like a lot of complaints to him. You know, those kinds of things.

MS. STANISH: Judge, if I can --

THE COURT: But -- but, you know, then you're presenting the evidence of 31 complaints, that's not going to come in any other way even if I were to say okay, we can get evidence of some of the complaints, you don't have all 31 people.

MS. WECKERLY: We have the complaints.

MR. STAUDAHER: Yeah, and they have a complaint.

MS. STANISH: I'm sorry, you're --

MS. WECKERLY: But, I mean, the whole point of them going through this line of questioning --

THE COURT: I get it. and I said you can get into it --

MR. WRIGHT: Excuse us for defending.

THE COURT: -- but only, you know, only in a -- a limited way and only in a certain way. Without you guys testifying about all these complaints, which is what I'm trying to avoid through the forms of your question.

MS. WECKERLY: Okay. But, I mean, that's why we're asking now rather than just springing it on him.

THE COURT: And I said you can ask him about complaints and then if he says that, yes, he knew about complaints you can ask and that doesn't -- and you still --

you know that --

MS. WECKERLY: Judge, we briefed this --

THE COURT: -- and he didn't say his opinion was this or that. You know, I mean the point of it was that this, you know, State opened but of course the -- the State continued to license this, notwithstanding any complaints. And where did the complaints go? I mean, were they found to be with merit, without merit. I don't know. I think we're --

MS. STANISH: Exactly right.

THE COURT: -- we're getting into some troubling area.

MS. STANISH: Judge, this -- if I may, because this was addressed in the briefing and as I recall Ms. Weckerly pointed to the fact that there were 30, 31 complaints that were filed. Correct me if I'm wrong. The Medical Board of Examiners took absolutely no disciplinary action on any of those -- writing -- and I practice before the Medical Board of Examiners so I have some idea of the procedures and so the -- the board writes back to the patient saying that there's not going to be any action, it's not founded. I mean, gee, if a criminal indictment is nothing --

MR. WRIGHT: And arrests, how many arrests? This is absurd.

MS. STANISH: -- I know. It's just -- there's no finding. And, you know, and then secondly, what are we

supposed to do when the -- in the way of a defense when the prosecution is disparaging our client, saying that he's such a cheapskate and putting people in harm's way? We're not entitled to address these matters as we have been doing through cross-exam through Dr. Carrol?

MR. STAUDAHER: Well, clearly they can do. I'm not precluding them from doing that. I'm just saying if they do it opens the door to us actually bringing in some evidence about the contrary.

MR. WRIGHT: It isn't evidence.

THE COURT: Well, what's your --

MS. STANISH: That's what you're doing all along.

THE COURT: I mean, what you're trying to bring in is the fact -- I mean, here's the deal. They can say yes, we continued to be licensed but now you want to essentially bring in an unsubstantiated complaint, which is clearly by definition hearsay that somebody's complaining that wasn't substantiated. I mean, they're allowed to say we continued to be licensed and we continued to be this and that --

MR. STAUDAHER: It's not that it wasn't substantiated, they took no action. They -- the letters are there, the information's there from not only individual patients but doctors --

THE COURT: Were they substantiated?

MR. STAUDAHER: That this actually happened?

THE COURT: No, that there was a complaint and was the conduct complained of ever substantiated or was it that --

MR. STAUDAHER: They acknowledged -- they acknowledged that -- that these things happen.

THE COURT: No, they --

MR. WRIGHT: No.

MS. STANISH: No.

THE COURT: -- did they acknowledge they had -- well, give me that complaint -- give me again the -- I mean, here's the thing. Somebody makes a complaint. I mean, there's complaints made all the time where nobody even investigates it. There's complaints made to the Bar about lawyers. There's complaints made to judicial discipline all the time and after an initial review. If they don't think that it may have some merit, they don't even do anything about it and you don't even know about it. Then they may determine, okay, well maybe there's something here and there could be contact to a lawyer or something like that. Okay? That's the first step.

And then after interviews and this and that, they may determine, okay, we think there's merit here and we're going to go forward with this. But the fact that someone sends a complaint in doesn't necessarily mean it's been substantiated by the board, that it had any merit. I mean, so you have to say A, did they even think it may have merit? B, was the complaint substantiated, meaning the conduct occurred? And

then C, was any disciplinary action taken or were they forced to remedy a situation based on the complaint? Was suspension or further -- I'm assuming it works similar to a lawyer. Was suspension or further education or something like that, any kind of action. Was there a hearing? I mean, just the fact somebody sends in a complaint --

MR. STAUDAHER: That's not what we're talking about, Your Honor.

THE COURT: Okay.

MR. STAUDAHER: What we're talking about is in a nutshell is this. There are complaints that obviously come forward. There's -- there's supporting information from those individuals that comes before the board. The reviewer sees this, looks at it, looks at what supposedly transpired and says I cannot say that that isn't something that is, you know, within the realm of normal or that it wouldn't be just a -- something that could have been a bad complication for normal practice. Once they get to a certain level with the number of complaints that come in, it generates a letter to Dr. Desai saying look we got this --

THE COURT: You're receiving an excessive number of complaints.

MR. STAUDAHER: -- and this is what we suggest you do. There's not just one letter from the board, there's at least two or three letters from the board on the same issue.

And it's different reviewers, we've listed them as witnesses potentially in the case, but we got the people who actually wrote the letters to Dr. Desai from the board basically saying you're on notice about this and you probably should take some corrective action. Now that rises to a higher level -- that's not just somebody that gets a complaint and they say oh, this is a lady with sour grapes, we're not going to even deal with this.

THE COURT: Okay. And what was -- refresh -- I mean, I know, there was a motion and it was months ago. There's been a lot of subsequent motions and other issues. Refresh my memory. What was the corrective action that was advised?

MR. STAUDAHER: That he has to slow down is the main thing, that he should take more time with his patients, that he should probably do --

THE COURT: That was advised in the letter from the board?

MR. STAUDAHER: Yes.

THE COURT: Is that -- is that true?

MR. WRIGHT: Slow down his procedures? No, ma'am.

MS. STANISH: Yeah, I'd like to see that.

THE COURT: Okay. Here's the way, if that's correct, you can say, are you aware that -- or, you know, that he -- Dr. Desai received a letter from the board telling him to slow down his procedures.

MR. WRIGHT: Let's first --

MS. STANISH: No, let's see the letter first.

MR. WRIGHT: -- I don't want them fishing.

MS. STANISH: I don't think that's correct.

THE COURT: Well, I'm going to the letter.

MR. WRIGHT: I wanted to ask outside of the presence of the jury. His questions, half of his questions are introducing evidence --

THE COURT: So are yours. I mean, unless you --

MR. WRIGHT: I'm cross-examining supposedly. He cross-examines more than I do.

THE COURT: Well, here's the thing. First of all, I need to see the letter again. What did they actually tell him in the letter? And then it's only relevant with this witness if he knew about it.

MR. WRIGHT: But if he doesn't it's out of the bag. They're supposed --

THE COURT: I'm trying to -- that's what I said, he couldn't ask the question, are you aware there's been 31 complaints. Mr. Wright, I already told him he couldn't ask that question, it's assuming facts. I'm -- I already said that. The issue right now is whether he can ask any questions about this. I've already said, they haven't given me enough information on the lawsuits for me to -- to me to form an opinion one way or the other as to whether or not that could

be relevant. You know, one lawsuit -- even if they're settled.

First of all, if they're settled that's always confidential so I'm sure nobody would necessarily know what the terms of that -- that is. All it would show is a settlement and dismissal on [indiscernible]. That's probably all we're going to know.

(Court recessed at 3:28 p.m. until 3:34 p.m.)

(Outside the presence of the jury.)

THE COURT: Yes, Ms. Stanish. I think --

MS. STANISH: You know --

THE COURT: Are we on the record?

THE COURT RECORDER: I am.

THE COURT: Okay.

MS. STANISH: I thought it might just be helpful to review the motions again. I mean we addressed it. I myself don't have the detailed recollection. I know we had a problem with having to have a bunch of mini-trials on medical malpractice and the need for additional documentation and review of this.

MS. WECKERLY: We're not asking to bring it in affirmatively, we're just asking about a question on cross given what was elicited on direct.

THE COURT: Well, it's only relevant, A, if he knew about it --

MS. WECKERLY: Right.

THE COURT: -- so you can ask him, you know -- well, first of all, it's only --

MS. WECKERLY: The testimony that was elicited on direct is that there was this quality control certification from AAAHC and they accredited the surgical center and they watched the procedures and they looked at the books and they came to the conclusion it was quote, a model unit. So that's what it's --

MS. STANISH: That certificate's in the government's exhibit, if I'm not mistaken, right?

MS. WECKERLY: Right, right, yes.

MS. STANISH: All right.

MS. WECKERLY: We're not disputing that that occurred but we're asking -- we'd like to ask about it.

THE COURT: Well, you can ask, you know, if they're aware -- is he aware of any -- well -- what -- I mean, what was the out -- does anybody have the letter from --

MS. WECKERLY: Mr. Staudaher's looking for it.

MR. STAUDAHER: I'm looking for it, Your Honor.

THE COURT: Unfortunately, Ms.Stanish, we don't have paper files so we --

MS. STANISH: Oh, right, right.

THE COURT: -- have to go back through Odyssey to try to find the motion, which I can do but it's not like I can

just -- well, it's not like the good old days where I can just go through the file and flip to it --

MS. STANISH: Pull it up on the -- you can't pull it up on the computer like in a federal case, I understand.

THE COURT: Oh, well, that was awhile ago. I mean I can -- it would be motion to introduce evidence of other --

MS. STANISH: Right, yeah.

THE COURT: -- bad acts or --

MS. STANISH: Okay.

THE COURT: Why don't we do this? Let's get started again. Can you do that and Ms. Weckerly maybe work on finding the letter and then just approach?

MR. STAUDAHER: Yeah, we can -- we can do that.

THE COURT: Can we do that? Due to the late -- I mean certainly if you are allowed to ask the question you're not going to be allowed to say, are you aware that there were 31 complaints? You can say are you aware of complaints made against the center or against Dr. Desai --

MS. WECKERLY: Yeah, I mean --

THE COURT: -- and whether, you know -- well, yes. Was any action taken?

MS. WECKERLY: Sure.

THE COURT: That would be --

MS. WECKERLY: I mean, I would think that would be legitimate given what they've elicited regardless of what we

have.

THE COURT: -- that would be the extent of --

MS. STANISH: But if I may, in your --

THE COURT: -- questioning --

MR. WRIGHT: And if the answer's --

THE COURT: What?

MS. WECKERLY: And if it's no, it's no.

MR. WRIGHT: Okay. So I can ask each of these -- I mean I can ask questions when I have no basis and fact for them?

THE COURT: Well, they have a basis --

MR. STAUDAHER: That's not true, we have basis.

THE COURT: -- and fact. They're aware of --

MR. WRIGHT: But he knows it?

THE COURT: Well, how do we know if he knows it or not?

MR. STAUDAHER: That's what we're going to ask.

THE COURT: It never came out but it's not --

MR. WRIGHT: That's what you asked in the middle --

THE COURT: -- like they're -- they're not on a fishing expedition.

MR. WRIGHT: -- of the presence of the jury.

THE COURT: They know there's been 31 complaints. They know that so it's not -- I can't say -- I mean, they're not -- they're not fishing about complaints, they know about

the complaints.

MR. WRIGHT: So they --

THE COURT: I mean, you don't ask a witness in a pretrial every conceivable thing. Oh, do you know this and do you know --

MR. WRIGHT: So I can ask every witness this?

THE COURT: -- and if they did then you'd say they were coaching him. So I mean --

MS. STANISH: If I'm not -- if I'm not mistaken, these were not all against Dr. Desai personally, some of them were against other doctors, if I'm not mistaken.

MS. WECKERLY: Right.

THE COURT: Well, we have to -- I think it's relevant if it's against the clinic, practices at the clinic. Right now he's going to find them, I'm going to see what it is again and would you go get the law book?

MS. STANISH: And if I'm not mistaken, I thought Ms. Weckerly conceded in her brief that none of these complaints were --

MR. WRIGHT: Were substantiated.

MS. STANISH: -- substantiated -- or what was the term you used?

MS. WECKERLY: They took action but it doesn't matter now because it's not a bad acts motion anymore, we're asking on cross. We're not asking to put this evidence in, this

Court hasn't made a ruling on that. But when they elicited that they got this certification on direct, it made these complaints and the issues with the medical board relevant. If they got a certification as model unit, certainly if this witness has knowledge about possible complaints or letters to remedy the practices at the clinic, it goes directly to that issue.

THE COURT: That would be the only -- the only relevance. And again, you can't ask it in a way that you are getting testimony but we're going to have you guys approach the bench with the letter once he finds it. In the meantime, we're going to bring the jury in and Mr. Staudaher you can turn that over to Ms. Weckerly and you can resume your redirect. When -- all right. Does Kenny know to bring the --

MR. WRIGHT: It still only comes in as another bad act.

THE COURT: Well, no, it's to -- it's to -- it's to show, okay, one opinion was that this was a model facility but there were other -- there's other evidence that it wasn't a model facility. That, you know, that you're getting letters from the board saying you need to take corrective steps. So that's -- it's counteracting that other evidence, if this is such a great facility. It's not to say that he acted -- I mean -- but I need to look at the letter again and see if it's -- you know, again, you know, unsubstantiated complaints.

(Jury reconvened at 3:42 p.m.)

THE COURT: All right. We need to get the witness again. Everyone may be seated.

Sir, come on up here to the witness stand and have a seat again.

And Mr. Staudaher, you may resume your redirect examination.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q When we left off we were talking about the anesthesia sort of charges. Do you remember that?

A Yes.

Q And just so we're back in place, on direct examination -- or cross-examination you were talking about a -- a facility charge, a doctor charge, and an anesthesia charge.

A Correct.

Q Now, prior to the CRNAs coming into the practice, were you able to charge for an anesthesia charge?

A No.

Q Okay. So that -- who would have charged for that?

A That's part of the facility fee.

