, are you sure this isn't a hardship. And I remember that because didn't -- I mean, I was thinking, oh, the Venetian, they're such good corporate citizens.

MR. WRIGHT: Why do we have to wait to talk to him? Can't we just see if it's going to affect his --

MR. SANTACROCE: No.

MR. WRIGHT: No?

MR. SANTACROCE: I don't --

THE COURT: Well, I mean, here's the thing.

MR. SANTACROCE: -- want to start, you know --

THE COURT: I want to find out, first of all, what hours does he work because they're not cleaning those pools, I can tell you right now, when they're full of people -- I worked at a pool -- when they're full of people floating on rafts. They clean those pools later, in the morning or after --

MR. WRIGHT: Pool? He's a canal guy.

THE COURT: Oh, he was the canal guy. I thought he was the swimming pool guy.

MR. WRIGHT: Pools and -- he said the canals.

MS. WECKERLY: Yeah.

THE COURT: But they have -- I mean, maybe they do the -- you know, they're not doing that in the middle of the day when you're full of tourists, I don't think. I mean, you may have to have people onsite. So I want to remember what hours he's working, he definitely can work the weekends, and see if there's any flexibility with him before we call him in and say, oh, yes, okay, we're going to excuse you.

Because, again, we, I think, bent over backwards to make sure he could be compensated. And it's not our fault, meaning collectively, he didn't check until Monday. I'm mindful and I'm concerned about it, but I don't think we need to question him today.

MR. SANTACROCE: I agree.

MR. WRIGHT: I agree.

THE COURT: I want to get more information. I want to know, did he -- was that his day of work when he came in to fill out the questionnaire? Was it his day of work when he came back from questioning? I'm going to go back over the record. I want to know, is he five days in or is he three days in to what he's going to be compensated for. So before I talk to him I need a little more information.

MR. SANTACROCE: And it could start a chain reaction back there.

MR. WRIGHT: Right.

THE COURT: Absolutely. Right.

MR. WRIGHT: He had an employed spouse also.

THE COURT: Right. Right. And he, you know, he's working -- he doesn't want to sit here five days and work two days, but he's working Saturdays and Sundays.

MS. STANISH: He may have personal leave, too.

THE COURT: No, so all I'm saying is we're not hitting -- you know, we're not hitting up into the time he's not compensated for yet. Most days in he has is five, and it may be as few as three.

MR. SANTACROCE: Right.

THE COURT: All right.

MR. WRIGHT: Go ahead and bring --

THE COURT: All right. So bring in Juror No. 17.

THE MARSHAL: It's only about 50 feet from wall to wall.

THE COURT: Well, see, I was close. I said -- I said yards, but I meant feet.

(Pause in the proceedings.)

THE COURT: And just to the media. Obviously, you can't film this, any interviews with the jurors, and please don't use the names of the people who are seated as jurors right now.

(Juror No. 17 enters the courtroom.)

THE COURT: You can just sit in your seat. Good morning.

JUROR NO. 17: Good morning.

THE COURT: First of all, I want to thank you for reporting what you observed to our bailiff. And it may not be fresh in your mind because we've been -- haven't really had a chance to have a break and call you in. But I just wanted to discuss with you for the record what it is that you observed that Juror No. 3 was doing that you then reported to our bailiff.

JUROR NO. 17: Just tell you the way I told the bailiff?

THE COURT: Right. Exactly.

JUROR NO. 17: She was very unhappy about being on the jury, and she'd been clear about that from the beginning. Nobody was happy about a six to eight week trial, but she was extremely unhappy and was making comments about how she would be homeless and no one helped her and she had small children and she couldn't feed them.

And so then I know that she had come in and spoke with you and came back that day. She was still saying that she was still going to be homeless and just all these horrible things were going to happen, that even her mother wouldn't help her. So I just kind of blew that off as her just being angry. And then she had made a comment that she wasn't --

that it wasn't over as far as her having to stay on the jury. She said, you know, it's not over yet.

Then later that day after we had the testimony of one of the witnesses, one of the attorneys had asked, and I don't remember who, how much the total sum of his civil case was. And the older man told him to add it up or something like that. And then when we went back into the jury room, she made a comment that she can't believe the attorney would ask him to add it up and, you know, was just like angry.

And then she said, oh, I guess I'm not supposed to say that. I guess I'm just a bad juror, aren't I? So I took that to mean that she was going to find a way to get off the jury, whatever that meant, and if that meant talking about the case in front of us in the jury room that would continue to happen.

THE COURT: All right. And when you first heard her complaining, who was she complaining in front of? Was it all of the jury?

JUROR NO. 17: Everybody. Just, you know, everybody was kind of like, oh, six weeks at first, you know, like, oh, and that kind of thing. But hers was beyond just -- I mean, we're all inconvenienced, but I think we all pretty much understand that this is important and why that it's worth it. And I don't think that she felt that way, but I don't know how she felt. But that wasn't the impression that I got from her.

THE COURT: So you're all just sitting back there and she's just kind of just saying that out loud pretty much --

JUROR NO. 17: It was almost as if it only affected her, that nobody else there was inconvenienced, nobody else there was missing work, nobody else there had anything to do but her.

THE COURT: Okay. And then when she later said, oh, it's not over, who did she say that to? Was she saying that --

JUROR NO. 17: Apparently when she came back in, she had come in and talked to you, I'm assuming, about her trying to leave. And I'm assuming that you said no. And when she came back into the room she was angry, and she said that it wasn't over yet. And she said -- and this was generally. She's just kind of having a temper tantrum and said that, you know, she wasn't going to be homeless and went on with how she would have no money and she can't take care of her children and that sort of thing.

THE COURT: Uh-huh. So she was saying this to kind of --

JUROR NO. 17: The whole room.

THE COURT: -- the whole room. She wasn't --

JUROR NO. 17: There wasn't --

THE COURT: She wasn't in --

JUROR NO. 17: She was not specifically --

THE COURT: -- the hall or on the phone --

JUROR NO. 17: -- talking to me.

THE COURT: -- or anything like that?

JUROR NO. 17: No.

THE COURT: Okay.

JUROR NO. 17: She was mad.

THE COURT: Okay.

JUROR NO. 17: It was from walking to the door back to her seat and while like picking up her purse and sitting back down is kind of when she was saying all those things.

THE COURT: Okay. And so do you know who else heard her say these things?

JUROR NO. 17: I think we all kind of heard her say these things. But there's times in there when people are talking and I'm reading or something and I don't listen, but as a general -- maybe a couple people didn't hear it, but these were general statements.

THE COURT: Okay. All right. Thank you. And, again, you did the right thing by reporting them because obviously, you know, our goal is to have the jurors comply with the Court's orders. And as I, you know, I keep saying it, but it's so critical, you know, not to --

JUROR NO. 17: I don't want to invest all of this time coming --

THE COURT: Exactly.

JUROR NO. 17: -- and people from my work are covering for me. There's a lot of people that are involved in making sure that I can do this. And I don't want to be three weeks into this and have something done where we're all kicked off and you have to start over.

THE COURT: Absolutely. And that's just what I was going to say because it is a huge investment for the jurors and for the system and everyone involved in this case of time and expense and everything like that. And so, you know, it is so important that when something like that happens you tell us because it's exactly what you say, we don't want something to happen where it's all sort of, you know, in the middle. You know, whatever happens at the end of the day, the Court takes no position, but, you know, it's part of -- again, it's so critical to keep --

JUROR NO. 17: I would want --

THE COURT: -- an open mind.

JUROR NO. 17: -- to be treated fairly if I was on trial.

THE COURT: It's so critical to keep an open mind and wait until you've heard everything and then discuss it as a -- as a group. So, really, thank you so much.

Does anyone have any questions?

MR. SANTACROCE: I just had a question about the

comment she made about adding up the numbers with the -- with the witness. Was that done in the jury room when all the jurors were present, or was it just done to you?

JUROR NO. 17: No, that was in the jury room when she says I can't believe they asked him to add up the numbers. And I just felt like she was just having a fit. I didn't feel like that was something that was going to affect my decision making, so I wasn't really sure if that was crossing the line, but I thought maybe I had better say something because -- just because it was something that was said in the trial.

MR. SANTACROCE: Uh-huh.

JUROR NO. 17: So -- but -- and that's when she -- I think she did that to prove that she was a bad juror because that's when she said I guess I'm not a good juror.

MR. SANTACROCE: Well, we appreciate you coming forward. Thank you.

THE COURT: Yeah, we really appreciate it. And just, you know, like I said, there are ramifications for juror misconduct. So thank you very much.

Any other questions?

All right, ma'am. And fair to say other jurors heard it but that some jurors may have been reading or --

JUROR NO. 17: We weren't all focused on her. I mean, we noticed her presence because she was walking through the room. We were all sitting. She wasn't whispering, but I

can -- the only reason it upset me was because it was from here. We already know that she kind of -- and people were kind of just tuning that out because we pretty much accepted this is how it's going to be and just deal with it, and she had not.

THE COURT: Okay. All right. Thank you.

JUROR NO. 17: All right.

THE COURT: Please don't discuss -- you know, they may wonder, well, why were you called in and, you know, singled out. So please don't discuss this with -- with the other jurors.

JUROR NO. 17: Okay.

THE COURT: All right. Thank you. And Kenny will lead you in the back.

(Juror No. 17 exits the courtroom.)

THE COURT: And, of course, the Court still has the option of issuing an order to show cause against Juror No. 3.

MR. SANTACROCE: Well, just for the record, when we first heard about this we thought it was just between this juror and the one that was excused, and now we find out comments were made in the jury room, and it kind of causes a concern to me. I don't know how Mr. Wright and Ms. Stanish feel about it, but I'm very concerned that this was done was in front of all the jurors and she was the only one that came forward? Why didn't any of the other jurors come forward?

THE COURT: Well, in terms of that, you know, they may not have appreciated, oh, this is juror misconduct by, you know, violating -- violating the oath. I could have asked this juror, well, were the other jurors aware that you came forward and reported it to the bailiff. Other jurors may have been aware that she reported it. I don't know. I probably should have asked that question, but I didn't -- you know, none of us asked it. But it's possible the other jurors know that she reported it as well.

Plus, we pretty much took immediate action. She reported it, and the very next morning we had the hearing with Juror No. 3 and then she was excused. So it's possible other jurors would have reported it had they had -- I mean, I know they didn't that morning, but had they had an opportunity to report it. So, you know, again, it's not like she brought in additional information or anything.

(Juror No. 4 enters the courtroom.)

THE COURT: Come on in, ma'am. Just have a seat. You can just sit in your regular seat. And we kind of didn't have a chance to bring you in when you reported that you recognize one of the witnesses to the bailiff because we've been trying to move through this. So now I'm bringing you in just to ask you on the record about that. My understanding is when Dr. Bui, was it --

JUROR NO. 4: Yes.

THE COURT: -- testified, you recognized his face.

JUROR NO. 4: Yes.

THE COURT: Okay. And you were a patient of his about ten years ago --

JUROR NO. 4: Yes.

THE COURT: -- is that right?

JUROR NO. 4: Yes.

THE COURT: Okay. And I don't mean to pry, but what did you see Dr. Bui for?

JUROR NO. 4: He was just a family physician.