Q Now, I'm talking about the person that would administer the anesthesia. Who could charge for that?

A I understand. The anesthesiologist could charge for that.

Q So prior to CRNAs, you could only charge the facility charge and the doctor charge; is that fair?

A Fair.

Q After the CRNAs you could then charge for the CRNA charge?

A Correct.

Q Now, were you aware in any discussions you had regarding this issue with -- because you said the entirety of your information came from Dr. Desai, correct?

A About what?

Q About the CRNA billing or charges or anything -- well, the CRNAs and supervising physicians and all that.

A Well, remember like I -- like I mentioned before, the concept of supervisory role or official supervising, to my recollection was never discussed with me until after this event occurred when I learned about this.

Q Were you aware at the time that you had these discussions with Dr. Desai that if you brought CRNAs in that you could bill for their services?

A Was I aware of that? I think I was aware of that. I just didn't know how that would work but I was aware of that, yes.

Q Were you aware that there had been any

discussions with Dr. Desai and I think you said a verbal agreement between Thomas Yee and Dr. Desai, correct?

A Correct.

Q Do you know how that financial arrangements, if any, would go with that?

A No.

Q I mean, did you know that essentially if Yee was involved that he would actually get the anesthesia billing?

A No.

Q You had mentioned that when you were at -- went through the whole litany about symptoms from hepatitis and all those things, you mentioned that one of the things that can happen is that a person can develop cirrhosis of the liver; is that right?

A Yes.

Q And you -- I think you mentioned that this was a process that typically took 15 to 20 years?

A Correct.

Q Is it reported in cases that it can actually happen much earlier than that?

A I don't know, even as an expert. I've heard of cases with accelerated cirrhosis before but I'm not -- I can't tell you've seen an article or a study about that.

Q Now you were also in the same vein of questions, you were asked about typically from the time of inoculation I

think is what counsel used as the word, to symptoms --

A Correct.

Q -- if -- if it's going to be an acute case --

A Correct.

Q -- right? You said -- I think you mentioned four to 12 weeks is the average?

A That's correct.

Q Is there -- I mean, how far out can it go typically before you could still have symptoms and -- of this type of an acute infection?

A The answer is I don't know because if there's any say outlier case that is longer than that, I'm not aware of it.

Q Okay. And you know that the health district notified people who had been exposed for a period. I mean, they were looking at people for six months. Does that ring a bell to you at all?

A Yeah, it rings -- it does ring a bell in terms of what they had planned on further testing, yes.

Q Now, you also mentioned related to that that they went back in time and -- and I think you were talking about a meeting that you had with Brian Labus where they talked about how far back they were going to go in the notification, correct?

A Correct.

Q In that same meeting, did -- I think you said they related that at least some of the CRNAs that they had observed, even mentioned to them that they had been doing this practice for a long time.

A At that meeting?

Q Yes.

A No, that's not accurate.

Q Okay. What is accurate?

A What's accurate is that Brian Labus said to me that this was the practice that we think caused this transmission, the changing of the needles as we've discussed.

Q When he was talking to you about how far back they were going to go, did he say why they would go back that far?

A No. What he said was since we cannot determine how far back this practice goes, we will start our notification beginning in 2004 when you had -- you opened your new center.

Q Did he indicate that -- that -- what information had been provided to him in making that determination? Meaning, provided to him by the CRNAs that they interviewed.

A They -- he did not.

Q So you weren't privy to any of that?

A No.

Q Were you privy to any of the real investigative

materials that they had talked about and -- and investigated, whether it -- you know, the different transmission sources, things like that?

A No.

Q And you yourself said that you went back and looked at those results -- those -- those actual patient files because you had access to them?

A Correct.

Q When you looked at those patient records, was -- I mean, I know one thing stood out, the time on the anesthesia records, but did anything else stand out as far as a possible commonality between the patients as far as a possible, you know, transmission source?

A On -- well, let's see. Like I've said before and I hope not to be too verbose but the transmission had to have occurred either in pre-op or during the procedure or post-op, there's -- there's no other way. So I didn't identify a commonality to those source -- to those patients that would put me in any one of those directions.

Q Are -- you're not an epidemiologist, right?

A No, I'm not.

Q I mean, have you ever been even remotely trained as an epidemiologist?

A No, I have not.

Q Do you know what one does?

A Yes.

Q What do they do?

A An epidemiologist is a person who looks at disease patterns and transmissions across populations and looks for -- and is involved in the management of identifying sources of infection and intervening to -- to decrease those possibilities.

Q So when they came -- when the CDC and health district come into the clinic, I believe your testimony was you were there when that happened?

A Yes.

Q So they come in and you're on the -- where are you in the facility when that happens?

A I'm on my way, literally walking from the medical side to the endoscopy side when I get the phone call.

Q So you didn't actually see them come into the building or anything like that?

A No.

Q When you contact them, did you say you were on the fourth floor of that building?

A I was on the first floor and I went up to the fourth floor where they were at Tonya's office.

Q That's what I meant. When you came in contact with them where was it, was it up there?

A Yes.

Q So they weren't milling around down in the endoscopy suites or in the -- in the file rooms or anything like that at that point? They were up in Tonya's office?

A Correct.

Q You get called up there, correct?

A Yes.

Q Now, when they came over that was the -- at least the call from Tonya was the first time I think you said that you had any inkling that they were coming over.

A Call from Dr. Sharma.

Q Sharma, I'm sorry. I mean you get the call from Dr. Sharma, you're to go up there?

A Yes.

Q When you met with them how many people were there?

A To the best of my recollection three or four.

Q Now, on that day, did you know that they were coming?

A No.

Q When you get up there and talk to them they tell you why they're there obviously?

A Yes.

Q And -- well, did I understand you correctly that they were going to come back the next morning and start to do some looking around?

A Yes.

Q So what time of day is this that they roll over to your clinic? Or when you actually contacted them up on the fourth floor?

A I think it was early afternoon or late morning to the best of my recollection.

Q So early in the day then?

A Yes. It wasn't, to my recollection, at the end of the day.

Q Now, the fourth floor, what is the fourth floor?

A The office building where we practice had four levels, different offices, different practices. On the fourth floor we had our -- our management offices up there and that's where Tonya's office was.

Q So there's no medical stuff going on up there at all?

A Correct.

Q Are there records up there?

A No, there are no medical records up there to my --

Q So it's mainly administrative stuff?

A Yes.

Q Billing, things like that?

A Billing is up there.

Q So do they then leave? Did they leave the

facility?

A To my knowledge, yes, they did.

Q Because you were there, right?

A Yes.

Q So they leave that day. So they don't -- they're not inspecting that first day?

A Correct.

Q Now, when they came back, do you know what they did when they came back?

A They started the investigative process. All the different things they wanted to do, look at records, look at procedures, interview staff, take our blood for analysis, they began that process.

Q Do you know how many days into the investigation -- because you had on cross, rather you said it was about a 10 day window that they were there, correct?

A Yes.

Q Does that include the first day when they came and just say we're going to come back?

A No, that -- that means the investigation process.

Q So 10 days they're physically on the site looking at stuff?

A Yes.

Q Do you know how many days into the investigation

it was before they actually came down and observed procedures in the procedure rooms?

A It -- it would be a guess. I don't really remember how -- how -- when that started.

Q If there was indications it might have been three days or something. Would that be about --

MR. WRIGHT: Object to guessing. He said he doesn't know. We'll have witnesses here day by day.

THE COURT: Overruled. He can answer.

BY MR. STAUDAHER:

Q I think we've actually already had that testimony, I'm just asking if that comports with your memory of the events; is that right?

A It comports --

THE COURT: Does that sound about right? That's the question.

THE WITNESS: It sounds about right to me.

BY MR. STAUDAHER:

Q The point is that even the first couple of days they weren't in the procedure rooms, right?

A I don't remember if they came in on the first day. They may -- they may have, I honestly don't remember what they started doing.

Q So they come back, they do their thing and then they leave, right?

A After the 10-day period.

Q Now, other than this exit interview where you get just some cursory information that Mr. Wright asked you about, did you have any further actual information about the things that they had found in the records, observed in the procedure rooms, statements by the employees, anything like that?

A No.

Q Now when you did your investigation and you said you did kind of an independent one yourself, right?

A Yes.

Q When you did your investigation, decide looking at the patient files and the records, did you interview any of the -- of the people?

A No.

Q I mean, I'm talking about maybe even people that were working on those days?

A No, I didn't.

Q Was there a reason why you didn't ask them if anything untoward had happened on those days or if they recalled anything, anything like that?

A Honestly, I just don't remember thinking of doing that.

Q Okay. But that's what an epidemiologist would do, right?

A Yes.

Q And to your knowledge, did they -- not only look at the records and observe, did they interview people?

A Yes. They were talking to people but, you know, I -- I knew more about that they had interviewed people after the fact.

Q So their investigation continued on after they left?

A No. I wasn't present during the time when they -- when they ostensibly sat with people and interviewed them. So did I know at the time, in real time, that they were interviewing staff? I'm going to have to say I didn't know that they were interviewing staff.

Q You learned at some point that they had done that?

A Yes.

Q And did you ever go back and follow up? I know you didn't do it initially, but did you ever go back and follow up to confirm what some of the things you were hearing had -- whether they had happened or not? Did you ever talk to Doctor -- to Mr. Lakeman and confront him? Give him a call and say, hey, look they're saying these things, did you ever do these?

A No, I did not call Mr. Lakeman.

Q Did you ever confront Dr. Desai and say, look

this is what they're saying, did you know anything about this?

A No, because I first learned that -- about this at the exit interview. So I don't -- I think maybe Tonya told Dr. Desai about it, but I don't remember talking to Dr. Desai about it.

Q Now, you mentioned a situation after the events took place and after you wrote your -- your sort of policy that you had every CRNA sign off on, right?

A Yes.

Q You said after that happened everybody signs off on it, you're in a room and you observe Linda Rhubarb.

A Yes.

Q You observe -- you're doing -- what -- at what stage of the procedure were you at when you saw this happen? This -- it's what you called -- did you call it pooling?

A Well, I called it -- I didn't call it pooling, I didn't use that term.

Q I'm sorry. What term did you use?

A I just -- I just labeled it as not discarding the bottle and holding it for the next patient. I didn't give it a term.

Q What did you see her do with the bottle?

A I saw her maintain it or hold on to it and put it on a brown table and not discard it and save it to use for propofol for the next patient.

Q Now, until the CDC came in, until you started doing things like you just described, were you paying attention to what the CRNAs were doing? Actually physically doing in their procedures during the time that you're -- you're doing your endoscopies?

A No.

Q So did you not pay attention to it or did you not see it at all?

A No. It wasn't in my consciousness or awareness that there was any issue or problem about propofol administration. I was never advised of it, never learned about it, or never heard of it. So to say was I not watching, I wasn't aware to watch or to look or to observe whether the propofol bottles were being used correctly. It was sort of an assumption that what was happening was proper.

Q Now you mentioned that Quality Care Consultants came in and did some work?

A Yes.

Q Who was Quality Care Consultants?

A Well, I learned at the time that Quality Care Consultants comprised two physicians --

Q And who are they?

A -- Drs. Anwar and Dr. Khan.

Q Were one of those individuals on the State Medical Board at the time?

A Dr. Anwar was.

Q And what position on the State Medical Board did he hold?

A I don't know.

Q But you're aware he was on it?

A Yes.

Q And the State Medical Board is what?

A The State Medical Board is that agency within the Nevada government that oversees licensure of physicians.

Q When they came in, what did they do? Those two -- it was just those two doctors, right?

A It's hard for me to tell you --

Q Is that right first of all?

A Yes, it is.

Q Okay.

A So they did some analysis, some evaluation of our practice, of our endoscopy practice. What that is and what that comprises I'm not exactly sure because I --

Q Did you see any report generated or anything like that afterward?

A I don't know if I -- I may have seen the report, I don't recall. But they did generate a report.

Q Do you know how many days they were there doing this work?

A No.

Q Was it more than one?

A Yes, it was. They were there at least two days.

Q Now, you mentioned that there was this entity called AAAHC?

A Yes.

Q And accredit -- is that a voluntary accreditation entity or is that something that's mandatory for these kinds of centers?

A It's voluntary.

Q So you choose to have them come in and look at you and then give you this accreditation?

A Right.

Q Is there any portion of that accreditation where you self report things?

A I don't know.

Q Well, when the people came in, how many people came into the facilities?

A Two.

Q How long were they there?

A I don't remember, a number of days, a few days, not many.

Q Three, five, 10?

A Two to -- I would say two to three days.

Q So about the same time period or frame that Quality Care -- Care Consultants came in?

A Similar.

Q So they were there about the same length of time?

A To my recollection, yes.

Q So we've got two people from Quality Care that come in at one time and do their thing and two people that come in from AAAHC and inspect?

A Yes.

Q And they're there about the same time period?

A It's the best I can recall for you.

Q Now, when AAAHC came in, were they just looking at your facility or were they looking at other facilities too?

A I don't know. I believe they were looking only at ours.

Q I mean, when I say yours, I mean the ones that were part of your group --

A Oh, I see.

Q -- medical group?

A I think at that time they were looking only at our endoscopy one or Shadow Lane facility.

Q Now beside AAAHC and Quality Care Consultants, you mentioned that there was another one, a Jaco?

A Yes.

Q What is that?

A Well, Jaco is an organization that oversees and

accredits hospitals and surgical centers.

Q Is that a voluntary type of organization or is that something that's mandatory?

A For surgical centers I think it's voluntary. For hospitals, I'm not sure.

Q So they came in as well?

A They -- they -- I don't recall them coming in. I just mentioned that those -- that is one of the accrediting --

Q Okay. I want to make sure, so they didn't -- they never accredited you?

A No.

Q So the only two accrediting -- or -- did -- did Quality Care Consultant accredit you or --

A No, they were not an accreditation company.

Q They were just checking to see if everything was --

A Right. They were hired to check, whatever that means.

Q But did -- you didn't know what exactly they were looking at?

A No.

Q Who dealt with them?

A It was not me. I think --

Q Do you know who dealt with them?

A -- Dr. Desai dealt with them predominately.

Q Now, beside those two entities, was there any other outside body that came in to inspect you and do things beside the BLC that you've talked about later?

A Not that I'm aware of.

Q And the BLC is the -- at least at that time was the Bureau of Licensing and Certification?

A Yes.

Q Were you there at anytime when they came onsite?

A Prior to these events?

Q Yes.

A No, not that I recall.

Q Now when AAAHC came to your facility to do the voluntary accreditation, did you know they were coming?

A Yes.

Q So did -- is that something you actually had to arrange for them to come out since it was a voluntary thing?

A Yes.

Q How far in advance did you have to arrange for them to come out and was it something you called them up and they were there the next day or was it a -- you know, you had to arrange it a month out or what?

A The answer's I don't know because I didn't make those arrangements. The reason I know that it was ahead of time because we -- we knew that they were coming, we were

told.

Q Okay. So you knew that -- was it well in advance though of their coming in?

A Yes.

Q Was it the same thing with Quality Care Consultants, did you know they were coming? Were they asked to come in as well?

A Well, I -- the answer to your first question is I did not know they were coming and I didn't ask them to come. I didn't know who they were and why they were there.

Q You just know that they were there?

A I saw them -- I saw the two doctors there one day.

Q You mentioned in response to some questions about the actual procedures, do you remember they were asking about -- or being asked about the setup and you said it was efficient and how you --

A Yes.

Q -- run that many patients through?

A Yes.

Q Whereas before you couldn't because it was a different situation?

A Right.

Q Walk me through, if you would, and I know this may be a little tedious but I -- I do want to get an idea of

it since you asked -- you answered those questions. In a situation where you're going in to do an endoscopy or colonoscopy, other than the procedure taking a different length of time depending on what you're doing, what are the -- what are the time frames that we're talking about between a patient rolling through the framed door -- frame of the door, into the room, rolling back out until the next patient actually rolls in. Tell us about the timing related to that as best you can.

A Well, again, it varies. So if there's one doctor starting out the day like on September 21st, like me, starting out the day alone, once I finish the procedure, say in room A and I finish my note and I walk over to room B and the patient's ready. The patient in room A is going to be there for a certain period of time to finish the vital signs that they want to have post-sedation and then taken to recovery area.

Then within a minute or two, if the next patient is ready, that patient is wheeled into that room prior to me finishing the procedure in room B. So by the time I get to -- back to room A that patient is ready. So the time between a patient leaving into the recovery area and the next patient being rolled in is a matter of a few minutes or less.

Q A few -- so it could be even as short as a minute?

A It can be -- sure, it can short as a minute or two. So imagine, the patient's being rolled out into a recovery area where there's curtains and the next patient is ready in a curtained area in the gurney, IV perhaps already in most likely and ready to come right in and a staff member rolls that patient right in.

Q And that's what I'm asking about. So you've got -- if I understand you correctly, what you just said, was that the patients that come into the room are on a gurney in what is termed the recovery room to start off with?

A Yes.

Q And from that room they come into a room?

A Yes.

Q Get their procedure and then did they go back to the same place?

A They go back to one of the five bays, one of the five curtained bays to -- for recovery.

Q So at any one time, how many of that -- those five bays are lined up with patients that are going to have a colonoscopy versus the ones who have just had one and have gone out to the recovery area?

A So again, that will -- that will vary as the day moves on. But at any given time there are patients who are recovering and patients who are ready to come in. Now, there may be a time, as I remember, that the recovery beds are

filled with patients who are recovering and there may be a patient up to one, two or three in the IV room sitting in one of those chairs in a curtained area, with an IV in waiting to be brought into the -- to the operating room or the endoscopy room.

Q But there would be no bed in those rooms, correct?

A We had enough gurneys for that I believe, we had a gurney. There'd be enough gurneys, there weren't just five as I remember, there were more than that.

Q How many more are we talking about?

A I think maybe seven. Again --

Q So there was one for each bay and then one for each room; is that right?

A As I remember. I can't be -- I can't be 100 percent sure of that.

Q Okay. Mechanically though, the patients are staged outside, come in, then go back outside to the same area?

A Yes.

Q Now, the turnover time between procedures when there's two doctors present, how does that work?

A When there's two doctors present it's literally like running two surgical centers. That room A, for example, if I'm in that room and room B has another doctor, I finish

the procedure, the patient is wheeled out to the recovery area and if the next patient's ready, then that patient would be wheeled in immediately to that room. If the patient's not ready I waited.

Q So the turnover time, would it be -- since your -- this is not a situation where they can take their time to get a patient in and out of a room while you're doing a procedure, you know you've got two doctors that are basically wanting to just go it sounds like.

A Right.

Q Patient rolls into your room, you're stuck in room 1, that's where you're going to be this day, at least for that time period.

A Okay.

Q The patient rolls in, you do the procedure, patient rolls out, next patient's going to roll in.

A Yes.

Q Are you following me? The turnover time for that is about how long then?

A Again, if the patient -- if the next patient's ready or if there's a, you know, a bed available or there's enough room in the IV room, if the patient's ready, it's within a minute or two they come right in.

Q Now what happens in that room from the time the patient leaves until the next time -- next patient rolls in,

what's going on in that room?

A The room is being -- anything on -- any debris on the floor is being picked up, new equipment is being ready, the scope is being ready to put onto the endoscopy processor, medicine is being ready for -- for administration to the patient, people are doing things to get the room ready.

Q Are they cleaning the room?

A No. There's not -- it's not being wiped down, you know, between cases.

Q What about a mop on the floor, anything like that?

A No.

Q So no cleaning of the rooms, just moving patients in and out; is that fair?

A Right. There's no -- again, to answer your question, is the room being mopped or cleaned between? Not that I remember.

Q Is it being cleaned in any way? I just want to make sure I'm -- I'm clear about that. You see somebody coming in and, you know, spraying down the beds or the gurneys or anything like that?

A The gurneys, not in the room, but on the outside if -- when a patient leaves the facility, that gurney is cleansed with antibacterial and virucidal solution completely.

Q Did you see that?

A Oh, yes.

Q On a daily basis?

A On a daily basis I did. I saw the -- those gurneys being cleaned all the time.

Q Okay. So when -- so now we've -- now I've got a picture of -- in my mind, I want to be clear on this. I mean, how many -- when you see that, how many of these beds are you seeing getting cleaned at any one time?

A There might be one or two being cleaned if -- if the patient has left, has exited, the sheets are taken off, the bed is cleaned, it's sprayed and wiped down.

Q You mentioned sheets, what about sheets? Was there any issue about using sheets in the clinic?

A Not that I was aware of. The sheets -- we -- we sent those sheets out to be cleaned. We had a laundry contract and those sheets were laundered and washed by a contracted provider.

Q Did you ever hear Dr. Desai say anything about not allowing patients to even have sheets to cover themselves with?

A No. I never heard that when it was happening. I heard rumors about that afterwards but not during -- when I was there.

Q Did you ever see that yourself?

A No.

Q Did you ever see Desai go up and actually take a sheet off of a bed and -- because somebody had used more than one and folded it up and put it back on the shelf or under the bed or anything like that?

A No, I never saw that.

Q Would that have alarmed you if you would have seen him doing those kind of things?

A I don't know that I was aware of what was happening. Again, I didn't have that awareness that that was -- there was anything happening like that.

Q Well, but you're -- you're observing things throughout the day, correct?

A Yes, yes.

Q Now, beside the fact that you're in a room, physically when they're moving the patients in and out, what are you doing during that time?

A I'm doing my notes and getting ready to see and do the next patient.

Q Do you ever follow the patients out and meet them at bedside and talk to them?

A Yes.

Q Did you do that on a regular basis?

A I did that on a regular basis when it -- it was definitely my policy, my practice, to talk to patients when there were findings. If there was an issue or finding or

tumor I made sure I spoke to the patient to make sure the patient understood to come back and see me or someone to follow up and to get proper treatment. Now, I didn't do that with everybody. Most -- most cases ended with no -- no findings. But I made sure that if there was a finding I spoke to the patient and that could occur in the recovery bay or that could occur in the -- in the discharge room.

Q So in the -- most cases where it -- there weren't findings, would you go out to the bedside and see the patients?

A No. Most cases it was to the recovery bay so my -- my practice was to say, and I said this many times, this patient cannot leave without me speaking to him or her first. And that usually would occur in the discharge room when there was a finding.

Q When there was a finding. But I'm talking about most of the times when there's no finding, are you talking to the patients there afterwards?

A No, the checkout nurse is -- the checkout person is.

Q Okay. So if the records show that literally every one of your cases you're at bedside on those days, that's not accurate, right?

A That's not accurate.

Q Now, the -- you had mentioned on cross that you

would do between four and five procedures an hour, you felt you could do that comfortably?

A Yes.

Q Just so we're talking -- we're looking at between what, 10 - 15 minutes a procedure; is that right?

A Ten, 15 minutes a procedure or -- or even less if it's an upper endoscopy.

Q And that's including the turnover time between patients that you talked about --

A So I like to be clear. When I say to you a few minutes for an upper endoscopy, I'm talking about the procedure time, what I do. So when I say it takes a few minutes to do an upper endoscopy, I'm talking about what I do once I insert the camera, look, take biopsies and pull the camera out.

Q So if you say that it takes three to five minutes or five to six minutes or whatever it is for an upper endoscopy, that's just procedure time?

A Yes, and for -- for me that's usually around three to five minutes.

Q And for colons it was about what?

A It varied. It could be anywhere from six or seven to eight minutes to 10, 12 minutes.

Q But on average that's what we're talking about?

A For me, yes.

Q So we would have to add on this couple of minutes each time for the turnover; is that right?

A Yes.

Q But still within that time period you think you could do the mixture of upper endoscopies and colonoscopies, four or five an hour?

A Yes.

Q Now, four or five an hour is not two an hour, right?

A Right.

Q And what I mean by that is you've seen those anesthesia records?

A Yes.

Q You saw that they were all 31, 32 minutes of anesthesia time, meaning in time -- under anesthesia, correct?

A Correct.

Q That would be at maximum two an hour, right?

A Two an hour per room.

Q Thirty minutes -- half -- I mean half an hour would be two procedures per hour.

A Yes.

Q In your experience, did you do procedures at that speed?

A No.

Q You've looked at this -- the charts where it

shows all of the different times, correct?

A Yes.

Q You mentioned I think that the start time for you was about 6:45 to 7:00?

A Yes.

Q And you tried to finish at 3:30 to 4:00 in the afternoon, something like that?

A Well, that was -- be an average. It could longer, 5:00, sometimes 6:00.

Q Okay. But on average?

A Four o'clock.

Q So we're talking 10 hours a day, something like that?

A Nine hours a day.

Q Okay. Nine hours a day, even let's give it 10 hours a day just to --

A Okay.

Q -- to make it easy. Thirty minutes a pop, 10 hours a day, how many -- how many procedures would we be able to do if it was 30 minutes?

A That would be two procedures per room, 30 minutes, times 10 hours would be 20 so 40.

Q Forty. And you've seen the numbers on those charts, right?

A Yes.

Q Is that possible?
A Is -- is --
Q You were there on those days, right?
A Yes.
Q Is that possible?
A I was there on September 21st.
Q Yes.
A So is what possible?
Q Is it possible to do the number of patients on that day as it says there is time on the anesthesia record?
A No.
Q Now you mentioned that there were times -- I think you even said that you had covered for Dr. Carrera when he had some sort of medical emergency -- personal emergency medical emergency, correct?
A Yes.
Q And that you did on that day 50 procedures in that one day?
A Yes.
Q Did you do all of the procedures that were done that day or -- or how did that work?
A On that particular day I did every procedure.
Q And that's 50 that were actually done?
A Yes.
Q Now the day in question, on the 21st when you

were there, we're talking in the 60s, correct?

A I think it was 61, 62. Again, you would have to show me but it was 60 -- a little -- 60 or more.

Q Thirty-two patients in one room?

A Sixty -- 63.

Q Sixty-three total. So that's quite a bit more than 50?

A Yes.

Q When you did 50 in that one day, did that -- I mean, how did you accomplish that speed to do that on every patient?

A I literally started at 6:50, 6:45 and did not stop. I just went back and forth to -- went back and forth to each room all day long.

Q So you -- I think you on -- you testified that you started about 6:45 and went to about 4:00 on that day?

A On -- on -- on the day I did 50?

Q On the day you did 50.

A I don't remember when I -- when I finished on that day.

Q Would that had been about the time that you would have normally finished, was around 4:00 or so?

A Usually around four but it could have been 4:30, five, I don't remember when I exactly stopped.

Q So we're talking about nine hours, you averaged

about nine minutes a patient --

A Yes.

Q -- throughout the entire day?

A Right.

Q If you had done 30 minutes a patient it would only be about 18 minutes, right? Or 18 patients? Nine hours times two, 18?

A Yes.

Q Now, speed, I wanted to ask you some questions you were asked -- that counsel asked you about that. You had testified on cross that Desai looked up to you, asked your advice, referred complex cases to you, things like that, asked for your assistance. Do you recall that?

A Yes.

Q Did that happen on a regular basis?

A Yes. He would ask me to see complex hepatitis cases, Crohn's cases, inflammatory bowel disease cases and occasionally he would ask me to try to finish a difficult endoscopic procedure and I would try. If I couldn't, I couldn't, but I tried.

Q What do you mean finish a difficult endoscopic --

A For example, there came a couple of occasions where he was doing a colonoscopy and someone said, you know, Desai would you like to come in, meaning from the medical

side, brought me in and said Cliff can you try this, I can't finish it, I can't get to the end. You want to give it a try? For whatever technical reason and I -- and I would do that whenever he asked and sometimes I was successful and sometimes I wasn't.

Q Were you his mentor?

A No.

Q Okay. Was it the other way around?

A Was he my mentor?

Q Yeah.

A No. I had full training. I didn't have a mentor.

Q So you were co-equals at least procedurally?