THE COURT: Okay. Did you have a regular relationship with Dr. Bui, meaning you saw him, you know, periodically, or did you -- was it a one-time deal or --

JUROR NO. 4: It wasn't a one-time deal, but it was really only when I needed to see him. It's not like I -- I didn't even go annually to see him. It was just whenever something came up, I would call that medical center and he was the doctor that I had always seen, so I would see him.

THE COURT: Okay. And is there anything about the fact that once you saw Dr. Bui and recognized him and remember having seen him about a decade ago, is there anything about that that would impact your ability to be fair and impartial in this case?

JUROR NO. 4: No. No, I just thought you needed to know that.

THE COURT: Yes, and I appreciate that. Because, again, we do need to know that and I thank you. I appreciate that you immediately reported it to Kenny. And like I said, we would have -- you know, we kind of had this on things -- things to do to bring you in to ask you -- ask you about that. But, yes, you absolutely did the right thing by immediately letting the bailiff know that you recognize one of the witnesses.

Does anyone have any questions for Ms. Enin (phonetic) Smith?

MR. SANTACROCE: I don't.

MR. STAUDAHER: No, Your Honor.

THE COURT: All right. Thank you, ma'am. I'm going to have Kenny take you back. And if the jurors want to know what we talked about, please don't discuss it with them.

JUROR NO. 4: Okay.

THE COURT: All right. Thank you. You're -- you can go into the back. We're just going to turn around and bring you back in in a few minutes, but --

(Juror No. 4 exits the courtroom.)

THE COURT: All right. Let's get Mr. Cristalli and his client. Somebody.

MR. STAUDAHER: Oh, I can get him.

THE COURT: You know, yeah, it's heard when you have the jurors in the back. I don't like to do it this way, but

we figured with this kind of a case it was better to have them in the back where we can monitor what they're seeing. Also, there are some -- at least one, possibly more, former patients who have been here and the audience, so --

As soon as we talk to Mr. Mathahs we can all take a two or three minute break and then we'll move into his testimony.

MS. STANISH: Your Honor, I'm sorry, but can we have a little bit longer? We need to confer with our client and use the restroom.

THE COURT: Okay. How -- how long do you need to confer with your client?

MS. STANISH: Five, ten minutes.

THE COURT: Where's Mr. Mathahs?

MR. CRISTALLI: He's here.

THE COURT: I need to see him.

MR. CRISTALLI: Oh, okay.

THE COURT: Come on in, Mr. Mathahs, along with your attorney Mr. Cristalli and Ms. -- okay.

Basically, Mr. Cristalli, the State just wanted, you know, out of an abundance of caution I'm just going to, you know, go over a few things with your client before he testifies.

MR. CRISTALLI: Okay.

THE COURT: Okay. Mr. Mathahs, come on in. You

don't need to come to the witness stand, but I just want you to come a little bit closer so I don't feel like I have to speak so loudly.

All right. Mr. Mathahs, my understanding is that in connection with entering your guilty plea in this matter, you've also entered into an agreement to testify; correct?

MR. MATHAHS: Correct.

THE COURT: And by doing that you understand that you're waiving giving up any Fifth Amendment right you might have had, even though you've pled guilty and kind of given that up. You understand all of that?

MR. MATHAHS: Right.

THE COURT: And you must respond to the questions, whether they be from the State, the defense attorneys, the Court, or the jurors, so long as this Court, meaning me, rules that they're appropriate questions. Do you understand all of that?

MR. MATHAHS: Okay.

THE COURT: Okay. And I believe that the agreement is that in exchange for the benefits of the agreement --

And, Mr. Staudaher, can you just state what those are so it's clear?

MR. STAUDAHER: Actually, there was a stipulated -- at least we entered into. Your Honor, clearly, is not bound by that. But if, in fact, at the end that stipulated

agreement is not entered into -- or not sentenced by you, that he would have a chance to withdraw his plea and actually go to trial.

THE COURT: Okay.

MR. STAUDAHER: Essentially.

THE COURT: But I -- I believe that contingent on the State not arguing is that he testify truthfully. Is that --

MR. STAUDAHER: Oh, absolutely.

THE COURT: -- part of the agreement?

MR. STAUDAHER: Yes. No, we retain the right to argue regardless, but he has to testify truthfully at the time of trial, and that's where we're at now.

THE COURT: Okay. And that it will be up to the Court to make that --

MR. STAUDAHER: Make the determination.

THE COURT: -- determination; correct?

MR. STAUDAHER: Correct.

THE COURT: Do you understand all of that, Mr. Mathahs?

MR. MATHAHS: Yes.

THE COURT: Okay. Is there anything else the State would like me to cover with Mr. Mathahs?

MR. STAUDAHER: I don't believe so. If Mr. Cristalli has some --

THE COURT: Mr. Cristalli, is there anything else you would like me to cover with your client?

MR. CRISTALLI: No, Your Honor.

THE COURT: All right. And obviously you'll be here in the courtroom during the testimony.

All right. We're going to take a quick break, Mr. Mathahs and Mr. Cristalli, so if you could just go back into that waiting area. All right. Thank you.

All right. We'll go ahead and give you some time to confer with your client and we'll just take a break.

(Court recessed at 10:41 a.m., until 10:55 a.m.)

(Inside the presence of the jury.)

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

And the State may call its next witness.

MR. STAUDAHER: The State calls to the Stand Keith Mathahs.

THE COURT: All right.

KEITH MATHAHS, STATE'S WITNESS, SWORN

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

THE WITNESS: Keith; K-E-I-T-H M-A-T-H-A-H-S.

THE COURT: All right. Thank you.

Mr. Staudaher.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Mr. Mathahs, before we get started with your formal questioning, I want to go through a couple of preliminaries with you.

A Okay.

Q Is it true that you were originally a defendant in this case?

A Yes.

Q And you have subsequently pled guilty in this particular case?

A Yes.

Q The charges to which you pled guilty are criminal neglect of patients resulting in death, criminal neglect of patients resulting in substantial bodily harm, obtaining money under false pretenses, insurance fraud, and conspiracy; is that correct?

A Yes.

Q Those events all pertain to the things that occurred at the Shadow Lane campus here in Las Vegas, Clark County, Nevada?

A Correct.

Q When I say that Shadow Lane campus, it's really a clinic over there, the Endoscopy Center of Southern Nevada, is that fair?

A Correct.

Q Now, in your -- in pleading guilty you've agreed to testify here today; is that fair?

A Yes.

Q And to give an honest and truthful testimony for the Court?

A Yes.

Q I want to go back a little bit, and for you it'll be quite a ways back. Let's talk about your background and training that led you up to become who you were at the time you worked at the clinic. Go ahead and tell us what your background was.

A Oh. I -- after high school I went to college in Annapolis for becoming a lab tech, so I'm certified in lab tech. After eight years of working in the lab I went back to school and became an RN. And after being an RN, I was accepted into the Mayo Clinic at Rochester to go through the anesthesia program.

Q Can you explain -- I mean, when you went through the anesthesia program did you get a certification or a license or something as a result of that?

A We were -- got a diploma. Actually, the certification came through the AANA, the Association of American Nurse Anesthetists.

Q So what is that organization?

A It's a national organization that CRNAs, or certified registered nurse anesthetists belong to.

Q And you belong to that?

A I do, yes. Uh-huh.

Q How long were you a member?

A Probably close to 40 years.

Q So up until the time that you stopped working at the clinic?

A Yes.

Q And when was that?

A It would have been '08.

Q And during the time that you worked as -- or that you were part of the association, and you said it was the American Association of Nurse Anesthetists?

A Correct.

Q Were you on their membership roll as an active member the whole time?

A I was from 1979, yes. Uh-huh.

Q I assume you had to fill out membership applications or dues or up, you know, renewals as time went on?

A Renewals, dues, but at the beginning it was an exam, you know. I think it lasted two days or something like that that we took an exam, you know, that was to get into the certification part of it.

Q Did you get some sort of publication as a result of that, meaning a journal or a newsletter or something periodically from them?

A Yes.

Q Did you continue to receive that, those kinds of correspondence from the 1970s up until the time that you stopped working at the clinic in 2008?

A Yes.

Q Was there any period of time in which you were not a member?

A No.

Q So you received all correspondence from them to the best of your knowledge?

A To the best of my knowledge, yes.

Q And they always had your address, current address, and the like?

A Yes.

Q Now, as a CRNA, can you tell me exactly what you do?

A Evaluate the patient to see if they're capable of going under anesthesia and getting a history and physical from them. And that includes medication and any things that they have in the past, that they might have had surgeries or anything like that or complications with an anesthetic or anything like that. And then going ahead and giving, planning

and giving an anesthetic to the patient.

Q Do other professionals do the same kind of visit or job that you would do as a nurse anesthetist?

A You're talking about a CRNA?

Q Yeah, other CRNAs. I mean, clearly, there must be some more of those than just yourself.

A Absolutely.

Q Are there other professionals that -- that work in a like capacity to a CRNA to your knowledge?

A MDs anesthesiologists, yes.

Q What's the difference between an MD anesthesiologist and a CRNA?

A MDs have their medical degree, where we have a nursing degree plus anesthesia. And they have their MD degree plus anesthesia.

Q But you do similar things?

A Exactly the same things, yes.

Q Is there any restriction on -- on your practice since you're not an MD?

A We always are under the -- have to be under the supervision of a physician, yes.

Q When you say physician, does it matter what physician it is?

A As long as an MD. I think even podiatry, I think, falls under being a physician that could, you know, say

we need an anesthetic for this patient.

Q So your understanding of your 40 years in -- in this practice in various jurisdictions; correct? I mean, you weren't always in Las Vegas?

A No, I wasn't.

Q And you practiced where else?

A Southern California.

Q Was that for the duration of the 40 years before you came here?

A 33 years, yes.

Q Oh, I'm sorry. So 40 years total, 33 years --

A Yes.

Q -- in California?

A Correct.

Q Now, as we go through this it's going to be important the court recorder can get down all the words that are being said here.

A Okay.

Q And I know in normal speech you know where I'm going to go, so you start to answer before I'm done. And same --

A I'm sorry.

Q -- thing with me. I can see where you're going, and maybe I ask you a different question before you're done. For the purposes of the clarity of the record, if you

could wait until I finish my question, I'll try to do the very same and wait until you finish your answer.

A I'll do my best.

Q Okay. Thank you. Now, as far as your time frame in California, did you work at just a single location or more?

A No, multiple hospitals and clinics.

Q Did you work with MD anesthesia people during that time?

A Not with -- I mean, you're talking about with as far as employment?

Q They were employed in the same group, for example, at times.

A No, we were always an independent group that functioned independently of the MDs.

Q Now, you said that you were part of an independent group.

A Yes.

Q Was this a group that you were just an employee of, or was it something you ran?

A It was a group that I started in 1971, and it grew to the point of being 12 anesthetists that we formally worked together. I mean, none of us had any more power than any other -- any one of the others, but we just worked together.

Q So you would provide anesthesia services to whoever called for you?

A Different hospitals, different surgery centers, and the like, yes. Uh-huh.

Q During the time that you had your sort of business, was that -- did you have a supervising MD anesthesiologist on staff or at least available for consultation, anything like that?

A No, I did not.

Q So when you were -- essentially when you had to have some supervisory doctor with you, are you talking about during the procedure itself?