A Well, procedurally, yeah. Even when I started he had been in practice a long time. He had done many more procedures then I had ever done but there are different skill levels and so you -- he would ask if I can give it a try and I -- I would.

Q Did he know how to treat hepatitis C?

A Yes.

Q Many patients come through your practice, I mean you said that that was one of the things you actually treated, right?

A Sure.

Q Now, are you familiar with --

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: Yes.

BY MR. STAUDAHER:

Q Showing you what has been marked and admitted as State's 108. If you could just flip through it, if you would and if you need to and I just want to know -- I'm not asking you anything out of it specifically, I'm just asking if you're familiar with that study, that report.

MR. SANTACROCE: What is the exhibit?

MR. STAUDAHER: 108. It's the 2006 colonoscopy report.

THE WITNESS: I -- I briefly scanned this just now.

BY MR. STAUDAHER:

Q Have you seen it before?

A No.

Q Are you familiar with anything out of it?

A I don't think so.

Q Have you ever read any reports at all about what average withdrawal times, average inspection times, pre-op times, procedures, how they're done, things like that? Any kind of a comprehensive study about colonoscopies, anything like that?

A Well, in recent -- in recent years I have.

Q Back then --

A No.

Q -- had you done that?

A No.

Q Okay. What is the most important part of the colonoscopy if you had to classify and break it down, going through the anus, doing the transverse across, all the way to the cecum, then the withdrawal and I think you mentioned the -- what do you call that where you bend it backward --

A Retroflexion.

Q -- retroflexion. What portions of those are the most important?

A I want to say there are four important parts to the procedure. The first is inserting it safely to the cecum and that is a function of feel and understanding of the pressure that's being exerted on the colon so that you don't over do it as you're pushing through to the cecum. So you imagine the camera is a long black tube, it's five or six feet long and if it's curved in the colon and you're pushing this way, the curve is putting pressure on the colon.

It's very important to understand that feel so that you don't perforate the colon. So for me I'm constantly aware of that pressure and I'm very often reaching my hand over to feel the belly to make sure I'm not overdoing it or putting too much air in, that's number one.

Number two is proper identification of the end of the colon to take a picture to make sure that you finished the

exam. To understand what the landmarks are so that you are confident that you've actually completed the colonoscopy and weren't halfway through thinking you made the whole thing.

Three is inspection both in and out. So inspecting the lining of the colon. As you're withdrawing you're watching on a big TV screen, it's a high definition TV screen and you're watching as you're pulling out, looking for polyps or tumors in the colon.

And finally, the retroflexion or turning the tip back on itself like a candy cane to look at the anal area because you don't want to miss an anal cancer.

Q Because that would be important not to miss that, right?

A Of course.

Q Okay. So to get over to the cecum, average colonoscopy, is that something you just kind of do? You get over there and then you do most of your inspection on the way out; is that fair?

A I would say that's fair.

Q Is that what you did typically?

A Typically I looked on both going in and going out.

Q How long would it take you to get over there?

A That really varies. It could be 10, 15 minutes if it's a difficult case or it can take me 90 seconds if it's

an easy case. It really -- that's hard to imagine but that's the range.

Q Now, part of what -- we mentioned it, supplies, KY Jelly and the like. I mean, is part of that whole issue with having enough lubricant and so forth is because you're putting a scope into somebody?

A Yes, the --

Q Is there a lot of resistance?

A The lubricant is important to -- so to minimize the resistance especially at the anal area so that there's -- you can push the scope through easily. Using water to push into the colon is a mechanism to make it much -- make the friction much less when you're pushing the camera through the rest of the colon. That black outer lining of the scope becomes slippery when it's wet with water and you want to minimize that friction. So you imagine the scope against the wall pushing, you want as little friction as possible so you minimize the risk of complication.

Q So water and KY Jelly are used for that purpose --

A Yes.

Q -- is that right? Okay. You had -- I want to make sure I understand this. You don't have an experience with propofol; is that fair?

A As a person who administers it?

Q Yes.

A Correct.

Q And do you know much about the -- I know you probably learned some things since that time --

A Right.

Q -- but did -- at the time did you have much knowledge about the drug?

A No.

Q And you mentioned or were asked on cross-examination about propofol's amnestic effect, the ability of -- or the -- sort of the quality of that drug to actually make people forget what has happened.

A Correct.

Q Do you know -- now did you know then what actual amnestic effect that drug really has? I mean how much of it is present in that drug?

A No, I don't know that.

Q So it could be a little or it could be a lot, you don't know?

A Right.

Q Do you think it's ever appropriate to treat a patient in a way that causes them discomfort or pain simply because they have a drug on board that is not going to allow them to remember what happened?

A No. I don't -- I don't think that -- no --

Q Do you understand the question? I mean that's --

A A strange question. Would you intentionally do something to hurt someone?

Q Not necessarily intentionally do something to hurt -- let me -- let me rephrase it. Do you think it is appropriate to treat a patient as you wouldn't normally -- and here's -- here's a hypothetical. You do -- do a procedure without anesthesia, you harm -- you hurt the patient, the patient's writhing around on the table, something like that. Would that be appropriate to do that?

A No.

Q Would you ever do that knowing that you were going to give them medication that would make the patient forget all of that and they wouldn't know about it?

A No.

Q Would that ever be appropriate in your view?

A My view, no.

Q Now, I don't know if I asked you this or if counsel asked you this, but were you asked if you ever had yourself, started a procedure knowing that the patient was not anesthetized?

MR. WRIGHT: I object. This counsel asked that yesterday.

THE COURT: I'm assuming he's trying to --

MR. WRIGHT: Well, this was asked and answered. He's the one that asked it.

THE COURT: I mean, it's been two days so maybe -- are you reasking the question? Are you --

MR. STAUDAHER: I guess I'm -- I'm trying to orientate him but --

THE COURT: -- orientate him to --

MR. STAUDAHER: I want to make sure we know. Okay.

MR. WRIGHT: He wants to repeat it and that's why I object, Your Honor.

THE COURT: Well, there's always some repetition in redirect examination so --

MR. WRIGHT: He's redirecting his direct, Your Honor. That's my objection.

THE COURT: Go on, Mr. Staudaher. Just be mindful not to, you know --

MR. STAUDAHER: I'll try, Your Honor.

THE COURT: -- repeat through direct -- the direct testimony.

MR. STAUDAHER: Fair enough.

THE COURT: Although in all fairness, there may be some memory lapse as to --

MR. STAUDAHER: My own memory lapse, Your Honor.

THE COURT: -- who asked what and when, you know, if it was asked or not so.

Q Now, getting past September 21, just going to CRNAs and whether they switch rooms. Okay?

A Okay.

Q When there are two CRNAs operating in the two separate rooms.

A Right.

Q Okay. Lunchtime they relieve one another --

A Yes.

Q -- one gets to go to lunch, one stays --

A Correct.

Q -- right? And the -- if one CRNA goes to lunch for what, half-hour?

A I think it was 30 minutes.

Q Thirty minutes. Then the other CRNA would like complete a procedure in the room he's in. Okay?

A Yes.

Q And then go to the next room and do a procedure?

A Yes.

Q And always CRNA totally completes a procedure, start to finish, correct?

A Correct.

Q Because they're there monitoring and making sure this patient is going to survive, right?

A Right.

Q They don't walk out, go get a cup of coffee or

go make a phone call or go potty, correct?

A Correct.

Q And in your -- you have never seen a CRNA like leave the room and run over and start someone else on propofol?

A Correct. I've never seen that.

Q Okay. And if you did you would have -- if you see something like that you would have stopped it.

A I think so, yes.

Q And so lunch, come back and forth between rooms, half hour's up and the other CRNA works two rooms while the other guy gets half hour lunch, right?

A Right.

Q Okay. And then you were asked yesterday that if the CRNAs would switch rooms, go room to room, other than lunch for like bathroom breaks and I think you answered I think that happened, it wouldn't be unusual?

A I remember that.

Q Okay. Now that -- do you recall what you told the Metropolitan Police Department about that?

A No. I don't remember but I -- I don't remember.

Q Okay. Do you recall telling them that it never --

MR. STAUDAHER: Objection, Your Honor. He said he doesn't remember. If he wishes to use something to refresh

his memory --

MR. WRIGHT: I'm trying to refresh his recollection with my question.

THE COURT: Mr. Wright --

MR. WRIGHT: I'm sorry.

THE COURT: -- show him the -- if you have the transcript or whatever. And before you do that, can I see counsel up here?

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, this might be a good transition time to take our lunch break. Why don't we go until 1:20 for the lunch break. And before I excuse you, I must remind you that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, person or subject matter relating to the case. Don't do any independent research and please don't form or express an opinion on the trial. If you would please all place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 12:15 p.m.)

THE COURT: Doctor, you're free to go to lunch. Are we going to finish with him today or --

MR. WRIGHT: Yes.

THE COURT: Okay. All right, everybody go to lunch.

(Court recessed at 12:15 p.m. until 1:19 p.m.)

(Outside the presence of the jury.)

THE COURT: Would you let the bailiff know we're ready?

MR. WRIGHT: He was just getting the jurors last --

THE COURT: What's that?

MR. WRIGHT: He was just bringing in the last juror.

THE COURT: Oh, okay. So -- yeah, I mean if they're all back.

MS. STANISH: Judge, did you say 9:00 on Monday after all?

THE COURT: Well, it will be in the morning, 9:30 I think --

MS. STANISH: Okay.

THE COURT: -- as long as Ms. Weckerly can now tell --

MS. STANISH: Get the doctor back?

THE COURT: -- her witness -- no, actually we can start at 9:30 --

MS. STANISH: I see.

THE COURT: -- because the lawyers on the evidentiary hearing agreed to move that so.

MS. STANISH: Okay.

THE COURT: And we're having -- just a heads up, we're having trouble find -- as of right now, a lot of people

are in trial next week so we're having a little difficulty finding coverage, so hopefully we'll find coverage. There's a possibility we won't be able to start at nine everyday depending on, you know, who's available and whatnot. I'll probably have to do -- wind up doing my own civil calendar. I have a reluctant volunteer for Tuesday and I'm still looking for Thursday so. But if those trials all plead then more people will be available so. Oh, and also a heads up on scheduling. We asked the jurors if they wanted to have an early day on the Friday before Memorial Day and they do.

MS. STANISH: I bet they said yes.

THE COURT: I'm sorry?

MS. STANISH: I bet they said yes.

THE COURT: So I'm thinking like starting at nine and maybe ending at like one or so and then obviously no lunch break. Does that impact your scheduling?

MS. WECKERLY: Well, not -- I'll -- I'll confer with counsel --

THE COURT: Okay.

MS. WECKERLY: -- to see how long but I don't think --

THE COURT: Okay.

MS. WECKERLY: -- we have two that are not that long.

THE COURT: If it does, I mean, we can go later but --

MS. WECKERLY: No, I get why they want to --

THE COURT: Right. And then I'm thinking --

MS. WECKERLY: I do too.

THE COURT: -- I mean, that works for me but --

MS. WECKERLY: I'll confer with counsel when we're On our next break and tell --

THE COURT: Okay.

MS. WECKERLY: -- who I'm thinking on that day. They have the week except for one more person.

THE COURT: Okay. So just to give you guys a heads up.

(Jury reconvened at 1:23 p.m.)

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

Mr. Wright, you may resume your cross-examination.

BY MR. WRIGHT:

Q I'm going to have you look at three pages, 77 to 79 of your statement through the police and the district attorney before the grand jury.

MR. STAUDAHER: Is there a question pending? I don't --

THE COURT: When we took our break there had --

MR. WRIGHT: I was going to finish.

MR. STAUDAHER: Okay.

THE COURT: Okay.

MR. STAUDAHER: Go ahead.

THE COURT: There had been a question and then he was going to refresh his recollection and then he -- Mr. Wright found it and then we took our lunch break. So I believe you're refreshing or attempting to refresh recollection at this point?

MR. WRIGHT: Yes. Regarding CRNAs room between room breaks, lunch --

MR. STAUDAHER: And the pages again? I'm sorry, counsel.

MR. WRIGHT: Seventy-seven through 79.

BY MR. WRIGHT:

Q Read all the way through because it's interspersed with other topics and read it to yourself. And once again, the highlighting is my own.

THE COURT: And for the record, he's looking at his own statement or somebody else's?

MR. WRIGHT: His own statement of March 3, 2010.

THE COURT: All right.

THE WITNESS: Okay.

BY MR. WRIGHT:

Q And where we had started on this is I had asked you if on direct examination when asked about switching rooms for bathroom breaks, you answered I think that happened, it wouldn't be unusual. Okay?

A Okay.

Q Now, reading your grand jury -- refreshing your recollection, do you believe that that did not happen?

A Well, I'm sorry that this is ambiguous and I don't mean to be disingenuous here but it's hard for me to remember whether or not CRNAs on every bathroom break switched off with each other. And like I testified before, to my best recollection and my memory of how it worked and I've testified this way before, CRNA -- CRNAs tended to stay in their rooms. Now when asked would it be possible, would you be surprised? I answered yes, I'd be surprised. I remember on September 21st after Kevin Rubino, I left the -- the room and I went to the medical side. So it's hard for me to know what happened if there's any movement back and forth after I left.

Q Okay. Did you tell the grand jury, I knew CRNAs stayed in one room. They didn't go back and forth unless there was a lunch break?

A Yes, I did.

Q Okay. Were you asked, "Now you had said just a moment ago about CRNA not going back and forth between the rooms except for a lunch break or something like that. Correct. Or I assume like a bathroom break or something along those lines too." And did you answer, "Yeah, usually bathroom breaks were rare. I mean they would be in and out quickly and there wouldn't have to be a switch in the room." Correct?

A I would say that's accurate to the best of my

recollection.

Q Okay. And that -- that's because these are ongoing procedures taking 10 minutes, 12 minutes, eight minutes, 15 minutes, correct?

A Correct.

Q And there's five minutes in between, correct?

A What does that mean five minutes in between?

Q In between procedures. New patient rolling in.

A Right.

Q Okay.

A There could be some time for a break.

Q Right. I mean, in between patients is approximately five minutes, correct?

A Correct.

Q Okay. And if someone needed to go to the bathroom that's when you would go, correct?

A To the best of my recollection that sounds fair.

Q Okay. And I mean this is -- this was further back -- closer to the time, correct? Your statement -- a couple of years ago --

A Yes.

Q -- right? And then you said, "It would be rare any bathroom breaks. And I mean they would be in and out quickly and they wouldn't switch rooms." Right?

A Right.

Q And then you reiterated again, "And the only time -- again, the only time I'm aware of them moving is when the lunch breaks occurred." Correct?

A Correct.

Q And you were asked if you'd be surprised to learn that there was an instance where they changed rooms and you said, "I'm surprised. For being there so many days I have never seen that happen, they stayed in one room and they switched at lunch," correct?

A That's what I said, yes.

Q Okay. But here on direct you answered I think it happened, it wouldn't be unusual.

A So, again, I apologize for the ambiguity. I'm trying to remember and think back on a day-to-day basis whether CRNAs during bathroom breaks switched. And as I think back on that, I don't remember if they switched --

Q Okay.

A -- I -- I -- that testimony I gave is what I gave and that's how I remember it.

Q And would that -- that was how long ago? Three years ago? Your memory would have been better then, correct?

A Perhaps.

Q Don't you think so? I mean, don't you think when we're going back eight years it's tougher than if you're going back four years?

A Perhaps, I --

Q You don't know?

A -- I have a pretty good memory.

Q Okay. So your memory was pretty good at the grand jury on it, right?

A Okay, yes.

Q And even when the prosecutor challenged you on it you stuck with it and said you had never ever seen that, correct?

A That's what I said.

Q A thing I forgot to address when we were talking about the quality care and safety at the clinic. Okay?

A Okay.

Q The -- first of all, your own quality care, meaning performing procedures. Okay?

A Okay.

Q The -- how many perforations have you ever had?

A To date?

Q Yes.

A Two.

Q Okay. Out of how many procedures?

A I would say about 40,000 colonoscopies.

Q Okay. And two is not good for the two people -- patients --

A Correct.

Q -- but two is a very superb record would you say?

A Yes.

Q Okay. Because like a perforation we're talking about an accidental what?

A A perforation is an accidental breach of the colon. The colon's a tube. It's a breach of the colon so that there's a hole in the colon that is a threat to the patient's well-being and life if it's not identified and addressed because you cannot have leakage of material into the abdominal space without surgical correction.

Q Okay. And like to put it in perspective, you're aware of the national averages for lack of a better word of number of perforations per colonoscopy or something?

A Yes.

Q And what is it?

A Well, Medicare has done studies on this and several years ago I saw a study in which Medicare reported that on average their statistics indicated that for one out of every thousand standard routine colonoscopies there was a perforation and for one out of every 500 diagnostic, meaning there was a reason to do the colonoscopy, bleeding, abdominal pain, rather than just a check-up colonoscopy there was a -- there were perforations.

Q Okay. So one out of a thousand for diagnostic

colonoscopies?

A It was for routine screening colonoscopies.

Q Okay. And routine screening is the majority of what you all did at the clinic?

A Yes.

Q Okay. And did -- are you aware that Dr. Desai never had any perforations in his entire career?

A No, I was not aware of that.

Q Okay. Do you think he has?

A I think he may have. I think we may have talked about it --

MR. STAUDAHER: Your Honor, may we approach please?

THE COURT: Sure.

(Off-record bench conference.)

BY MR. WRIGHT:

Q How about at the -- the clinic at the time you were there, how many transfers out from the clinic like to the hospital were required over all your years there?

A I remember very few. I can actually remember two. It doesn't mean there were not more than two. I wasn't there all day every day, but I remember two transfers to the hospital. One was the patient who required protection of the airway and the other was an asthma attack post procedure.

Q Now I believe when you were testifying on direct regarding a meeting with Dr. Desai where the issue had come up

on 31 minutes and you had learned from your lawyer in the Rexford case that the plaintiff's, the other lawyers were asking for all of the billing records around -- anesthesia records around the Rexford incident. Do you recall what I'm focusing in on?

A Yes.

Q Okay. And so when you were asked -- and you learned that from your -- your lawyer that hey, they're asking about anesthesia records and times and then you went to Dr. Desai, correct?

A Incorrect.

Q Okay.

A I did not learn about that request from my attorneys; I learned about that request through Tonya Rushing who told me that that request had come through.

Q Okay. Thank you. I misunderstood it. The -- but when you learned it, that they now were asking for the records, you went and talked to Dr. Desai, correct?

A Yes.

Q To tell him they are now asking for the billing records?

A Yes.

Q And I think on direct examination, tell me if I'm wrong, but I think you said you walked in and said they're asking about billing records and is there any problem with the

billing and Dr. Desai answered there is no billing fraud. Is that what you testified to?

A Yes.

Q Okay. Is -- isn't it a fact that you went and saw Dr. Desai and said they are asking questions about the billing records regarding billing fraud, you using that word, and he answered that there is no billing fraud?

A I don't remember it that way, sir.

Q Okay. Page 38 --

MR. STAUDAHER: Which -- which one?

MR. WRIGHT: Metro. Approach the witness?

THE COURT: You may.

BY MR. WRIGHT:

Q This one's all marked up, but I'm showing him the top five or so lines, but read all you want.

A Okay.

Q Am I misreading that?

A No, but this is sort of a thought process that -- as I read it, that my thought process was that this is stated here.

Q Oh, okay. So I'm just going to read it. Okay?

A Okay.

Q And in the request apparently he asked also for every anesthesia sheet. Are you talking about the request that came in from the lawyers?

A Right.

Q Now, I'm reading again, "So I went back to Desai's office and I said, 'You know there's this request, is making this request sort of suggesting that there's a billing fraud issue here?'"

A Again, as I read that, that's not -- this part of it is not what I remember as saying. This is my thought process related to that, this is not a full quote to my recollection.

Q Okay. Well look, I'll tell you when the quotes end, let me read it. I mean -- "You know there's this request," blank, there's an intelligible word, right?

A Yes.

Q "Blank is making this request, sort of suggesting that there's a billing fraud issue here. He's looking, he wants every one of these records." Right?

A I see that.

Q Okay. Then Desai said, "There's no billing fraud." Correct?

A I see that as you -- as you pointed out to me.

Q Okay. What am I reading?

A I'm just -- I'm just saying to you that it's -- that what looks to be a quote of mine is more -- I'm just extemporaneously talking about what I was thinking here. I don't remember saying that he's looking for fraud.

Q But that -- that's what you said then, correct?

A Again, I can't remember if I said those words to him. I'm not sure that's my --

Q Well, it's a transcript.

A I understand that.

Q This isn't a report. I mean, do you think there's a transcription error?

A I'm thinking that when I -- when it says here is making this request sort of suggesting there's a billing fraud issue here. That's my thought process talking to the person interviewing me. This is not my kind of -- my kind of words that I would be using. I don't really speak like that, sort of suggesting, it's my thought process.

Q Okay. On that -- going back to your direct -- direct examination on the endoscope purchase. Okay? Recall that?

A Endoscope purchase?

Q The endoscope purchase. Maybe I have the words wrong. I'm talking about the time they got something new at UMC and you thought --

A Oh, the endospot.

Q Endospot, I'm sorry. The endospot purchase. That was a new piece of equipment and you talked -- or -- was it you personally or the other physicians talked to Dr. Desai?

A Well, I don't remember if I spoke to Dr. Desai

directly about it. I may have spoken to the, you know, the nurse manager about purchasing this.

Q Okay. But it was new equipment, beneficial to the practice?

A New product.

Q Okay. And you and others said we ought to get that?

A Yes.

Q Answer came back no, right?

A As I recall it.

Q Okay. Other physicians said I'll buy it myself, right?

A Yes, Dr. Faris.

Q Okay. And the clinic went ahead and then bought it, correct?

A Yes.

Q He didn't have to buy it himself and the clinic got it?

A I think that's correct.

Q I want to go to this Stacy -- patient Stacy Hutchinson and you being the boss issue. Okay?

A Sure.

Q You're familiar with that issue, correct?

A Yes.

Q Okay. And Stacy Hutchinson is -- was a patient

who was treated on September 21st, correct?

A Yes.

Q Okay. And she had come in to the clinic to see -- for a consultation with Dr. Desai, correct?

A Are you talking about the medical clinic or the endoscopy side?

Q I think the medical side.

A After the --

Q After the procedure.

A After the procedure, yes.

Q Okay. I mean this was -- she had a procedure done and I don't -- it's all of record. On September 21st she had a procedure done.

A That's correct.

Q Okay. And then she came down with -- got hepatitis C, correct?

A Yes.

Q Okay. And when she is coming in to see Dr. Desai she's -- has hepatitis C, right?

A Yes.

Q Okay. And she had blood tests and everything already showing it, correct?

A Yes.

Q Okay. And yet this is before the CDC knocks on the door?

A I don't think it was before. I think it was after the CDC knocked on the door.

Q Okay. I'm -- I'm not sure either. Was it before or after?

A It was -- to my recollection it was afterwards.

Q Okay. And so she comes in and she has hepatitis C, right?

A Yes.

Q Okay. And she's -- she's seeing Dr. Desai, right?

A Yes.

Q And then you see her, right?

A Yes.

Q And then if I followed this right, you were then asked are you Dr. Desai's boss?

A No, that's not how it happened.

Q Okay. I know it's not how it's happened, I'm going over your direct examination.

A Okay, go ahead.

Q I thought the impression was left, you're not Dr. Desai's boss and you were asked, did Dr. Desai just pass her off to you and you answered yes.

A Okay.

Q Okay. And is that what happened? He just simply passed her off to you?

A No, he asked me to see her. He asked me to come into the room and talk to her and help manage this problem.

Q Okay. It wasn't a just passing her off, correct?

A No -- no, if -- that's a pejorative phrase. It was he asked me --

Q That was the question that was asked --

A Right, so --

Q -- and it was asked by Mr. Staudaher and --

A -- I understand.

Q -- you answered yes.

A I understand.

Q And it's not a fair characterization, is it?

MR. STAUDAHER: Objection. Argumentative and mischaracterizes his current testimony.

THE COURT: Well, he's talking about the past testimony so you can answer the question, Doctor.

BY MR. WRIGHT:

Q Is that a fair characterization of what transpired?

A No.

Q Okay. Now, what -- you tell me, she's in there, she is crying, correct?

A Yes.

Q She has Hepatitis c, acute, correct?

A Correct.

Q And Dr. Desai goes to the person, as he has done in the past, for most knowledge about care, correct?

A Yes.

Q Asks you to come in and treat her, consult her, correct?

A Correct.

Q And you did that?

A Yes, I did.

Q And you -- you looked at all of her, what you look at, blood results, everything else?

A Blood results, yes.

Q Okay. And at that time you believed it -- her tests were improving, correct?

A Yes.

Q Okay. And -- and I think you testified you told her that it may well be that she is going to self-clear that -- the virus and not have to go through treatments, correct?

A I did say that to her.

Q Okay. And you understand that Dr. Desai in the exchange, in some way, referred to you as I'm going to get the boss to assist you, correct?

A Now, I heard about that after the fact, some other time in the future. I didn't hear it then and there.

Q I understand but that -- that was something that

you've been asked about, correct?

A Correct.

Q And when asked about it, you explained that that was, in your opinion, a term of endearment and respect by Dr. Desai to you because you are the boss of hepatitis C, for lack of a better word. Am I characterizing it correctly?

A Yes, you are.

Q Okay. Now, Dr. Desai's cost cutting measures, is it fair to say that he was extremely conscious of wasting supplies, product, anything in the business?

A I think that's fair to say.

Q And if there's two things that he -- was his oddity for lack of a better word, is that he didn't want waste and he didn't want people standing around. Were you aware of that?

A That's fair.

Q Okay. And if he came in, if you didn't have anything to do, start polishing a scope or whatever you do, because he's going to get mad if people are standing around, right?

A Yes.

Q And in all of his -- using the KY Jelly. Okay?

A Sure.

Q Taking a little roller like you put on a toothpaste tube and make sure it's empty before you throw it

out, skimping on KY Jelly, on complaining about gown changing, your gowns, reuse of bite blocks, on those things did you ever perceive those at any time as being a risk to any patient or patient safety?

A No.

Q And you -- at times you would -- and the other physicians would roll their eyes at his anti-waste campaigns; is that fair to say?

A That's fair to say.

Q And things like reusing a hard plastic bite block, that was put in the Medivator and sterilized, correct?

A Cleansed. I mean sterilization requires an autoclave.

Q Okay. Disinfect -- a high level disinfectant?

A Correct.

Q Okay. And it -- and in your opinion those things were unnecessary? Meaning, reuse and skimping on gowns, bite blocks, chux being cut in half, no patient safety issue ever on those?

A I agree with you.

Q And it -- I mean, I think you've said in reading your testimony that it was embarrassing because you're the biggest and best clinic, correct?

A Yes, I've said that.

Q And basically, this type of micromanaging is

going on for silly reasons.

A Did I use the word silly then --

Q I think so.

A -- okay.

Q I mean to you it was silly, correct?

A Yes.

Q You were asked on direct examination about a partners -- or a physicians meeting in which the suggestion was made to utilize saline in addition to propofol in the sedation process. Do you recall that?

A Yes.

Q And if I understood your direct testimony correctly, you stated that the purpose for doing this was so there's a little tiny microscopic amount of propofol still left in the heplock after the injection of the propofol and so Dr. Desai was saying to get that little tiny, tiny bit left and not waste it, you guys use saline.

A That's the way I understood it, yes.

Q Okay. And that's -- do you -- that's what you testified to, correct?

A Correct.

Q You think that's a fair characterization of that meeting and what the purpose of the saline was?

A Yes.

Q Metro report, 60 -- page 65 and 66. Read those

two pages to yourself.