A During the procedure, the surgeon, yes, would be the supervising person at that time.

Q Who is ultimately responsible in a situation like that for the care of the patient?

A We were. The anesthetists would be.

Q So would it be fair to say that you could shut a case down if you felt that the patient wasn't a candidate for the procedure?

A Yes, we should and could.

Q And the practice that you had in California for the 33 years, were there times when patients would come in and you felt that it was not appropriate to give them an anesthetic?

A Yes, that would be, you know, decided when we had our interview with the patient if they were competent to undergo anesthesia and if they had some kind of medical history that would contradict it or whatever. Sure.

Q So talk to me about that. The normal course, and I'm talking about your experience before you came to Las Vegas, when you would have a patient that you were going to do an anesthetic procedure on, how would that go? Would that be somebody you would call the night before to talk to, would it be somebody you met in the morning, would you wait until they were in the procedure room? How -- how would your interaction with the patient begin and continue until the patient was undergoing its actual procedure?

A It could go both ways. If they were in the hospital, we usually made rounds in the evening, saw the patient, then ordered pre-ops if they were to have a pre-op in the morning. If it was done in like a surgery center, day setting type surgery center, we would see the patient in the morning.

Q In the situations where it wasn't that way, where it was, let's say, you went to an outlying surgery center or an ambulatory care center or something like that -- did you do that, first of all?

A Yes.

Q When you went into those situations, had you

been able to contact the patients before in all of cases?

A Not always, but sometimes we would try and call them, you know, by phone the evening before.

Q So in those instances where that was not done, where you just got to the facility and had not spoken to the patient previously, how would it go?

A Could you repeat that, please?

Q In situations where you had not spoken to them the night before, but you arrive at, say, an ambulatory care facility and you're going to do a procedure, how would your interaction proceed at that point?

A we would absolutely see them in the morning before they came into the operating room, try and meet then, you know, in the post recovery room or wherever so that we could interview them and that type of thing.

Q Okay. So when you interviewed them, that was not in the -- typically in the procedure room itself?

A Correct.

Q Is that a point where if you interviewed somebody in advance, that if they had a problem you would make an election to either go forward or not go forward?

A Correct.

Q For example, if they had come in to you and said that they had eaten in the last -- or had a big breakfast right before they came in.

A They would have been cancelled right there.

Q Now, I want to -- I want to move to -- or I want to ask you some specifics about that pre-procedure sort of evaluation.

A Okay.

Q Was there a requirement, or is there a requirement that there be a history and physical on the patient before you actually interview them?

A Yes, there is to be an H&P, or history and physical, on the chart before we actually should interview them and before the procedure goes, yes.

Q Is that something that you would do the history and physical on, or would that be something that the doctor that you're going to do the work with would have done before you?

A It would have been done by the physician that was going to do the surgery or one of his associates, and then we come along and do our own history and physical with our anesthetic record.

Q What is the purpose of that?

A The double?

Q Yes.

A Just to make sure that we're satisfied with what the patient has said or what they've given to the doctor because sometimes we could run into a conflict or all the

medications might -- might not be on the chart that the patients are going to tell us about and that type of thing. We just want to make sure everything is -- is proper.

Q Is it also to make sure that if there's something in the history and physical that you want to specifically follow up on that might be germane to your anesthetic that you're about to give that you have that ability to do so?

A Yes, especially some lab work or something like that that might not have been caught, that might be abnormal or something like that that might change the anesthetic plan or maybe cancel it altogether.

Q Are some of the questions that you typically ask a patient, do they have anything to do with their prior history of anesthetic use? Meaning, have they had a procedure, have they been under anesthesia before, and how they reacted to it?

A Yes, that's one of the very pertinent questions you would want to know.

Q And why is that an important question?

A Well, if someone has had maybe an allergy to a certain medication or something like that or had some kind of a severe reaction to one of the agents that you're going to use or something like that. You would certain want to know about it to stay away from it.

Q So on a patient's record that they had undergone a procedure and they'd been given certain anesthetic agents and they had been under for a period of time, would that be something that would make you more comfortable that they might be able to tolerate the anesthetic that you would be putting them under?

A Yes, it would. I mean, if the -- if the time was a factor, sure.

Q So it's important to have -- I mean, is it fair to say that the record itself, the medical record is important in a case?

A Absolutely.

Q Is it important that the medical record be accurate in a case?

A Yes.

Q I want to move you away from California for a minute and to Las Vegas, if we can.

A Okay.

Q When did you come to Las Vegas?

A 2003.

Q And roughly when in 2003?

A I think I started in January.

Q So at the beginning of the year in 2003. Did you come to work at any particular place at that time?

A I started at the facility on Burnham. I mean,

sorry, not Burnham, on Shadow Lane.

Q So you're talking, when you say the facility on Shadow Lane, are we talking --

A Gastro -- gastro center. Uh-huh.

Q So the Endoscopy Center of Southern Nevada?

A Correct.

Q Now, has it gone through some name changes over the years while you were working there?

A Not that I'm aware. It could have. I don't recall.

Q For the purposes of your testimony today I'm going to assume when you talk about the clinic or the endoscopy center that it is the Shadow Lane location at 700 Shadow Lane here in Clark County, right over there by Valley Hospital unless we -- unless it is at a different location, and then I want you to tell us it's in a different location. Okay?

A Okay.

Q So just so we're clear so we know which facility we're talking about.

A I'm talking about -- I started at the Shadow Lane facility.

Q So when you say start, does that mean you eventually worked elsewhere?

A Yes, I did.

Q Where else did you work?

A I worked at the Burnham facility and one on Rainbow.

Q So what was -- what was happening out at Rainbow?

A I'm sorry. Can you --

Q Were procedures being done out at Rainbow?

A Yes, the facility was new. I don't remember when it opened, but I was giving the anesthetics out there after the facility opened. Yes. Uh-huh.

Q Had it been opened very long before the actual clinic on Shadow Lane was closed?

A A few months, maybe four months.

Q So relatively new?

A Yes.

Q The Burnham facility that you referenced, that had been open longer?

A I don't know when it opened. It had moved from the top floor down to the bottom floor sometime during the time that I was here and worked there. But I don't remember the -- recall the years when it happened.

Q Eventually you start -- I mean, you work at the Shadow Lane location.

A Correct.

Q Now, when you started working there, who were

the doctors that you worked with?

A When I started, it would have been Dr. Desai, Dr. Carrol, Dr. Carrera, and I think Dr. Herrero was there at that time, maybe Dr. Sharma.

Q So Dr. Desai was one of the physicians you worked with?

A One of the main ones, yes.

Q During the time that you were working, and that was from 2003 until we -- until we essentially had the clinic closed in 2008, is that fair?

A Yes.

Q During that time is it fair to say that you worked with Dr. Desai a lot?

A Yes.

Q Was the main body -- or main location where Dr. Desai worked the Shadow Lane location?

A I think that's the only place I ever worked with him, yes. Other than --

Q Was there?

A Than other two, I don't believe he ever -- that I ever worked with him there.

Q Did you work five days a week or six or seven? I mean, how often were you at Shadow Lane?

A When I started I was five days a week, and then there were some Saturdays that were put on as well. I

don't -- can't recall how many.

Q Now, the time period that we're talking about at the Shadow Lane location, if it closed in 2008 and you came there at the beginning of 2003, I mean, that's a number of years; correct?

A Yes.

Q During that time did you go anywhere else, meaning anywhere outside of Las Vegas to another location and do work?

A No.

Q Comparing the time that you had in California to the time you had in Las Vegas at Shadow Lane, was there a difference in how things were operated?

A Yes.

Q A significant difference?

A I felt there were.

Q We're going to get into some of the details of that in a moment, but when you were working at Shadow Lane, when you came to work there initially and as time went on, did things change in how things were done at Shadow Lane during the time you worked there?

A As far as procedures? I mean, we can -- a lot more procedures.

Q So the procedures increased over time?

A Yes.

Q Did it ever become a situation where it became, in your view, unmanageable?

A Yes.

Q Can you describe for us the typical situation, typical day at Shadow Lane?

MR. WRIGHT: Time frame, please.

BY MR. STAUDAHER:

Q Well, we'll break it down. When you first came to work there back in 2003.

A When I first started, that was in the old facility, and I think it was '04 sometime that they rebuilt the facility on the same floor, and then there were two -- two operating rooms. But when I came in '03, there was just a single room and it was -- we only would do somewhere between 25 and maybe 32 patients a day or something like that.

Q Did that change to the point where it closes? I mean, 25 to 30 patients a day. What were you up to at the end?

A Well, usually somewhere between 60 and 75 to 80.

Q So a big difference.

A Big difference.

Q So did you notice that ramping up over time, or was it just all of the sudden a big increase?

A Well, when the new facility opened, it was a

big -- big push to do more and more all the time.

Q And that was in 2004?

A It was either '04 of '05 when it opened. I don't recall the exact date.

Q As time went on from whenever it changed and became sort of a revamped facility there at Shadow Lane up to the point where you're doing the 60, 70, 80 patients a day, did -- was it a constant increase in numbers, or did it stay pretty constant for most of that time?

A You're talking about from the time that it opened?

Q In 2004 when they revamped it, until it closed.

A In 2004 we were still not up to running that many patients. It gradually kept going up and up, you know, over the years. I would say we would probably maybe do 40 or so, you know, when we started in '04, and then it just gradually kept going up in numbers.

Q So your numbers almost doubled in that period of time --

A Yes.

Q -- is that correct?

A Correct.

Q Now, when you would typically go into the facility, and let's talk about the time when the numbers are

higher, in the -- in the anywhere from 60 to 80 patient range that you mentioned, can you give us an idea of what your day was like when you went to work?

A I usually tried to -- I'm one that -- I'm, I guess, a Type A. I like to have things set up properly. I would start at 6:00 in the morning and try and get all of the rooms, both of the rooms set up, you know, with the proper amount of propofol, syringes, and needles and everything that were needed for the day. So I'd try and get both rooms set up to make sure. And I usually would be the first one to give an anesthetic for the day. I would start at, you know, usually around 7:00 when the doctor would finally get there.

Q And so if you start around 7:00, is that when the first patients are being done?

A Yes.

Q And then you would go until about when?

A You mean in the evening?

Q Yes.

A It could be as long as 6:00 or even later. But --

Q On average --

A -- nearly --

Q -- thought, what was the hour of operation of the clinic?

A I'm sorry. I didn't --

Q On average, what were the hours of operation of the clinic?

A We would start at 7:00, and usually try and finish by 4:00 or 4:30 or 5:00.

Q Was it -- is it fair to say that -- that 5:00 is when you tried to at least be done with patients at that point, whether you stopped procedures earlier to get to that or not?

A Usually try to have one room finished by 5:00, yes.

Q And in this instance, on a daily basis did people not show up sometimes?

A Yes, they did.

Q Was there any issue of scheduling more patients than you physically could do, and what I mean by that is double booking or triple booking or anything like that? Did you ever -- were you ever aware that that was going on?

A Yes.

Q Was that a regular occurrence on a daily basis?

A As far as I remember it was pretty much because patients were complaining a lot about sitting so long waiting to have their procedures done, yes.