MR. STAUDAHER: Is there a pending question that he's asking to refresh on instead of just having him --

THE COURT: I think it's something relating to the last --

MR. WRIGHT: I'm going to have him refresh his recollection and then ask him again if he thinks it's a fair characterization of what --

MR. STAUDAHER: Is that -- I just want to make sure that's what we're talking about.

THE COURT: I understood that was where Mr. Wright was going.

THE WITNESS: Okay.

BY MR. WRIGHT:

Q Do you still think your testimony on direct was a fair characterization in that meeting?

A Yes, I do.

Q Okay. Do you -- what was the purpose of the propofol? Pardon me. What was the purpose of the saline flush?

A The purpose of the saline flush, as I understood it, was to clear the -- any remaining amount of propofol in that heplock into the circulation.

Q Okay. Did you state, "I remember this is important. It wasn't that saline would be used in lieu of

propofol -- additional propofol, he had told us that Dr. Nayvar had -- had given him an idea on how to make the propofol circulate better in patients." Is that correct?

A Is that correct physiclogically or is that what I said? Is that what you're asking me?

Q Is that what you said?

A That's what I -- it's written there, yes.

Q Okay. And is -- and is that what happened at the meeting?

A I don't remember.

Q Okay. You don't remember the meeting?

A I do remember the meeting.

Q We -- we were given -- I strike that. I -- "We were giving through a heplock and Desai said the idea was that after the propofol was given by the IV -- was given by the IV push, that would be followed immediately by a flush of sterile saline."

A Yes.

Q Correct?

A Yes.

Q "He said he mentioned this to us and he said you know, don't grumble about it, don't -- don't disparage me about it, it's -- I think it's a good idea that Nayvar gave me to help the propofol circulate through." Correct?

A Correct.

Q And it wasn't being given like at the end or at any point to -- in lieu of propofol, right?

A Correct.

Q It was being given -- propofol dose then saline to increase the circulation of the propofol, correct?

A No. It was to clear the heplock of remaining propofol --

Q Okay.

A -- because it doesn't make physiologic sense that the circulation of that molecule, propofol, would be enhanced by giving more saline behind it. Once it's in the venous system it circulates as a part of cardiac function.

Q Okay, and is that --

THE COURT: All right. The jury needs a break. So ladies and gentlemen, let's go ahead and just take a 10-minute break, that will bring us to 2:15. And once again, I must remind you of the admonition not to discuss the case or anything relating to the case, not to read, watch, or listen to any reports of or commentaries on the case, person, or subject matter relating to the case and not to form or express an opinion on the trial. Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 2:03 p.m.)

THE COURT: All right. Well, we can all take a break now too.

MS. WECKERLY: We -- just to let the Court know, we have that witness at 9:30.

THE COURT: Oh, terrific. So we'll start at 9:30 on Monday and apparently we found a judge to volunteer for next week, maybe his trial went away. So we're good to have early starts all next week.

(Court recessed at 2:04 p.m. until 2:11 p.m.)

(In the presence of the jury.)

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

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

BY MR. WRIGHT:

Q Okay. Go back on the saline flush of propofol. Okay?

A Okay.

Q Were you asked, "Do you recall there --", pardon me, "Do you recall there being a meeting of all of the doctors when Desai actually made a presentation and discussed the use of saline near the end of a procedure instead of giving additional propofol?". That's the question. Okay?

A That's the question.

Q And then you answered, "I remember, this is important. It wasn't that saline would be used in lieu of additional propofol. He told us that Dr. Nayvar had given him an idea on how to make the propofol circulate better in

patients. We were giving them through a heplock and Desai said the idea was that after the propofol was given by IV push that would be followed immediately by a flush of sterile saline. He said he mentioned this to us and he said, 'You know, don't grumble about it. Don't -- don't disparage me about it. It's -- I think it's a good idea that Nayvar gave me to help the propofol circulate through.'" That's -- that's what you say thus far. Now, is all of that correct to your understanding of what was said at the meeting?

A That's what I recall. But again, it's -- I'm referring to the -- the material in the heplock, in the flush.

Q Okay. We're talking about a saline flush, sterile saline being pushed into the veins, right, through the heplock, ostensibly to make propofol circulate quicker into the bloodstream, right?

A No.

Q No?

A No. We're talking about the use of a saline flush to clear the remaining propofol from the heplock into the circulation, not to improve the circulation of the propofol that's already in the blood because it -- to me it doesn't make physiologic sense. The --

Q I didn't -- go ahead, I'm sorry.

A -- the propofol, once it's in the circulation to -- to my understanding, is not going to be aided to get to the

brain any faster.

Q Well, those were my words --

A Okay.

Q -- I don't even know where it goes.

A And that's where it goes.

Q Okay.

A To -- to -- through a saline flush. I hope I'm being clear, I'm sorry if I'm not, but that's the way I understand it.

Q Okay. I'll continue. And this would reduce the amount of propofol needed. So we're talking about reducing the amount because he was concerned that the nurse anesthetist was giving 300 milligrams, 400 milligrams of propofol and it was too much. Do you recall that?

A Yes.

Q So he said, "This would -- this is a way to a -- to give -- to use less propofol and then it -- I thought it was silly and I thought it was unnecessary and I think a lot of people rolled their eyes at that.". Right?

A I said that, yes.

Q Okay. "But then a couple weeks later he said, yep, it's working, we're using less propofol.". Correct?

A Correct.

Q Okay. And then after a little more exchange you went on and said, "So again, I want you to understand that it

wasn't that saline slush would be given at the end of the procedure rather than giving more propofol, it was a flush right afterwards."

A Correct.

Q Is that correct?

A Yes.

Q Now were -- did you ever attend another propofol meeting with the partners or anyone?

A Not that I recall.

Q Okay. Do you -- do you recall any meeting where multi-use of propofol was discussed and debated among the physicians?

A I do not recall that.

Q Do you recall any meeting -- if someone were to say there was a meeting and it was at the time the propofol purchases were going from 20s to 50s, there was a meeting called to discuss that?

A I actually don't remember personally that meeting.

Q Okay. Show you what's been marked as Defense D-1.

A Okay.

Q Do you recognize that?

A Yeah, the letter I wrote to Dr. Desai, a thank you letter.

Q Okay. In March 6th, 2007?

A Okay.

MR. WRIGHT: Move it -- move for the admission.

THE COURT: Any objection?

MR. STAUDAHER: No objection.

THE COURT: All right. What is -- what's the number or designation, it would be a letter.

MR. WRIGHT: D-1.

THE COURT: All right, D-1 is admitted.

MR. WRIGHT: First exhibit?

THE COURT: No, D -- or we're doing letters but Mr. Lakeman's exhibits are letters and then the designation two to indicate they were introduced by Mr. Lakeman and then Dr. Desai's are letters and followed by the number one to indicate that they were introduced by Dr. Desai.

(Defendant's Exhibit D1 admitted.)

MR. WRIGHT: Thank you.

BY MR. WRIGHT:

Q It's a letter to Dr. Desai from yourself thanking him, correct?

A Yes.

Q Okay. And it says, "It meant a great deal to me personally when you acknowledged my effort at endoscopy center. I feel a great sense of relief with your solution, which will allow me to continue performing at this level

safely and accurately. As always, I look forward to our continued success together. With great appreciation and gratitude I remain. Sincerely, Clifford Carrol." Correct?

A Correct.

Q Okay. And what -- what had transpired then that he worked with you that you're talking about?

A Now, that's March, 2007 so I think I was writing a letter to him thanking him for trying to figure out a way for me to have my call covered so that I could be ready and awake and alert every morning to do the procedures, the best I recall.

Q Okay. I think you testified about that already that he -- he -- when I was asking you about how hard the work was --

A Yes.

Q -- whether you were content or not --

A Yes.

Q -- that he had arranged a -- a method by which you could work -- get more sleep and more efficiently and do your job?

A That's what I think I was writing him about.

Q Okay. Now, you have an immunity contract in this case, correct?

A Yes, I have an immunity statement, immunity protection.

Q Okay. Let me show you Exhibit E, proposed E-1.

A Okay.

Q Do you recognize that?

A Yes.

Q Is -- is that your Immunity Agreement?

A Well, this is a letter to my attorney outlining the agreement. Whether this is the actual agreement or there's another document, I'm not sure.

Q Okay. Well, I don't think there is. I'll ask the -- I think this is the Immunity Agreement? Okay, Mr. Staudaher acknowledged yes. It actually says if you agree to all of it, sign it and return it --

A Okay.

Q -- okay; is that correct?

A Yes.

MR. WRIGHT: I move the admission of E-1.

THE COURT: Any objection?

MR. STAUDAHER: No, Your Honor.

THE COURT: All right. That will be admitted, E-1.

(Defendant's Exhibit E1 admitted.)

BY MR. WRIGHT:

Q Do you see that?

A Yes.

Q Okay. This is to your attorney, correct?

A Yes.

Q And February 22, 2010, "It's my understanding your client, Clifford Carrol, M.D., desires to make a proffer to the State, which will be useful in making an evaluation of our position in this case." This letter sets forth the ground rules for such a proffer, correct?

A Correct.

Q And this letter is from the District Attorney's Office, correct?

A Yes.

Q That you were aware you were being investigated at the time criminally?

A Yes.

Q "First, your client agrees to provide complete and truthful information. This provision obliges your client not only to provide truthful responses to any areas of inquiry, but also to volunteer any and all information related to the subject areas that are being explored." Correct?

A Yes.

Q You have to tell the truth, right?

A Yes.

Q And the next paragraph will be what the State promises you. "The State will not use any statement made by you or your client or other information provided by you or your client during the proffer against your client in any criminal case." Correct?

A Yes.

Q So essentially, you waive your Fifth Amendment right, go in there, talk to them and ultimately testify truthfully, right?

A Right.

Q And it cannot be used against you, correct?

A Correct.

Q Except "In any criminal case except for cross-examination or impeachment, should your client ever testify contrary to the information he provides during the proffer." Now you understand that?

A Yes.

Q Okay. Because pursuant to this proffer you're going to go in there and tell them what you know, right?

A Right.

Q And they're saying we won't use it against you but we get to use it against you if you ever say anything differently than what you tell us, correct?

A Yes.

Q Okay. And they can use in a prosecution for perjury, right?

A Right.

Q Okay. So you don't have immunity for perjury but they can use it in a prosecution for perjury where the information that you give them may be used to prove your

client testified untruthfully or contrary to the information provided in the proffer. Do you understand that?

A I think I do, yes.

Q Okay. That means you're going in, you're telling them your story, and if you ever change it they get to prosecute you for perjury for saying something differently. Do you understand that?

A Yes.

Q The State -- and then there's an extra -- the next paragraph deals with derivative use, that just means any leads they get from you, from what you tell them they can't use against you. Do you understand that?

A Yes.

Q "Then as the State discovers what your client has to say and what he is willing to do for the State, our unilateral evaluation of his position will be undertaken in good faith." Do you understand that?

A Yes.

Q Okay. So under those rules they're saying bring him in for a proffer and we'll not only see what he has to say but we'll see what he's willing to do for us and then we'll decide if we'll take him. Is that fair?

A Okay.

Q So you then, with this agreement, go talk to the police, go to the grand jury, right?

A That's correct but it wasn't -- as far as I remember I didn't -- I agreed to speak to the district attorney at his invitation, not as a condition or after signing this. This came afterwards.

Q You -- I'm misunderstanding what you're saying. Let me -- you're -- the district attorney and -- secret notes.

THE COURT: It's not so secret because it's up on there.

MR. WRIGHT: Thank you.

BY MR. WRIGHT:

Q The district attorney invited you in for a proffer. Is that what you're telling me?

A Initially he invited me in for an interview.

Q Okay. Well, okay, an interview. Proffer's like a legal term. He invited you in for an interview, correct?

A Yes.

Q And your lawyer Frank Cremen said, okay, we'll do an interview but only with certain conditions, correct?

A You know, I don't remember exactly the time line. I remember that my -- Frank Cremen said the district attorney wishes to speak to you, would you be willing to speak to him. I said I -- I answered yes, I would. And then he arranged the meeting with the district attorney. I honestly don't remember the time frame between that -- acceptance of that invitation and this immunity statement.

Q Okay. Well, do you think you were interviewed before you went in and sat down for an interview before the immunity proffer agreement?

A I don't remember. I bet we can find out, but I honestly don't remember.

MR. WRIGHT: Okay. Well, I'm -- I'm -- I'm quite certain that this is his first interview after the proffer agreement; is that correct?

MR. STAUDAHER: I believe so.

BY MR. WRIGHT:

Q I believe so also. The -- you -- you understood that we -- we call this a Immunity Agreement?

A Okay.

Q Okay. And you understand that provision, the last one I read about if you ever say anything differently than what you tell us during the sit down, do you understand that that's a lock in testimony provision?

A Well, I don't understand the term lock in testimony.

Q Well, that means once you tell us something, if you back up and say something different all bets are off and we get to prosecute you for perjury.

MR. STAUDAHER: Actually, Your Honor, that's not correct as far as what a proffer is concerned and maybe we need to approach?

THE COURT: Well, sure.

(Off-record bench conference.)

THE COURT: All right. Mr. Wright, go ahead.

BY MR. WRIGHT:

Q Before you went and gave the interview, your attorney met with the district attorney, correct?

A I don't believe he met personally with him before I went in. I think there were conversations, but I may be wrong on that I don't remember if he met personally with him.

Q Okay. Well do you remember your lawyer wrote you a letter and said he had --

MR. STAUDAHER: Objection. Hearsay, Your Honor, as to his lawyer now talking to him, communication?

THE COURT: Yeah, I mean that's --

MR. WRIGHT: It's not privileged when I get a copy of it in discovery.

MR. STAUDAHER: Well, it's hearsay.

THE COURT: Well, that's true. I mean --

MR. WRIGHT: It's a letter to him. I'll introduce it.

THE COURT: Well, what's the -- okay. I'll see counsel up here again.

(Off-record bench conference.)

THE COURT: Is there anyone who didn't hear the

conference at the bench? All right. Well, you know, I had told Kenny that he should go over there and tell jokes or something and I saw him do it at least once but he must have run out of material. So -- all right, Mr. Wright go on.

BY MR. WRIGHT:

Q I'm going to show you the letter to yourself from Mr. Cremen. Read it to yourself. Okay? We'll see if it refreshes your recollection of when I'm asking you about did Mr. Cremen tell you about a meeting with the district attorney's office.

THE COURT: All right. And just so it's clear --

MR. WRIGHT: About speaking -- speaking -- about speaking with the district attorney involved.

THE COURT: Okay. Just so it's clear, Mr. Wright, so we don't get into any privileged communications and Dr. Carrol, just so it's clear to you, Mr. Wright is only allowed to ask you about what was actually -- the information conveyed in the letter. Other conversations that you may have had with Mr. Cremen are privileged and they're not subject to questioning by Mr. Wright or the prosecutors or anyone else.

MR. STAUDAHER: And for the record, we'll object to hearsay if it's actually getting into what was said other than what his subjective belief was.

THE COURT: Right. The letter is only relevant as to what the witness's subjective knowledge and belief were at the

time he made the proffer, not as to any -- the truth of any communications as to what Mr. Cremen may have conveyed.

BY MR. WRIGHT:

Q I think all those others are just fax transmissions.

A Right, they're duplicates.

Q Right.

THE COURT: So just the first two pages.

BY MR. WRIGHT:

Q Yeah, the first two pages of the letter, the rest is just a trail. And just so you understand, sir, that was produced in discovery I mean is why -- I wouldn't want you to think Mr. Cremen handed me his letter or something.

A Okay. I've read it.

Q Okay. Did -- did -- did you understand -- does that refresh your recollection about the chronology?

A Yes.

Q Okay. Did you understand that Mr. Cremen had -- your lawyer, had spoken with the district attorney's office and learned information that they wanted to question you about and accusations against you?

A Yes.

Q Okay. So that you had advance notice to prepare for what you can -- what you were willing to do for the State, correct?

MR. STAUDAHER: Objection to the -- the form of the question, Your Honor.

THE COURT: Well, overruled. I mean, it -- he can -- if he can answer. He can agree with that statement or question or not agree with it.

THE WITNESS: I just don't understand what you mean, sir, about what I was willing to do for the State.

BY MR. WRIGHT:

Q Well, I was reading from your proffer agreement. You entered into this and it said, "They will see what he is willing to do for the State."

A I understand that that's in the proffer.

Q Okay. And then in preparation for you going in to talk to them and show them what you are willing to do, they -- prosecutors disclosed to your attorney to talk with you certain subjects that they were interested in, correct?

A I agree that this is an outline of certain subjects of interest.

Q Right. And so you knew and had plenty of time to talk to Mr. Cremen about this, correct?

A I have -- I knew about this letter and I spoke to Mr. Cremen about it, yes.

Q Okay. And about the subjects of interest?

A Yes.

Q Okay. So that when you went in you were

prepared to be interviewed, correct?

A Well, when I went in I did not know what would be asked entirely. I had this letter, I sat for four and a half or five hours it took and answered the questions.

Q Okay.

A Okay?

Q Yeah. I marked -- I'd offer that letter, a clean copy.

THE COURT: All right. Well, the Court will reserve ruling on that and that would be, what, next in order? Is that E or F? That would be next in order is F-1.

MR. WRIGHT: Thank you. I think that wraps it up for me, sir.

THE WITNESS: Thank you.

THE COURT: All right. Let's move into redirect.

REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q I'm going to go ahead and start off by going back to -- remember when Mr. Wright had you up there with this whole thing about the saline flushes. Do you recall that?

A Yes.

Q And had you actually read a set -- he actually read a section of that transcript. Do you recall that?

A Yes.

Q And it was all about the whole issue, the

circulation thing?

A Yes.

Q You went I think over and over again saying that it was related to the actual part -- little bit that was in the heplock, the needle -- or that catheter part in the heplock, that that would get flushed into the patient and that that would be what would be essentially reducing the propofol?

A Correct.

Q And that's what Dr. Desai said to you?

A As I recall, yes.

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q Same page, 65, just below the area that counsel read into the record about that very issue. Would you read those next couple of lines?

A Can you point out where you'd like me to start?

Q Midway down, those lines.

A Read it to myself?

Q Yes, just yourself.

A Yes.

Q In fact, isn't it true that you basically said exactly your explanation here in court just following that paragraph that Mr. Wright read?

A Yes, it is.

Q And it was what you were referring to specifically, at the time, during the exact interview, that it was that little bit inside the heplock that was being flushed in?

A Correct.

Q You also were asked some questions about -- in part of that, one of the reasons why that Dr. Desai wanted to have that sort of plan implemented was because the CRNAs were giving 300 to 400 milligrams of propofol at a time or for a patient and that that was too much, his words?

A That's how I recall it.

Q And now you've been -- you -- I think you've even said you've done 40,000 plus colonoscopies?

A Best as I can recall, yes.

Q Did you do a lot of those when you were working at the endoscopy center?

A Yes.

Q Did you ever know the CRNAs, during the time that you worked with CRNAs, to give so much propofol that it caused a problem? Meaning that they gave too much propofol and the procedure's done and the patient's asleep for extended periods of time?

A Not that I recall.

Q In fact, you said it was a short acting type drug, correct?

A Correct.

Q Don't give it if a patient wakes up?

A Right.

Q Was it your impression that in all the procedures you did that there was some problem with the CRNAs giving too much propofol?

A No.

Q But that's what he said the reason for this whole process was?

A As I recall, yes.

Q Now, you were asked some questions also with the -- well, let me go back to the beginning. You were asked some questions about how much you made and -- on cross-examination. Do you recall that?

A Yes.

Q And that you participated, I guess, in CRNA fund, things like that?

A Right.

Q You were asked some questions related to some of the other doctors, their pay. Did you know how much anybody else made?

A No. I -- I knew that fundamentally if I received a check for X amount of dollars as a owner of one share, that everybody else received that same distribution as well as me but I didn't know how anybody else got any extra

bonuses or any extra pay for work or for -- for working hard, I didn't know that.

Q As far as the CRNA account, did you have any idea even how much money was in it?

A No.

Q Or how it was distributed?

A No.

Q You would just get bonuses from it and from other sources?

A And from other sources, yes.

Q Who knew the information about what everybody made?

A I didn't. I can only assume so I -- I don't really -- I can only assume who knew that.

Q Was there ever any sort of policy in place that look, we don't talk about salaries or anything like that in the group? Salaries or bonuses or how much everybody makes?

A Well, it was sort of understood. I don't know if there was a written policy like that, I never saw such a thing, but it was understood that that was at the discretion of the -- of the managing partner.

Q And you were not that person?

A Right.

Q Now, you -- you were asked a couple of questions about Vishvinder Sharma that he took at some point after the

discussion of Dr. Desai possibly retiring and was voted as possibly the successor --

A Yes.

Q -- are you with me? That he took over some role? Some management role or at least in name.

A In name he became a co-manager.

Q What did he do?

A The answer's I don't know.

Q Did you ever see him assert himself making decisions and -- and the like?

A No.

Q Now, you said that throughout the time that you were working there, that you were -- you felt you were working really hard?

A Yes.

Q Did you ever feel that you were working so hard that you couldn't continue at the same pace?

A Yes.

Q And that's you as the doctor doing procedures, correct?

A Right.

Q What about the staff? Did the staff work equally hard and try to turn over the room -- and get the rooms and get the patients in there and being prepared so you could do your procedure?

A Well, remember that when I told -- referred to that, I referred to a -- the global situation for me. Doing many, many procedures every day, then being on call, you know, the staff wasn't on call after hours, weekends, nighttime call. So I'm talking about the entire picture. But the answer is everybody worked hard and -- in the endoscopy and on the medical side.

Q Do you think it was difficult to do the numbers of patients every day that you guys were doing it?

A I think it was difficult, yes.

Q Do you think that it was -- I mean, the very next day after you kind of take over, what is the very first thing you do?

A I reduce and limit the number of endoscopy procedures.

Q Did you think that that was significant enough that that would be your first act as kind of person in charge?

A Yes.

Q Does that not just reflect on the stress on you but on the staff as well?

A Yes, sir.

Q You mentioned a hike that you were on and Dr. Desai called you. Do you recall that?

A Yes.

Q What was that about?

A Well, in the -- I believe it was July or June of 2007, in the summer while I was on a hike, Dr. Desai called me to tell me that his cardiologist was concerned about his health and that his cardiologist had recommended that he not do as much work, as many cases and could I step in and do procedures on a daily basis. At that time I was doing it maybe twice or three times per week.

Q And he wanted you to do it every day?

A He wanted me to do endoscopy Monday through Friday in the morning.

Q Well, what did you tell him?

A I told him that I think I could do it but I can't do it if I have to be on call as well and I need some help to figure out how to not take call at night and be up and tired and come in to do cases. And he said let me take care of it.

Q So what happened?

A I think what we -- I began to pay other people to take my call and Dr. Desai agreed to reimburse me for that either from his own funds or from the funds of the center and the practice.

Q Did that mean that you were then -- since you were working, doing all the procedures essentially or would be, that you then took over the management portion of the practice in any way?

A No.

Q So it was basically you were due to work but not manage?

A Correct.

Q And you had -- is it fair to say that you then -- did you actually do that, pay others to take your call so you could do all the procedures?

A Yes. I paid others to take my call so that when I came in every morning I was fresh.

Q Okay. So you come in every morning and you're fresh, you're not taking call because you're paying people to do it, right?

A Correct.

Q And whether Desai reimburses you or not, at least that's the plan?

A Right.

Q So now you're -- you're like the staff, you're not taking call at night, you're there every day doing procedure, after procedure, after procedure, day in and day out; is that fair?

A That's fair except I'm also -- I'm still taking weekend call.

Q Not during the week though?

A During the week.

Q Were you exhausted by the time the weekend got

around?

A Pretty tired but I still did my -- my responsibility.

Q Now you mentioned in some questions regarding Dr. Yee and the anesthesia. Do you remember that?

A Yes.

Q As Mr. Wright said, that he would -- that Dr. Yee was the go-to guy for anesthesia questions and problems?

A I remember that, yes.

Q Where did that come from?

A Well, I remember back in the early 2000s that when there were questions and issues that Dr. Yee would be called.

Q Hold it. When was this?

A In the 2000s, early 2000s.

Q So is this before the CRNAs come on board?

A No, after.

Q Afterwards?

A Afterwards, yes.

Q So initially the CRNAs are hired at I think you said 2000 --

A 2000, 2001ish.

Q And that Dr. Yee -- you said you never saw him in the facility ever?

A Right.

Q So what -- how did you even know that he was the one that was being contacted if there was anybody being contacted?

A I just -- I -- I know that -- I would hear Dr. Desai talk about calling him or hear Dr. Desai talk about his name.

Q Okay. So Dr. -- this information came from Dr. Desai?

A As best as I remember, yes.

Q So you didn't have a conversation with Dr. Yee about any consultation? You didn't call him up and ask him questions or anything else?

A No.

Q So Dr. Desai is telling you that Dr. Yee is the one who is filling the role of the co-supervising anesthesia person?

A Well, remember that there's -- I never heard the phrase co-supervising. I just heard that Dr. Yee was the person that was the person he asked questions to and consulted.

Q State's Exhibit 106, section marked number nine, anesthesia services. You were asked some questions about this as well, were you not?

A Yes.

Q Have you seen this document before you were

shown it in Court?

A Yes.

Q Was it during the time that you were practicing at the clinic?

A No.

Q When was that?

A When did I first see this?

Q Yes.

A Sometime after the events occurred in 2008.

Q Okay. So while you were practicing you never saw a policy and procedure manual for the staff and how to clean things and how anesthesia was done, anything like that?

A No, I never looked through it.

Q Why was that?

A I just never thought that I needed to or thought that I should.

Q And you saw the things that are listed in here, correct?

A Yes.

Q And it's referring to adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians?

A Correct.

Q Who are approved and have privileges granted by the governing body.

A Correct.

Q The governing body to you was what?

A Well, remember, like I just told you, I had never seen this before until afterwards and now I understand the governing body to be those people who are -- who are responsible for decisions for the endoscopy center.

Q People that were responsible for decisions or a person?

A People.

MR. SANTACROCE: Objection. Asked and answered. Leading.

THE COURT: Overruled.

BY MR. STAUDAHER:

Q Well, did you not say a moment ago because I asked you about Vishvinder Sharma and --

A Yes.

Q -- I asked you about you --

A Yes.

Q -- and I asked you about the other doctors. Did you say that anybody else had any -- any say so in how the practice was run and decisions that were being made?

A Right. I answered that that no, we didn't.

Q So who was the one who had the responsibility for making decisions?

A Dr. Desai had that responsibility.

Q So essentially was he the governing body then?

A See, the answer is I don't know. The governing body actually has a list of names on it.

Q Okay. Were you ever -- maybe that's a -- a poor characterization. Let's step back for a second. The governing body, who did you believe was part of it?

A Well, I did -- I believed that Dr. Desai, Jeff Refuge and Katie Maley were part of it.

Q So some nurses were part of the governing body?

A Yes, nurse managers.

Q Do you think that they had say so in how the practice was run? I mean nurses?

A Well, I don't think they had say so, you know, I think that they -- if they had concerns they would raise them. If they had issues.

Q So you don't think they were contributors then?

A Yes.

Q Okay. Because you as a managing partner, almost second in command, didn't have any --

A Remember, I was never a managing partner.

Q I'm sorry. Did I say that?

A Yes.

Q I misspoke. You as one of the partners, and I'm talking about the partners who share -- who get the shares and so forth, right? The money that's divided up.

A Correct.

Q Because there were employee physicians and there were partner physicians, right?

A Right.

Q So as one of the partner physicians, you didn't even have any kind of real control over the practice?

A No official control.

Q Unofficial control?

A No.