Q When you're in the -- and we've gotten a layout, and I -- forgive me, I don't have it with me right

now, but a layout of the facility. As far as where you were during the day, were you at different locations in the facility, or did you remain in one place predominantly?

A The rooms -- you mean when we started giving the anesthetics? We usually stayed in the same room if there were two anesthetists or three anesthetists there.

Q If there was just one anesthetist, what would happen?

A You would have to go between the rooms.

Q So you would go from one room to the other and back and forth?

A Correct.

Q Now, the time period, and I would imagine that if you're talking about 60 to 70 to 80 patients in a day, that you're pretty busy.

A Very, very busy.

Q Did you ever have concerns that the speed, the number of patients was somehow compromising patient care?

A We tried not to compromise patient care on our part, but, you know, we felt that it definitely was, yes.

Q When we're talking about those numbers, and let's -- let's start off with a situation where you're going room to room.

A Okay.

Q You're the only anesthetist, you're going from

one room to the other and then back again. Do you ever take breaks?

A Not usually. I mean, if I -- when I started in '03, I mean, I didn't know what a break was. I would be in the room from when I started in the morning until I left at night.

Q In fact, was there some sort of medical condition you developed as a result of having to stay in the room and never leaving it?

A In '03 the facility that we were in was just a little cubicle. It was not air conditioned, and it was very hot in there, and, yes, you would perspire. I absolutely ended up with foot rot.

Q So you can't even get up and leave the room, and you actually developed foot rot because you can't move around.

A That's exactly -- well, --

MR. WRIGHT: Object to the --

THE WITNESS: -- I couldn't go out.

MR. WRIGHT: -- questioning, the summations, and leading.

THE COURT: Well --

MR. STAUDAHER: Actually --

THE COURT: -- it's kind of summing out, but don't -- don't lead or restate in your own words.

MR. STAUDAHER: I'll try not to restate. And if I do and I get it wrong, please correct me.

THE COURT: You can -- I mean, to orientate the witness, you can restated for that purpose.

MR. STAUDAHER: All right.

BY MR. STAUDAHER:

Q Now, related to that, that's when you're in one room; correct?

A Yes.

Q When you were -- when it was a situation where there were two rooms and there were two anesthetists, did you also remain in the same room the whole day?

A The only reason that we wouldn't have remained in the room would have been to give a lunch break to whoever was in the other room.

Q Were there any times when during, you know, it wasn't a lunch period time for a lunch break, but earlier or later in the day that somebody just -- they had a bathroom emergency or something along those lines and you might go from one room to the other?

A We would cover, yes.

Q So there were instances when that would occur?

A Yes.

Q In the situation where you're in the room, though, are you able to have enough time when you have these

numbers at 60 to 80 patients a day go out and see people in the pre-op area and deal with them?

A Not usually. We would talk to them when they were rolled into the procedure room.

Q So you're in the procedure room and the first time you see the patient typically is when they roll into the procedure room?

A If there's just two of us there, yes.

Q If there's one of you there, would it be even more busy for you as being a single person?

A It absolutely was, yes.

Q In those instances, would you ever go out and interview patients and put in their IVs and do all that stuff out in the pre-op area?

A The only chance we would have had is we would have been switching doctors, you know, to do the procedures and the doctor that would have been coming was -- wasn't there yet. That would have been the only way would have gotten --

Q Did that --

A -- time --

Q -- happen very often?

A Not really.

Q So let's go on the back end of the procedure. Whoever it is, whenever the procedure is done, is it something where you have to stay in the room after the patient rolls out

before the next one comes in or --

MR. WRIGHT: I'm going to object to this line of questioning. I mean, the method of questioning, excuse me. I mean, let's just ask what he did.

MR. STAUDAHER: Actually, that's not what I --

THE COURT: Okay.

MR. STAUDAHER: -- believe I --

THE COURT: All right.

MR. STAUDAHER: -- am entitled to do.

THE COURT: Ask your question, Mr. Staudaher.

BY MR. STAUDAHER:

Q With regard to coming out of the room, did you stay in it? The patient leaves the room. Do you stay in the room, typically?

A We could have. We could have gone out. It was -- it just depended on the patient. If the patient wasn't quite awake enough for my satisfaction, I would have gone out to the recovery area with them.

Q When you're talking about numbers in the 60 to 80 patients per day, and these -- each one of these procedures takes a fixed amount of time, does it not? I mean --

A Yes.

Q -- roughly?

A Yes.

Q In reality, were you leaving the rooms to

IN THE SUPREME COURT OF THE STATE OF NEVADA

DIPAK KANTILAL DESAI, Appellant, vs. THE STATE OF NEVADA, Respondent.	CASE NO. 64591

APPELLANT'S APPENDIX VOLUME 7

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question after he hired CRNAs.

Q Okay. What I'm saying is your discussions with him about it would have taken place before he went to the CRNA practice.

A Yes.

Q Okay. And then your discussions continued because you -- you signed an additional agreement or letter of intent --

MR. STAUDAHER: Objection, mischaracterizes --

MR. WRIGHT: Letter of intent, I'm sorry.

MR. STAUDAHER: And he never indicated he signed an additional, only a single.

THE COURT: Okay. That's -- that's correct.

BY MR. WRIGHT:

Q You signed a -- you signed a letter of intent in 2006, correct?

A Yes.

Q Okay. And I -- and you had conversations with him then?

A He approached me in 2006.

Q Okay. Meaning Dr. Desai?

A Yes.

Q Okay. So you discussed it again with him in 2006.

A Yes.

Q Okay. And at that time you said I will remain available, however, if I do any -- I'll be available for on-site supervision if called upon --

A Yes.

Q -- and for any other telephonic type supervision --

A That's not -- that's not supervision.

Q Okay. Well, I'm -- correct me because I'm sure I'm not using the right words, consultation. I won't be responsible if I'm not on-site, right?

A Right.

Q Okay. And then other than that you agreed to be available if need be for consultation for quality care; is that correct?

A Chart review.

Q Chart -- chart review for quality care.

A Yes.

Q Okay. And that did not come to pass.

A No.

Q Okay. Now, you -- you gave -- you were asked about how long an upper endoscopic procedure took generally and then also a colonoscopy.

A Yes.

Q Okay. And do you recall what you said?

A Yes.

Q What?

A The EGD would take five to 10 minutes.

Q Okay.

A And the colonoscopy would take probably eight to 15 minutes.

Q Okay. Did -- did you previously state that a -- the endo takes 15 to 20 minutes and the colonoscopy 15 to 30 minutes?

A It can take that long, yes.

Q Okay. Is that what -- do you recall when you were interviewed by the police department that you told them it was 15 to 20 minutes for the EGD and 15 to 30 minutes for the colonoscopy?

A Yes.

Q Okay. Is that accurate?

A Yes.

Q Okay. Now propofol. You -- you commenced your practice after your residency in about 1993, correct?

A Yes.

Q Okay. And by then propofol was already on the market and being widely utilized.

A Yes.

Q Okay. And before -- what -- what did propofol replace?

A It replaced sodium pentothal.

Q Okay. And did you -- you are a -- your specialty is cardiologist -- tell me what you are?

A Well, strictly speaking my specialty is anesthesiology --

Q Okay.

A -- but I also subspecialize in cardiac anesthesia.

Q Okay. Cardiac anesthesia.

A Yes.

Q Is that like heart surgery?

A Yes. It's anesthesia for surgeries on the heart and the major blood vessels.

Q Okay. And so that's your subspecialty, correct?

A Yes.

Q Okay. Now, for those procedures do you -- do you use propofol?

A Yes.

Q Okay. And do you use propofol to start and then use other anesthesia -- what do you call it?

A Other anesthetics.

Q Yes.

A Yes.

Q And tell -- tell me, with propofol -- tell -- I'm -- I'm confused on what a sedative is and an anesthetic is.

A A sedative can reduce the level of consciousness, but a anesthetic, for example, a hypnotic can make the person lose consciousness.

Q Okay. And is a -- a -- a sedative put me to sleep?

A It can put people to sleep, but it's usually used to reduce the level of anxiety in a person.

Q Okay. And propofol is an anesthetic that puts me to sleep, right?

A Yes.

Q Within 10 seconds.

A Yes.

Q I'm in for a procedures, within 10 seconds in it goes, I'm asleep and I feel no pain, correct?

A Correct.

Q Okay. And then when I wake up it's -- it's quick acting, meaning it wears off like in -- say in 10 minutes I'm coming to and drowsy.

A Yes.

Q Okay. And it -- at that time, how's my memory?

A You would not recall what happened in that 10 minutes.

Q Okay. While I was asleep?

A Right.

Q Okay. And then, but as I am coming to, you know

the twilight period or whatever, I mean because it's wearing off, correct?

A Yes.

Q At what point does it -- does my memory come back 100 percent?

A Only after you fully wake up.

Q Okay. So there's a period of time like when I'm in recovery -- you do a procedure and I'm talking about a procedure with propofol. Okay? And then I'm in to recovery, and I'm still asleep, but as I start coming to, until I am fully awake, I may not remember certain things that transpire; is that fair?

A That's correct.

Q Like maybe a doctor could have come by and talked to me and I may not even know it.

A That's correct.

Q You have -- you still -- aside from hospital anesthesiologist work, you also do work at ambulatory surgical centers.

A Yes.

Q Okay. Like -- like an endoscopic clinic.

A I haven't been to any endoscopy centers in 10 years.

Q Oh, okay. Then what -- currently just give me an example of your outpatient surgical center activity.

A This would be accredited outpatient surgery centers also known as ASC, Ambulatory Surgery Centers.

Q Okay.

A Once I have privilege at such a place, if and when a surgeon calls for -- for me to go to that particular surgery center to provide service, I will go.

Q Okay. And you are presently doing that.

A Yes.

Q But not -- not the endoscopic centers but to centers where they perform what other services?

A Basically short surgeries.

Q Okay. Like what? Give me examples. I'm not familiar with it?

A One example would be excision of lipoma. These are benign masses that's on -- grow on the skin and the surgeon would take that off and the patients would be more comfortable if they slept through it.

Q Okay. Now when -- when you have used propofol and only propofol for a short procedure like an endoscopy, okay, and you -- in an out -- outpatient surgery center, so you're not in the hospital with IV bags, et cetera, you're using propofol and a syringe and a hep-lock. Okay?

A Yes.

Q Okay. And that's standard procedure in out -- in ambulatory surgical centers.

A Yes.

Q Okay. And so when -- when you are doing that, you are dispensing propofol, intermittently redosing if the patient needs it.

A Yes.

Q Okay. So that you start the procedure, patient goes to sleep giving them so many -- whatever the amount is, but you start enough to put them to sleep. And then the procedure's going on and if they start to awaken -- and, of course, you are there monitoring everything, right?

A Yes.

Q Okay. And so they may need an additional dose of propofol, right?

A Right.

Q Okay. And then it's you who makes the determination as to what size and how much more they need, right?

A Yes.

Q Okay. So then when you what I call redose the patient, okay, you take -- when you first dose the patient, you took out a new, brand new needle and syringe, correct?

A Yes.

Q And you dose the patient, right?

A Yes.

Q Okay. Now the patient's stirring and the doctor

says I'm going to be a little while longer -- the surgeon says it's going to be a while yet, so you determine to give a second dose?

A Yes.

Q Okay. So you take the same needle and syringe and insert it into the propofol and redose that patient with the same needle and syringe.

A Yes.

Q Okay. And that is absolutely perfect -- perfect practice, correct?

A As long as you throw away the bottle at the end of that patient's procedure.

Q Okay. What do you do with the needle and syringe?

A You throw that away too.

Q Okay. But you would never use the needle and syringe on an additional patient.

A I would never use the syringe, the needle or that bottle on another patient.

Q I understand that. I'm asking you about the needle and syringe and reusing it for the same patient multiple times.

A Same patient is acceptable; different patient is unacceptable.

Q Okay. Thank you.

THE COURT: Is that it, Mr. Wright?

MR. WRIGHT: That's it.

THE COURT: Mr. Santacroce, do you have any patients -- I'm sorry --

MR. SANTACROCE: Patients, no. I do have a few questions.

THE COURT: Freudian slip. Do you have any questions?

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Doctor, you're a licensed anesthesiologist here in Nevada, correct?

A Yes.

Q Are you aware that it's perfectly legal for a licensed CRNA in Nevada and California and other jurisdictions to administer anesthesia without a supervising anesthesiologist?

A I'm not familiar with that.

Q You have no -- I shouldn't say no, you have limited experience supervising CRNAs, correct?

A Yes.

Q And the last time you did that was when?

A In the early 1990s.

Q So a lot of things have changed since then; isn't that correct?

A Yes.

Q Now you testified -- you were shown that billing chart or that anesthesia record and on the bottom -- do you have that record?

MR. WRIGHT: It's part of the exhibit.

MR. STAUDAHER: Yeah, it should be up there.

MS. STANISH: Maybe down there or something.

MR. STAUDAHER: Down -- no, that's not it. It's up -- it should be over there.

THE COURT: Did they leave any exhibits in front of you, Doctor?

THE WITNESS: No.

MR. WRIGHT: It's part of Exhibit 65.

BY MR. SANTACROCE:

Q Never mind. Anyway, do you recall on that exhibit where you were talking about the billing and you said that you would -- if you were supervising a CRNA you would put CRNA slash and then the anesthesiologist, correct?

A Yes.

Q How many times have you actually done that?

A Just a few times in my career.

Q And when was the last time you did it?

A In the early 1990s.

Q So that was the last time you ever did such a thing.

A Yes.

Q Submitted a bill like that. Would you charge for the CRNA's time as well as your time?

A When I did that I was a -- a temporary employee for the anesthesia group that serviced Los Angeles Medical Center and I did not do the billing.

Q So you -- so you didn't do the billing at all. All you did was put your time, correct? Or the CRNA's time, correct?

A Yes.

Q And then that went to a different department.

A Yes.

Q And that department then did whatever they wanted to do with it to get paid, correct?

A If -- my understanding is if there was misrepresentation --

Q I didn't ask you about misrepresentation --

MR. STAUDAHER: Objection, Your Honor. Let him finish his answer.

MR. SANTACROCE: It's nonresponsive.

THE COURT: All right. The question was, and once it went to the billing department, then the billing department would take it from there?

THE WITNESS: Yeah, but they cannot do whatever they wanted like you just said.

THE COURT: Right.

BY MR. SANTACROCE:

Q Okay. They would submit it to the --

THE COURT: That's a fair answer.

BY MR. SANTACROCE:

Q That's fair. They would submit it to the -- either Medicare, Medicaid or the proper insurance company to get paid; is that fair?

A Yes.

Q Okay. And it was out of your hands once you submitted it to the billing department or billing company, correct?

A Yes.

Q I'm curious, Doctor, how much do you get paid an hour or do you bill as an anesthesiologist per hour?

A Different payers pay at different rates.

Q Okay. Well, just give me a ballpark figure.

A Medicare pays us $17 a unit.

Q Okay. What about a health plan in Nevada?

A Probably $39 a unit.

Q And other companies, Blue Cross Blue Shield?

A I would say in the high thirties, low forties.

Q Per unit?

A Per unit.

Q You -- you testified that you bill in increments

of 15 minutes, correct?

A Yes, that's one unit.

Q Okay. And you testified that if it went to 16 minutes you didn't particularly bill for the extra unit but other anesthesiologists did.

A Yes.

Q And it's perfectly legal and ethical to do that, isn't it?

A It's legal --

Q You just chose not to do it?

A It's legal, I don't think it's ethical.

Q Okay. From your point of view it's not ethical.

A Right.

Q But it is legal.

A Yes.

MR. SANTACROCE: I have no further questions. Thank you.

THE COURT: Redirect.

MR. STAUDAHER: Yes.

REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q The question he just asked you about the insurance billing where you were talking about if there was any information that was false on there it would be a problem.

A Yes.

Q Okay. So you know that the information you put down on the -- on the record is going to go to an insurance company to get reimbursement.

A Yes.

Q And that's the whole purpose of submitting it, right?

A Right.

Q And so if you -- you know that if you put anything false in there that's it going to potentially cause a real problem and you're not going to either get reimbursed or you could even get in trouble.

A You can go to jail.

MR. WRIGHT: I object to the leading.

THE COURT: Well, overruled.

MR. STAUDAHER: This, Your Honor --

THE COURT: It's over -- Mr. Staudaher, it was overruled.

MR. STAUDAHER: Okay, I'm sorry.

THE COURT: You don't need to fight with me.

MR. STAUDAHER: I'm sorry, Your Honor.

THE COURT: Save the fighting for when I rule against you.

BY MR. STAUDAHER:

Q You were asked some questions by Mr. Wright about redosing of propofol and the syringes and all that. Do

you remember that?

A Yes.

Q So just so I'm clear, you would never use a -- a syringe that you used on a patient on a new patient?

A Never.

Q Even if you took the needle off of it?

A Never.

Q What about the bottle of propofol, if you -- if there was some left over and you drew some out of that to -- to have a patient and you went back into the bottle with the same syringe, even if you changed the needle or something, and went back into that same bottle, would you ever use that bottle on another patient?

A No.

Q In fact, if you open the bottle and you used it on one patient, regardless of the situation, would you ever use that bottle on another patient?

A No, never.

Q So the medication stays with the patient?

A Yes.

Q And you were -- said -- or you were asked if that's pretty standard practice among the anesthesia people that you work with?

A Yes.

Q Why -- what is the reason why you would not do

that?

A Because of the risk of cross-contamination.

Q Is that well known?

A Yes.

Q Amongst all providers that you've ever worked with?

MR. WRIGHT: Objection.

THE COURT: Overruled.

THE WITNESS: Any anesthesia providers that has been trained would know that.

MR. SANTACROCE: I'm going to object, it calls for speculation. He can't speak for all anesthesia providers. He can speak for himself.

THE COURT: All right. Are you -- are you speaking for anesthesiologists?

THE WITNESS: Yes.

THE COURT: All right.

BY MR. STAUDAHER:

Q Now you were asked also about -- well, I guess it was even standard procedure in ambulatory care centers is what the question was about. Remember that --

A Yes.

Q -- with regard to this stuff? The things we've been talking about about not reusing syringes or not reusing bottles of propofol, is that pretty standard in that setting?

A Yes.

Q Have you ever run across anybody that didn't understand that or didn't know that?

A No.

Q Now flip side of that. You are working at an ambulatory care center or in any case, any situation, and a doctor that you're working with tells you to do that, to reuse that stuff, not waste it, would you do it?

A No.

Q Ever?

A No.

Q Would you ever tell somebody you were supervising if you had entered into an agreement to do so, that it's okay to reuse syringes or propofol or any medication like that from patient to patient?

A No.

Q Why not?

A Because that would put -- put a patient in danger.

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

THE COURT: Uh-huh.

BY MR. STAUDAHER:

Q Two -- two companion questions. A procedure that you would do and -- an endoscopic procedure in a hospital, in an outpatient setting, whatever, would you ever

allow a patient -- the procedure to actually start before you had the anesthesia on board? Meaning that you've given the anesthesia.

MR. WRIGHT: Objection, outside the scope of cross.

THE COURT: I'm sorry?

MR. WRIGHT: Outside of the scope of cross.

THE COURT: Oh, overruled. You can answer.

THE WITNESS: I would not allow the surgeon to proceed.

BY MR. STAUDAHER:

Q So what would you do in a situation like that?

A I would tell him to stop.

Q What if they didn't stop?

A I would wake the patient up and leave the room.

Q Other side of the procedure, getting to the end but the patient's starting to move around or -- or -- and you think in your clinical judgment that that patient needs additional medication to finish the procedure, the doctor tells you don't give it.

A I would still give it.

MR. STAUDAHER: Nothing further.

THE COURT: Recross, Mr. Wright.

RECROSS-EXAMINATION

BY MR. WRIGHT:

Q I just want to be clear on this syringe you --

and -- and we're talking about aseptic technique, correct? You know what that means?

A Yeah, but do you know what that means?

Q Pardon?

A I know what it means. Do you know what it means?

Q That's what I asked you. Tell the jury what it means. I wasn't saying you don't use aseptic technique. Aseptic technique means safe, sterile practices; is that correct?

A The different levels of aseptic standard.

Q Okay.

A Aseptic means no germ. Septic means germs.

Q Okay.

A A means none. So in the highest level, that's what a surgeons do, they -- they wash their hands outside the room for a standard five minutes. They come in, they put on sterile gowns, sterile gloves, mask, hats and shoe covers.

Q Okay.

A And the surgical site is scrubbed.

Q Okay. I was going to focus on syringe use, aseptic technique. Does that mean no germs?

A The use of --

Q I mean is that -- aseptic means that, right?

A No.

Q Oh, okay. What's aseptic?

A Aseptic is not an appropriate description for using syringes on patients because the person taking the syringe in his hands, he didn't scrub his hands.

Q Okay. I'm -- I'm -- I must be using the wrong terminology. When CDC talks about unsafe syringe use and says it's not -- it's not aseptic technique, what are they talking about?

A The syringe should be a one-time use syringe ideally. If it's not it has to have been properly sterilized prior to use.

Q Okay. I want to talk about reusing the same needle and syringe on the same patient. Okay?

A Okay.

Q Absolutely proper, correct?

A Same syringe, same needle on the same patient is acceptable.

Q Okay. And that's aseptic technique, correct?

A That's -- you're using the wrong word.

Q Okay. Is -- it's not?

A Once a syringe and needle has come in to contact with patient body fluid, it's no longer aseptic but it's the same patient so you can use that syringe and needle and insert that into say the original bottle of medicine, draw some more medicine, give it to the same patient because a patient cannot

contaminate himself.

Q Correct. And so that is perfectly safe and acceptable and you do it, correct?

A Yes, it's acceptable.

Q And all of those -- all of your brethren anesthesiologists in the community that you know, and you know all of their practices, they all do the same thing. Only one needle, it's safe to use, same patient, then toss it. Can't use it on another patient, correct?

A And you must toss the bottle of drugs too.

Q No. I'm talking about the needle and syringe. Okay? All of them across the board, standard of practice in Las Vegas is reuse needle and syringe, same patient perfectly proper, correct?

A Yes.

MR. WRIGHT: Thank you.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: Yes.

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q Doctor, how many colonoscopies and endoscopies have you done?

A I would say a few hundred.

Q Okay. And when you worked at the clinic you -- I believe you testified you did 20 per day?

A Up to 20 per day.

Q And at your practice now, what size propofol bottles do you use?

A The 20 ml bottles.

Q Twenties?

A Yes, 20 cc bottles.

Q You ever use the 50s?

A I have, yes.

Q And why is it you don't use the 50s now?

A It's not available to me.

Q Okay. So it's just a matter of supply and demand?

A If it's available, both, I will use the one that's more appropriate for the case. If a case is only going to require 10 cc I will use the smaller bottle. If I think the case is going to run long and I need to give 30 cc then I will use the bigger bottle.

Q So you don't use the 50s now because you can't get them, is that your testimony?

A The hospital does not provide it to me.

Q Okay.

MR. SANTACROCE: Nothing further.

THE COURT: Any redirect?

MR. STAUDAHER: No, Your Honor.

THE COURT: Do we have any juror questions for the

witness? I'll see counsel at the bench while the bailiff retrieves the question.

(Off-record bench conference.)

THE COURT: -- questions up her from a juror. Doctor, you talked about your procedure before going in to surgery. What is your procedure following surgery? Meaning what is your responsibility after the surgery to the patient?

THE WITNESS: After the surgery we take the patient to the recovery area and we give report to the nurse in the recovery room and we take a set of vitals. For example, blood pressure, heart rate, respiratory rate, and the oxygen level in the blood. And we also give instruction to the nurse on what to do to treat the pain, anxiety or nausea problems.

THE COURT: Do you wait until the patient becomes conscious to speak to the patient?

THE WITNESS: I would not necessarily wait until the patient can speak. If the patient can maintain his airway, can breathe adequately and the vital signs are stable and then it's acceptable for me to give the instruction to the nurse and give the nurse a way to contact me such as my phone number and then leave the recovery area.

THE COURT: All right. Thank you, Doctor. Any follow-up questions based on that last juror question?

MR. STAUDAHER: Yes, Your Honor.

FURTHER REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q If you were in the situation where you just -- you didn't follow her out there, you just stayed in the room and waited for the next patient to come in, would that end your involvement with that patient?

A If I did not follow the patient to recovery room?

Q Yes.

A Then -- first of all, I -- I don't think I've done that but if I were to do that then my involvement with the patient would end there.

Q Would your time for your billing end at that point?

A Yes.

Q So whenever you walk away from the patient or are done with the patient for whatever reason, your billing time ends.

A Yes.

Q Would you ever calculate or -- or add vital signs on to get more time?

A No.

Q Would that be something that would be false information on a record?

A I believe so, yes.

Q Okay. Would you ever submit something like that

to an insurance company?

A No.

Q The companion thing is you are in a situation where a patient goes out to the recovery room, maybe you even follow them, and then you walk away from that patient where you're time ends with them and you start another patient. Would you continue to bill or do vital signs or anything for that patient when you're working on another patient?

A The time cannot overlap.

Q It can't?

A Cannot.

Q Why not?

A To -- in my understanding that's not legal.

Q Okay. You don't believe you could bill for -- that would be false information?

MR. WRIGHT: Objection. I ask the Court to reinstruct --

THE COURT: All right. Once again, the witness can testify about his practices and why he --

MR. STAUDAHER: Certainly.

THE COURT: -- does it but any -- cannot make legal conclusions or tell you what the law is.

BY MR. STAUDAHER:

Q And one last question. Mr. Wright said, you know, industry standard across all anesthesiologists that you

work with, do you know any anesthesiologist in town that has ever continued to bill --

MR. WRIGHT: Objection, Your Honor -- objection Your Honor --

BY MR. STAUDAHER:

Q -- after they --

MR. WRIGHT: -- objection.

THE COURT: All right. That -- that's --

MR. WRIGHT: Can we approach the bench?

THE COURT: No, we don't need to. That's sustained. You can phrase the question a different way.

MR. WRIGHT: This isn't a follow-up on the juror's question.

THE COURT: Well, sometimes it reopens --

MR. STAUDAHER: I think it's along the same lines. I'm asking him what happens after a procedure.

MR. WRIGHT: Can we approach the bench?

THE COURT: I don't -- I sustained the objection to the question as asked.

BY MR. STAUDAHER:

Q Across the board, as far as you know, anesthesiologists you work with in the community --

MR. WRIGHT: In -- in the recovery room.

BY MR. STAUDAHER:

Q -- in the recovery room, patient's out there and

you walk away. Do people get to continue to bill for that time?

A No.

MR. STAUDAHER: Nothing further.

THE COURT: Anything else from the defense?

MR. SANTACROCE: Yes, Your Honor.

FURTHER RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q Your post surgical procedure that you just told us about, that's in a hospital setting, correct?

A That's in both hospital and surgery center setting.

Q Well, when you did these 20 procedures a day at the endoscopy center, you didn't do that, did you?

A I would push the bed out to the recovery area --

Q Uh-huh.

A -- and tell the nurse what we just did and then go back to the room.

Q Okay. And that -- that ended it for you, correct?

A Yes.

MR. SANTACROCE: Nothing further.

THE COURT: Mr. Wright, anything else?

MR. WRIGHT: No.

THE COURT: Anything else from the -- oh, I'm sorry.

Did you have anything, Mr. Staudaher?

MR. STAUDAHER: No, Your Honor, I don't.

THE COURT: Anything else from the jury? All right, Doctor, thank you for your testimony. You are excused at this time.

All right, ladies and gentlemen, we're going to go ahead and take our evening recess. We will be reconvening tomorrow morning at 9:30. Before I excuse you for the evening recess I must admonish you that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch or listen to any reports of or commentaries on this case, any person or subject matter relating to the case by any medium of information. Do not do any independent research by way of the Internet or any other medium. And please do not form or express an opinion on the trial. If you would all place your notepads in your chairs, follow Kenny through the rear door and we'll see you back tomorrow morning at 9:30.

MS. STANISH: Judge, can we approach?

(Jury recessed at 4:55 p.m.)

(Off-record bench conference.)

(Court recessed for the evening at 4:57 p.m.)

CERTIFICATION

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

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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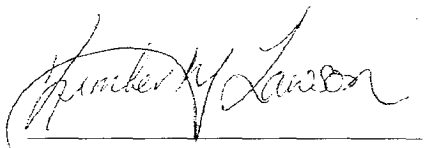

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TRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

STATE OF NEVADA,	)	CASE NO. C265107-1,2
	)	CASE NO. C283381-1,2
Plaintiff,	)	DEPT NO. XXI
vs.	)	
	)	
DIPAK KANTILAL DESAI, RONALD E. LAKEMAN,	)	**TRANSCRIPT OF PROCEEDING**
	)	
Defendants.	)	

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 12

FRIDAY, MAY 10, 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.

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TRANSCRIBED BY: KARR Reporting, Inc.

I N D E X

WITNESSES FOR THE STATE:

E X H I B I T S

LAS VEGAS, NEVADA, FRIDAY, MAY 10, 2013, 9:30 A.M.

* * * * *

(In the presence of the jury.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State, the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

And the State may call its next witness.

MS. WECKERLY: Thank you, Your Honor. The State calls Jean Scambio.

THE COURT: All right.

JEAN SCAMBIO, STATE'S WITNESS, SWORN

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

THE WITNESS: Jean, J-E-A-N, Scambio, S-C-A-M-B-I-O.

THE COURT: Thank you.

Ms. Weckerly.

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Good morning.

A Good morning.

Q How are you employed?

A How?

Q Uh-huh.

A I was a nurse at the --

Q And what --

A -- endoscopy center.

Q -- type of nurse?

A An LPN.

Q What does --

A A practical nurse, licensed practical nurse.

Q Okay. And I know this is a little bit awkward, but we'll have to not talk over each other, so just wait. I know you know the answer to how you're employed --

A Uh-huh.

Q -- but just wait until I say it --

A Okay.

Q -- and I'll wait for your answer. Okay.

A Uh-huh.

Q What kind of training have you had that allows you to work as an LPN?

A Well, I did a year of schooling like 35 years ago.

Q Okay.

A And I worked in a county hospital in Rhode Island for 22 years, and then another five years in a radiation oncology office there before I moved to Las Vegas in 2005.

Q So you came to Las Vegas in 2005. Did you

work somewhere when you arrived in 2005?

A Yeah, I worked at Home Health Agency for about seven or eight months first.

Q And what is that?

A Going into patient's homes doing blood pressures, diabetic teaching, wound care, things like that.

Q So it's in-home treatment for --

A Yes.

Q -- for patients who aren't able to go to a hospital or need kind of day to day care?

A Well, yeah. Usually they had been discharged from the hospital and they needed, you know, some little short term care at home to get them back on their feet.

Q Okay. At some point did you work at the Endoscopy Center of Southern Nevada?

A Yes.

Q And when did you start working there?

A I believe it was January, the end of January in 2006.

Q Okay. Who hired you?

A Ms. Rushing.

Q That would be Tonya Rushing?

A Yeah, she did my interview.

Q And you so you think you worked there in January of 2006.

A Uh-huh.

Q What position were you hired into?

A It was mostly in the discharge of the -- of the clinic, going over discharge instructions, kind of like preliminary test results and scheduling follow up visits, and then also we would do call backs the next day to see how patients were doing at home.

Q Okay. Let me ask you a couple questions about that. You weren't the person that checked patients in once they arrived at the clinic before -- before their procedure?

A No.

Q And you didn't work in the pre-op area installing a hep-lock or a needle or anything into the patient prior to their procedure?

A No.

Q And were you ever in the procedure room when you worked there?

A No.

Q And the way I understand it there was a recovery area prior -- that you went to prior to the discharge.

A Yes.

Q And you were in that last stop?

A Yes.

Q From where you actually physically worked in

the discharge area, could you see into the recovery area?

A Yes.

Q As the -- the discharge nurse, I believe you said your duties were to give the -- the patients their results and schedule a follow up appointment?

A Yes.

Q And then you also were to, I guess, call them the next day to see what their reaction was to their procedure?

A Yes. There was two or three of us, and we kind of like rotated the duties, LPNs --

Q Okay.

A -- doing those -- those things.

Q When -- when you were working during the time you were there, what was your typical shift, your work hours?

A We rotated a little bit just to stagger coming in and leaving. Generally, I would say I did either like 8:00 to 4:30 or 8:30 to 5:00. And then one of the other nurses, I believe, almost always did the earlier shift, like 7:30 to -- to 4:00, I believe.

Q Now, you said that you reviewed the discharge instructions and also the test results with the -- with the patients.

A Yes.

Q What types of things were you telling the

patients about their procedure?

A Well, they printed out a preliminary report after every procedure was finished, so we would kind of look at what was stated in this document and go over like a general synopsis of what it -- what it said.

Q And were you comfortable doing that?

A No.

Q Why not?

A Because on occasion there was possibly results that really didn't look good, and I didn't feel it was up to me to be telling patients that they possibly had tumors.

Q Did you -- did you feel like you had the medical background to be discussing that type of result with a patient?

A Not really.

Q And were you -- were you concerned about the -- the accuracy of the information you might be giving the patient?

A Yes.

Q When you had that -- that duty, did you ever ask a doctor to come out and discuss the results with the patient instead of you doing it?

A There were only a few doctors that, in my time I was there, that if they saw something that really seemed concerning would actually go in and talk to the patient in the

discharge room.

Q And who were those doctors that would come out if you --

A I don't remember their names.

Q You don't remember their names?

A There were so many doctors that --

Q Do you remember if Dr. Desai would come out?

A No, when I was there he -- I don't remember him doing that many actual procedures.

Q And obviously you were aware of who he was?

A Yes.

Q Did you ever see him in your area, in the discharge area?

A The discharge area had like a nurse's desk, and up on the counter was the daily schedule that would be taped to the desk so, you know, we could see who was going to be coming in and take the next person in. He would come out and look at that and schedule frequently. And if patients didn't come in or cancel, they would get crossed off.

Q And did you ever hear him comment or --

A Yeah.

Q -- say anything?

A He didn't seem happy when we were having like quite a few no-shows for the day.

Q He didn't seem happy?

A No.

Q Well, how did you -- how could you tell that? What would he do?

A I don't know. I don't remember exactly what he said, but it just seemed like there was grumbling about, you know, not enough patients being seen for the day.

Q Not enough patients for the day. But those comments weren't directed at you.

A No.

Q You could just hear it?

A Yeah.

Q Is that yes?

A Yes.

Q Okay.

A Sorry.

Q What was the -- the atmosphere like at the clinic during the time you were there?

A It was very fast paced, very stressful, there was always roomfuls of patients. The waiting room was always very full, patients were angry about how long they had to wait to come in, get out. It just wasn't a nice atmosphere.

Q And in your recollection, how many patients do you remember being seen a day?

A I believe on like just any given day on the schedule there was anywhere from 65, 70 or so, I believe.

Q Yeah, and it was -- I think you described it as very crowded.

A Oh, yeah.

Q How quickly were the patients moved through?

A It seemed like after their procedure they'd be brought into the recovery area. I think about two sets of vital signs every 15 minutes may have been done. And then they would be gotten up and dressed and brought over to a seating area to wait for one of us to go over their results and schedule their follow up appointment.

Q Okay. And how long -- I mean, were patients in one area very long, or how -- how did it seem to you?

A In one area?

Q In one area of the -- of the clinic, like in pre-op or in recovery or --

A Well, they moved through pretty quickly.

Q Okay. And it was just always high volume --

A Yes.

Q -- is your recollection?

A Yes.

Q Did you stay -- did you stay there a long time working?

A No, five months.

Q Five months. Why only five months?

A Once I got actually totally trained, oriented

to the position, got a feel for how the place was -- the facility was run, and I didn't really care for it, it was nothing like I had ever seen back in Rhode Island in an office, and then the time to find another job and leave.

Q How soon did you start looking for another job?

A I don't remember for sure, maybe three -- three and a half, four months maybe.

Q After you were there?

A Uh-huh.

Q Is that yes?

A Yes.

Q Were you worried about your license?

A I didn't feel comfortable there. I felt that the place was unsafe and I just didn't feel comfortable, yes. I felt like something may happen there. I thought it more would be -- might be missed -- missed cancers, you know, because it seemed to me that they were putting way too many patients through there and that they weren't in the procedure rooms very long.

Q You mentioned that you rarely saw doctors come out to the recovery area and deal with patients. How about the CRNAs? Did you see them come to the recovery area very much?

A No, not that I remember.

Q And you said that you left after five or six months?

A [Nods head yes].

Q Is that yes?

A Yes.

Q And then you're -- are you working in the healthcare field now?

A Yes.

Q And so you've -- how long have you worked in total in the healthcare profession?

A I graduated from nursing school from 1977, so it's almost 36 years.

Q And I know you did the home care, but have you worked in other kind of outpatient surgical facilities?

A No.

Q Have you worked in emergency rooms or something similar to the endoscopy center?

A The only thing that would be similar would be the radiation oncology office that I worked at. They did radiation procedures on -- on patients.

Q And was that a similar atmosphere in terms of the number of patients that were seen or how quickly patients were moved through?

A No.

Q Anything like what you experienced --

A No.

Q -- at the endoscopy center?

A No.

Q Thank you.

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

THE COURT: All right. Cross.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good morning.

A Good morning.

Q I'll let you pour your water. Where are you currently working?

A I work at Rhode Island Hospital right now.

Q So you're back in Rhode Island?

A I am back in Rhode Island, yes.

Q The -- Tonya Rushing was the one that interviewed you?

A Yes.

Q And was there any kind of negotiation on your salary with her?

A I pretty much -- she asked me what I would, you know, was asking for a salary, and I stated what I -- what I thought I should be paid, and she -- from what I remember she told me that was a little more than what they usually pay there, but if I was agreeable to not getting a raise for

awhile that she would pay me that.

Q All right. And as I understand it you were the discharge nurse.

A Yes.

Q And you shared that responsibility with two other nurses on a rotating basis?

A Yes.

Q Can you please identify for us the other two nurses if you remember?

A One woman's name was Lorraine. I don't remember her last name. She's actually the LPN that trained me, and then there was another woman who, I think she worked part time in our clinic, her name was Martha.

Q Martha --

A And I believe the one more was -- was it Sharon?

Q Oh, so there were three other woman who --

A Yeah.

Q -- had that position.

A Yeah.

Q And when you -- you were trained by Lorraine, you say?

A Yes.

Q Okay. How long did that process take?

A I don't remember for sure. I don't remember

whether it was two or three weeks.

Q You were an experienced nurse. It wasn't that hard for you to figure out?

A Yes.

Q And just a question on the preliminary test results that you had to discuss with the patients. I understand you were uncomfortable with that.

A Yes.

Q When you did those -- when you had those discussions with the patients after the procedures, were they usually accompanied by their escorts?

A Yes.

Q Okay. So they --

A They always had a --

Q Why --

A -- family member.

Q I'm sorry for talking over you.

MR. SANTACROCE: They always had a what? I didn't hear that.

THE WITNESS: They almost always -- always -- well, actually, they always did have to have a family member with them because they were, you know, being anesthetized.

THE COURT: And they can't drive afterwards.

THE WITNESS: Exactly. Yes.

BY MS. STANISH:

Q That's what I was going to ask. They can't drive. And in addition to discussing the preliminary test results, which I'll come back to, did you also discuss with the patient and the escort instructions for after care?

A Yes.

Q And what -- what would that include generally speaking?

A Pretty much what they could eat and drink for the day. I believe there was something to the effect that they shouldn't sign any legal papers within the next 24 hours. If they had any problems to call a facility.

Q Do you know why they couldn't sign any legal papers?

A It has something to do with being anesthetized. Any procedure that you have, surgeries, anywhere they will pretty much tell you not to get into any legal signings because it still could be, I guess, affecting you.

Q Is it a fair statement that patients are sometimes fuzzy after --

A Yes, that's why they would have to have a family member along with them being -- being driven.

Q I have to repeat what Pam told you. Let me finish my question first.

A I'm sorry.

Q Because it is a weird situation, isn't it?

A Uh-huh.

Q So the -- is part of the escort's job, if you will, not only to drive the patient safely home, is it also to listen to what you have to say as a discharge nurse?

A Yes.

Q All right. And you -- you had the -- you were scheduling follow up appointments with doctors; correct?

A Yes.

Q And what was the purpose of those follow up appointments?

A Usually if there were biopsies done, by the time they were seen in their follow up they would have those results and the doctor would go over the final results with them.

Q And so when you would get this preliminary report, would it basically say things like, well, we found a hemorrhoid or we took out, what do you call those things --

A Polyps.

Q -- polyps? Is that basically what we're talking about?

A Yes.

Q And in some -- occasionally there would be something more serious where they would have to take a biopsy that would have to be studied later on to determine if it was

cancerous; is that correct?

A Yes.

Q So really the doctor would have to be -- wait for those biopsies; correct?

A To go over the final results, yes.

Q Right. So there's not much you could tell the patient or a doctor at the time of checking out; is that correct?

A Right. Yes.

Q And if a patient asked you a medical question that you didn't know the answer to, am I right to assume you would say I don't know, you'll have to wait until the follow up appointment and discuss I with the doctor.

A Of course. Yes.

Q And the next day you would -- your responsibility was to call up the patient and to ask them how they were doing?

A Yes.

Q All right. And did you record those results or document it in some way?

A Yes, there was a follow up call sheet.

Q And would you also remind them when the follow up appointment was?

A Yes.

Q Did -- did you conduct patient surveys?

A The patients were given surveys, yes.

Q And were you the one to hand them the survey.

A I don't remember in what part of the process they were given their surveys.

Q So they were actually given a paper document, a survey?

A Yes.

Q And do you know what kinds of questions were on that survey?

A I don't remember.

Q All right.

A I guess their overall happiness with -- with their procedure, the whole -- the whole process from start to finish.

Q All right. And did you have anything to do with the surveys, like calling up patients regarding the surveys?

A No.

Q All right. So your contact with the patients by telephone was simply to make sure they were comfortable and okay --

A Yes.

Q -- as well as to remind them of their follow up appointment.

A Yes.

Q Why did you do that?

A To see if they were having any problems from -- especially if they had biopsies, they could have bleeding. Just to see how they were feeling the next day.

Q Now, let me talk to you a bit about the three other women who served as discharge nurses. I understood when you were testifying on direct that you had staggered shifts with one other gal. What about the other two women, when would they come in?

A One of them always came in the early shift. I believe her name was Sharon. That was from 7:30 to 4:00, I believe. Me and Lorraine were basically -- we switched off. And Martha did not work at the facility every day.

Q And when you say you switched off with Lorraine, I'm not sure I understand what you mean.

A One day she would come in 8:00 to 4:30 and I would come in 8:30 to 5:00, and then other days I would come 8:30 to 5:00 and she would come 8:00 to 4:30. So one of us would always be there a little bit later.

Q But you worked five days a week?

A Yes.

Q All right. So are there four discharge nurses --

A Yes, there were --

Q -- working on any --

A -- at times.

Q -- given day?

A Yes.

Q All right. How many -- if you remember, because I know this was --

A Seven years.

Q -- seven years ago; right?

A Uh-huh.

Q Do you know how many people were employed at that time?

A Overall, I have no idea. I don't remember.

Q Fair enough. And when you got there in 2006, January 2006?

A Yeah, the end of January. Yes.

Q Were there two procedure rooms operating, or just one at that time.

A Two.

Q And do you know, or if you -- do you recall whether there was a transition of the clinic going from one procedure room to two procedure rooms?

A I don't understand what you mean.

Q Yeah, that wasn't good, was it? Do you know whether or not there was -- before you got there were you aware of whether or not there was only one procedure room operating?

A I'm not aware of that.

Q Do -- were you aware that there was an expansion of the clinic?

A At the time I was there I believe they were opening up another clinic at -- at a different location.

Q I see. How is it you learned of this job opening?

A I believe I saw it in the Review Journal.

Q Let's see, the recovery area, can you describe that area for us, please, if you remember?

A If this was the facility, the nursing desk would up here, and straight through there were maybe four or five beds off to the right with curtains that would go around them.

Q I have to stop you because --

A Okay.

Q -- you're making gestures.

A I'm sorry.

Q That's okay. I just want to --

A I'm trying to --

Q -- explain for the record that you are -- when I asked you what the recovery room looked like you put your hands forward pointing to this courtroom --

A Uh-huh.

Q -- and if you are -- let's pretend for the

moment that the witness stand is your station as the discharge nurse. And pretend I just got out of a colonoscopy.

A Uh-huh.

Q Where should I be in the recovery room? How far should I be from you?

A You were --

Q Here?

A No, further. There were four beds -- I believe it was four beds to the right. Probably back to the door up to -- maybe a little bit further, maybe up to the desk there.

Q So I'd have to go out of the courtroom to go to the furthest --

A Yes, probably.

Q Okay.

A Uh-huh.

Q Understood.

A And the nurse's station was up at the front, and then there was another small office to the left of the nurse's station that had a little computer in there and a couple of chairs and we would call the patient and the family member in there and go over their results and schedule their follow up appointment.

Q I'm not really good with distances. Any idea how far that might be?

A Uh-huh.

MS. STANISH: What do you think, Judge? You've been in this courtroom a long time.

MR. WRIGHT: Some Judges have it measured out.

THE COURT: Well, I'm sorry, Mr. Wright. At break I'll pace it out for you. Well, actually, Kenny will pace it out for you.

MR. WRIGHT: All right.

THE COURT: I don't know, but a fairly large room, is that fair?

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: Probably a little bit larger than this room --

THE COURT: Okay.

THE WITNESS: -- maybe lengthwise. Maybe not quite as wide.

MS. STANISH: I guess I go by football fields. That's got to be at least 30 yards, 40.

MR. STAUDAHER: What?

MS. STANISH: 30 yards?

MR. STAUDAHER: No.

MS. STANISH: Really, I'm a baseball --

THE COURT: Well, I was going --

MS. STANISH: -- fan. That's first base.

THE COURT: -- to say 50 yards. And I'm thinking of the 50 yard dash from grade school, and I'm thinking, well, where would that eraser be? And so, I don't know. We'll -- we'll measure it out --

MS. STANISH: That's fine.

THE COURT: -- at the break.

MS. STANISH: I just want the record to be clear and I'm not good at measurements without a measuring tape.

BY MS. STANISH:

Q Would you please describe for us, ma'am, what the -- the place where the patients would, you know, lay down to recover or be rolled in on the gurney, I should say? Describe for me that area of the recovery room.

A Like I said, there was approximately four gurneys like side by side, and there was little curtains that would go around them.

Q So there were privacy curtains around the -- each gurney?

A Yes.

Q You've worked at hospitals --

A Yes.

Q - primarily for 22 years?

A Uh-huh. Yes.

Q And I don't know if the hospitals are configured the same as ambulatory surgical centers in this

regard, but is it unusual in your experience for patients to be in a recovery room separated by curtains?

A No.

Q It's not makeshift, is it?

A No.

Q It's something that is --

A It's even --

Q -- common?

A Yes, even in hospital rooms there's -- if it's a two-bed or a four-bed room it has a curtain that would go around the bed.

Q Correct. Okay. Were the -- how far were the recovery area -- how far was the recovery area from the procedure rooms?

A Directly across.

Q And could you estimate how many feet from the recovery room to the procedure room?

A To the procedure room door or to --

Q Yeah.

A 20 maybe.

Q Is that your --

A Yeah. I mean, it was fairly close. I'm not good with measurements, either.

Q I understand. I identify. Do you know how many doctors would be there on any given day?

A At times there was only one, and usually at the most two, I believe, from what I remember.

Q Did the doctors work in shifts?

A Yes.

Q Do you recall that -- I know we're talking about 2006 here. But in 2006 --

A Uh-huh.

Q -- when you were there, do you recall what the shifts of the doctors were?

A It tended to be broken down to morning or afternoon, I believe. Certain doctors would be there in the morning, and certain in the afternoon. And sometimes one of them might have been there all day.

Q That reminds me. The scheduling sheet that you had.

A Uh-huh.

Q Was that kind of a computer generated --

A Yes.

Q -- document?

A Yes.

Q And would it have the patient names and the time of their appointment?

A Yes.

Q And I believe you said there were approximately 65 patients scheduled on any given day.

A Yes.

Q And the -- was it your experience that there would be no shows?

A Yes, there would be.

Q Did that happen often?

A Well, I'm sure on any given day that not every patient showed up. I would say that would probably be rare for every single patient to show up.

Q So there's always --

A Some days -- you know, but some days most did show up.

Q All right. And if you know, colonoscopies require the patients to prepare for the procedure the day before by drinking some untasteful fluids; correct?

A Yes.

Q And cleaning out their system; correct?

A Yes.

Q And would there be times where patients did not adequately cleanse themselves?

A Yes.

Q Did that happen often, if you recall?

A On occasion. I wouldn't say quite frequently.

Q What would happen to those patients that didn't properly cleanse?

A They'd have to be rescheduled and go through

the prep again.

Q And those patients, so just so I'm clear on this, if I -- I come in for my appointment and is someone going to ask me about my prep, if I --

A Yes.

Q -- did a good job? And who would that be normally?

A Must have been the nurse that was asking the questions pre-procedure.

Q And then if that person didn't properly cleanse, they would be sent to reschedule the appointment?

A Usually -- I'm not sure.

Q Oh, you're not sure.

A I'm not sure whether most patients usually would say they prepped like they were supposed to and you wouldn't find out until the procedure was actually going on that maybe it didn't work so well for them.

Q And if it didn't work so well, would that mean the procedure would be cut short?

A Yes. Well, no, they usually did, you know, the whole procedure just to see if -- what they could visualize.

Q Uh-huh.

A And if they thought that, you know, they didn't get as good a, you know, visualization they should

have, yes, they'd have to be re-prepped.

Q And you --

A They might change the prep to something different for them.

Q Okay. And you know that because you had to review the preliminary report?

A Yes.

Q And is the preliminary report, is that a computer generated --

A Yes.

Q -- document? And what does that look like?

A There were some color pictures of different areas of the colon, and the esophagus and stomach, if they were they were doing the upper endoscopies also. And then, you know, like a synopsis of what was seen.

Q All right. So if you happen to have the patient who didn't cleanse properly and that was discovered during the procedure, would they be instructed to reschedule?

A Yes.

Q Would patients arrive on time for their appointments?

A I didn't have anything to do with --

Q Oh, that's right.

A -- when they --

Q I'm sorry.

A -- came in.

Q You're not in the front desk.

A No.

Q You were in the back. Right. Where do you work now?

A Rhode Island Hospital.

Q That's right. I asked you that. Are you full time, part time?

A Full time.

Q Okay. I have nothing further. Thank you.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Ms. Scambio -- I'll let her clear first. You begin your employment at Endoscopy Center in January of 2006; correct?

A Yes.

Q And your testimony was that you stayed there for five months?

A Yes.

Q So you would have left sometime in June of 2006?

A Yes.

Q And your -- you were in charge of the

discharging of patients, basically going over their records before discharge?

A Along with a couple of other LPNs, yes.

Q So you weren't the only one that was doing that in any one particular shift?

A No.

Q And you were -- your desk was in the recovery room?

A No.

Q Where was it?

A It was to the left of the nurse's station. There was another little room with a desk and a computer and a few chairs in there that we would bring the patient in and their family member.

Q Was that closed off --

A Yes.

Q -- from the recovery room?

A Yes. Not even near the recovery room.

Q Nowhere near it?

A No.

Q So the patients would go from the recovery room, into your office, discharge?

A They would actually go -- there was another area across from the nursing desk to the right that had four or five chairs over there that they would come and sit and

wait for us to go over their results.

Q Okay. But I want to be clear. You couldn't actually see the recovery room, or you could?

A I could.

Q But you were very busy, weren't you?

A Yeah.

Q So your attention wasn't directed at the recovery room all the time?

A No, it was more towards the chairs where the patients waited for me to bring, or one of the other nurses to bring them in to go over their results.

Q So when you testified that you didn't see a CRNA wheel a patient into the recovery room, you couldn't really see because you were busy, weren't you? Isn't that a fair statement?

A I didn't -- wasn't sitting looking at the recovery room all day, but at the times maybe one of the other nurses was doing discharge results over the -- in the room, I might have been on the phone which was at the desk for an hour or two calling patients from the previous day. So, yes, you had a good luck at the recovery area.

Q But your attention wasn't devoted to that the whole time you were on your shift?

A No.

Q So it would be fair to say that you don't know

if the CRNAs ever wheeled the patient into the recovery room or not, isn't that true?

A Not for sure.

Q Not for sure.

A Not for the whole day, no.

Q Okay. Now, isn't it also true that in the recovery room there was a recovery room nurse?

A Yes.

Q And that was an RN; correct?

A Yes.

Q And you are an LPN?

A Yes.

Q Can you tell me the difference between an LPN and an RN?

A An RN has more schooling. LPN goes to school for one year. RNs go for anywhere from two to four years, and they can do legally more -- more things than an LPN.

Q So there was an RN in the recovery room with the patient.

A It wasn't really a recovery room. It was a recovery area.

Q I'm sorry. Recovery area. And there was four beds in there?

A Yes.

Q And there was an RN in there?

A Yes.

Q And isn't it true there was also an RN in the procedure room?

A Yes.

Q And what were the RNs, if you know, what were the RNs responsibility in the recovery room?

A I wouldn't know exactly for sure.

Q And what were the RNs responsibilities in the procedure rooms, if you know?

A I don't know. I was never in a procedure room.

Q And, in fact, you never witnessed any procedures by the --

A No, I didn't.

Q -- by the CRNAs; correct?

A Correct.

Q And, in fact, you weren't employed on July 25, 2007, or September 21, 2007; correct?

A Correct.

Q So you can't testify as to what happened at all in 2007; correct?

A Correct.

MR. SANTACROCE: I have no further questions.

THE COURT: Any redirect?

MS. WECKERLY: Just two questions.

REDIRECT EXAMINATION

BY MS. WECKERLY:

Q When -- when you were -- when you were on the phone scheduling patients for the -- the follow up appointment --

A I scheduled the follow up appointment that day.

Q Oh, okay. So with the patients?

A In the -- in the discharge room, yes.

Q When -- when you were doing that, what was the -- how were you instructed to schedule the people?

A There were four slots every 15 minutes. So four patients would be scheduled in follow up in one 15-minute slot.

Q Okay. So four patients per 15 minutes --

A Yes.

Q -- for the follow up appointment.

A Yes.

Q And you mentioned that you worked with, in discharge, with another LPN, and there were times when you were directly meeting with the patients going over their results.

A Yes.

Q And at that time your attention was probably not on the recovery area.

A Yes.

Q There were times when you were on the phone, and was that for an extended period of time?

A Well, we had to make follow up calls for every patient's procedure from the day before, so it could be most of the morning.

Q Okay. And it was during those times that you did not observe CRNAs or doctors in the recovery area?

A Yes.

Q Thank you.

THE COURT: Any recross?

RECROSS-EXAMINATION

BY MS. STANISH:

Q Just for purposes of clarification, the folks that were coming in for their follow up appointments, would they go to a different facility than where you were working?

A I believe there was a couple of offices around the valley. There was one right at the endoscopy center on Shadow Lane that I worked with. It wasn't in that same room, but it was in -- in the same building.

Q Did it have a separate waiting room, or did it share --

A Yes, they had a separate waiting room.

Q Okay. And the people in the waiting room in the area where -- in the part of the building where you