Q Now under the next section here, and I know we got into this thing, it says one and there's another one, I don't know if that's a typo or a continuation or what, but under the first one it says, The attending physician will provide on-site and continuous supervision of the Certified Registered Nurse Anesthetist." Do you see that?

A Yes.

Q Now, the attending physician was who?

A The attending physician refers to what it says in B, one or more qualified physicians who are approved and have the privileges granted. That's how I understand this.

Q Okay. Now, who were the physicians who fell into that category?

A Those physicians who were on the supervisory agreement.

Q Okay. So the supervisory agreement would it

have had Dr. Desai and Vishvinder Sharma or just Dr. Desai? Would those be the people you're talking about?

A Yes.

Q Because we have a couple of different ones.

A Correct.

Q And you've seen those at some point?

A I did see those.

Q So the attending anesthesiologist would provide on-site and continuous supervision. It was Dr. Desai or Vishvinder -- well, Vishvinder Sharma didn't even work at the Shadow Lane facility almost at all, did he?

A Well, he did. He -- not as much as others but he did procedures there. He had an assigned day that he did procedures there.

Q Okay. But it was -- was it a day a week, was it less than a day a week, what was --

A I think it was one or two days a week.

Q Okay. So he's there. When he's there he would be the guy in charge, or the guy responsible for these CRNAs? Well, at least according to this agreement.

A Well, according to this agreement, he's in charge at all times.

Q Okay. And Dr. Desai clearly is one --

A Yes.

Q -- right? Now, when it says provide on-site and

continuous supervision, were there times when both Dr. Sharma and Dr. Desai were not on-site?

A Yes.

Q Based on the policies and procedures of the clinic, that would be something that wasn't happening, correct?

A Correct.

Q That they weren't on-site and doing continuous supervision?

A That's right.

Q So was there ever any discussion about what would happen in the situation where both of those individuals would not be there?

A No.

Q Did you ever think about it?

A No, because like -- like I told you before, this piece of the policy book came to my attention in 2008 after the events unfolded. I had never seen this.

Q I mean, it wasn't that it wasn't available to you, you just never looked at it; is that right?

A I never looked at it nor was I ever counseled or informed of this -- of this supervisory or this part of the document.

Q Okay. Because that's what I want to go back to then because you were asked about whether or not Dr. Yee was

the go-to guy.

A Right.

Q And you said that that information came from Dr. Desai?

A Yes.

Q Was that at a partners meeting, in passing, I mean how did this subject even come up?

A Sort of in passing. Just as we were developing the anesthesia part of the practice as nurse anesthetists, Dr. Carrol -- or Dr. Desai and Dr. Yee had -- they had a relationship, they had conversations.

Q Well, at least that's something Dr. Desai is telling you?

A Right.

Q Because you never met with Dr. Yee, never saw him there?

A I never saw him there. Dr. Yee and I did cases together at the hospital but I don't recall seeing him at our center.

Q And when you saw him in the hospital, did you ever have any discussions about this, hey, I understand you're coming over and you're going to be supervising our CRNAs?

A Never.

Q From Dr. Desai then, you understood this to be an informal verbal type agreement?

A That's what I understood, yes.

Q I'm sorry, I didn't mean to interrupt you. You said that you independently at one point looked up the requirements for CRNAs in the State of Nevada.

A Yes.

Q You actually looked them up and researched it enough that I think you said you made a presentation to Valley Hospital?

A Yes.

Q Which was rejected, they wouldn't use them, correct? You said that -- that according to the rules, there must be a supervising doctor but it did not have to be an anesthesiologist.

A That's correct.

Q Now, according to this policy, this written policy that you saw I know afterward, it looks as though there's some sort of supervision, correct?

A Correct.

Q But if Dr. Yee is not present or -- or a like person, and Dr. Sharma and Dr. Desai are not present because they're physically not there, was that requirement being met? Because you certainly weren't falling into that role, right?

A Right. So the answer is the way you just outlined it, that requirement was not being met.

Q Do you know why they have a requirement for that

at the -- in doing all this research that you did?

A Yes.

Q Why is that?

A Because in the -- in the State of Nevada, but not in every state, nurse anesthetists can or may not, according to individual states, practice independently without a supervising physician. In Nevada, Nevada continued and did not opt out of the Medicare rule, which allowed a state to opt out and let a nurse anesthetist practice without a supervising physician, independently. So in the State of Nevada a nurse anesthetist, in order to practice, needs to be supervised but it doesn't -- it doesn't mean it has to be an anesthesiologist. It has to be a physician, a surgeon or a, I believe, a podiatrist or dentist. We'd have to look it up but it doesn't have to be an anesthesiologist.

Q Well, fair. I mean, that's what you've said and you did the research on it, correct?

A Yes, yes.

Q And I don't think anybody's disputing that.

A Okay.

Q The issue is that Desai and possibly Sharma are not present, Yee's clearly not there, you never saw him.

A Right.

Q The only doctor in the facility that's -- like in the morning when the -- you said you started alone would be

you?

A Yes.

Q Or a physician in your -- in your place, correct?

A Correct.

Q So the only doctor in the whole facility wouldn't even know that they were supposed to be supervising the CRNAs?

A Well, remember, that -- you heard how I interpret this.

Q Yes.

A But the answer to your question is the only doctor in the facility, say me, personally, I had no knowledge of this agreement or this statement or this policy statement.

Q Sorry. Was there ever any discussion at any doctors meeting about this issue?

A Not that I recall.

Q To your knowledge, was there any discussions with Dr. Desai and any of the other doctors at any time about this issue?

A Not that I remember.

Q And you didn't know until you saw this post event that you were even potentially the person who would be considered an attending physician?

A Correct.

Q Now, you said that this thing that went on with Valley Hospital, I think counsel actually asked you, brought up the thing that there was a turf war between the CRNAs and the anesthesiologists, correct?

A Correct.

Q And that the -- the issue proffer -- or the reason proffered to you for not using the CRNAs was it was not safe for patients to just use a CRNA without an anesthesiologist associated with them, correct?

A Correct.

Q So the hospital felt it was not safe to do it in that manner?

A Right.

Q Yet you would acknowledge, based on -- and I can show you even the day in question, you've looked at that incident day with all the names on them, correct?

A Correct.

Q In the afternoon when Dr. Desai isn't there or in the morning when he's not there, depending on which day you're looking at, I mean, Sharma's clearly not there, right?

A Correct.

Q That wouldn't fall into either category of something that would be allowed? Either the State requirements or this, your own policies and procedures.

MR. WRIGHT: That's an absolutely false statement of

the law, Your Honor.

MR. STAUDAHER: It's not a false statement of the law.

THE COURT: I mean, that -- you need to rephrase the -- you need to rephrase the question.

BY MR. STAUDAHER:

Q Dr. Desai is not present, you or another doctor present and just the CRNA, you with me?

A Start again.

Q Dr. Desai is not present.

A Okay.

Q Other doctors are present, maybe even you, you're not doing any supervising of these -- of these CRNAs, correct?

A Correct.

Q You talked about the charge -- remember you were asked questions about the charging of -- for anesthesiologists and you were -- you gave the whole thing -- or it was given to you the -- the facility charge, and the doctor charge, and the anesthesia charge, right?

A Correct.

Q So you were -- you were familiar that those kinds of charges were going out to the patients?

A Yes.

Q So you knew that the facility was charging for

anesthesia services provided by the CRNAs?

A Yes.

Q Now counsel asked you about capitation and about flat fees and all that. Did you know how much was being charged for each procedure for a CRNA?

A No. I understood that -- I believed that it was always a fee. I believed it was $90. I remember hearing that figure as our charge for anesthesia.

Q Where did you hear that?

A I don't remember, but I heard that it was $90. I remember that one of the -- one of the insurance companies, one of the major insurance companies had come to that agreement with us and that was $90. So I believe it is always --

Q Did Dr. Desai ever talk about that issue to you?

A I don't remember him talking to me personally about it.

Q Was it brought up during a doctors meeting at any time?

A No.

Q But you're --

THE COURT: Let me --

MR. STAUDAHER: Go ahead. I'm sorry.

THE COURT: Oh, I'm sorry. I was going to say maybe we should take our -- our break because we'll have to take

another one at the end of the day.

MR. STAUDAHER: That's fine, Your Honor. We can do that.

THE COURT: So ladies and gentlemen, just a real quick break, no more than 10 minutes, if you can try to keep it to that. And once again, you're reminded of the admonition not to discuss the case or anything relating to the case with each other or read, watch or listen to any reports of or commentaries on the case, person or subject matter relating to the case and please don't form or express an opinion on the trial. Notepads in your chairs and follow the bailiff to the rear door.

(Jury recessed at 3:13 p.m.)

THE COURT: I'm guessing 5:00?

MR. WRIGHT: What?

MR. STAUDAHER: We have an issue.

MS. WECKERLY: We have an issue that it'd probably be easier to discuss it now.

THE COURT: Okay. Should we -- we need to excuse the witness. Sir, this may concern your testimony so I need you to step into the vestibule, please. There's a little conference room there at the -- yes, oh, I'm sorry, one moment. Yes?

MR. STAUDAHER: I know the Court has not yet ruled on the bad acts issue and I don't intend to --

THE COURT: And we haven't had a Petrocelli Hearing even if the Court --

MR. STAUDAHER: -- I don't intend to get into anything related to specific instances or patients or whatever. But I think based on the questioning that has gone forward with this witness alone with Mr. Wright and not Mr. Santacroce per se, but Mr. Wright regarding the quality issues and whether or not there was -- he had [indiscernible] and what?

MS. WECKERLY: Quality control certification.

MR. STAUDAHER: Yes, and that whole issue about the quality control certification that the AAAHC coming, that they didn't see anything wrong, there were all this -- everything was running above board, that he didn't see any problems in the clinic, that he wasn't aware of any issues with, you know, himself and Dr. Desai. He started even to ask the questions about --

THE COURT: Well, he did start saying he was aware of a perforation.

MR. STAUDAHER: I think at a bare minimum that the State should be able to ask this question -- this witness the question, are you aware that Dr. Desai was one, sued by the people related to incidents in this case and not this case particularly but the -- and also that he had 31 complaints for -- the State Medical Board for doing various things like the

perforation issue that was directly asked by counsel. That that doesn't get into the details of what took place but just what his knowledge would be if he knows it. I think it's a -- it's a germane and reasonable question that has been opened -- the door's been open to based on the direct questions of the defense counsel. And that's -- and that's like getting into the substance of what took place or having a witness testify, it's just saying is this witness aware --

THE COURT: Well, first of all, how many lawsuits against Dr. Desai are we talking about?

MR. STAUDAHER: Well, there --

THE COURT: How many malpractice lawsuits?

MR. STAUDAHER: -- there were multiple, I don't know --

MR. WRIGHT: How many?

MR. STAUDAHER: -- every single one --

THE COURT: What does multiple mean? Because I mean --

MR. STAUDAHER: I don't know -- I don't know the number.

THE COURT: -- let me just tell you, many good doctors get sued. So just the fact that there was a medical malpractice lawsuit without a finding of -- of culpability does not mean anything and it's -- I don't think it's that unusual for a reasonably competent physician to be sued more

than one time. Now, you know, six, seven lawsuits, I think now that's getting to be a lot of lawsuits.

MR. STAUDAHER: Well, we're talking about this case. Not this case --

THE COURT: No, no, I'm saying -- I'm saying but how many times was Dr. Desai sued unrelated to the hepatitis C outbreak?

MR. STAUDAHER: I don't know the actual number. I'd have to go back and look. It was --

THE COURT: Okay.

MR. STAUDAHER: I've seen the transcripts. He's on multiple ones of those transcripts, that were at least represented in either as directly by the clinic or by him being named directly.

THE COURT: I know and I asked you how many lawsuits?

MR. STAUDAHER: I don't know the actual number.

THE COURT: Okay. Is it more than five or less than five?

MR. STAUDAHER: I don't know.

THE COURT: Because like I said, many good doctors are sued and that does not -- that's not evidence of anything that they're a bad doctor, which is what you're trying to suggest. And it may be evidence that he's a bad doctor and it may be evidence that he's not a bad doctor. But what I'm saying is just the fact somebody sued doesn't necessarily mean

anything. So that's a problem there.

Now the 31 complaints is troubling but I don't have a reference -- I mean that sounds to me like a -- a lot of complaints, 31 complaints.

MR. STAUDAHER: Well, and the problem --

THE COURT: Sounds to me like a lot of complaints. I don't have a reference point on that. How many complaints --

MR. WRIGHT: Individually --

THE COURT: -- other doctors have but it sounds like a lot, I give you that.

MR. STAUDAHER: I can certainly ask this doctor if he had any complaints at the State Medical Board that he's aware of. He would be aware of those because he would be notified like Dr. Desai was notified. And are you aware if in fact there were complaints -- not only was Dr. Desai notified, and that's what part of the issue is, but he was given essentially a couple of letters saying, look, we're getting all these complaints, you need to change your practice. And part of the practice was the exact issues that are coming up in this case. The speed of procedures, how he handles patients, things like that, it's all come up. Now we have at least three organizations, Quality Consultants, AAAHC, [indiscernible] that has supposedly come in and given them a clean bill of health.

The BLC even alluded to as trying to say that they

washed their hands of the situation and thought that they were doing okay after -- after the correction letter was given to them. I mean, all of those things are coming in to make it sound like this is just a hunky-dory operation and that this individual believes Dr. Desai is golden. He even produces a letter where this witness --

THE COURT: Okay, I get the point.

MR. STAUDAHER: -- is saying that this guy's really good.

THE COURT: First of all, you can't ask him, you know, are you aware there were 31 complaints because now you're putting in evidence that there's 31 complaints. You can ask him, you know, are you aware of -- of, you know, complaints against Dr. Desai and then see where it goes -- it goes from there. Because again, 31 complaints sounds like a lot. Without knowing the number of medical malpractice cases and the outcomes, I'm inclined not to allow that question because I just don't know how many there were. And I think to lay people a medical malpractice case sounds like oh, my God, there's been this medical malpractice case.

As a Judge I know that a lot of times those don't go anywhere and good doctors get sued. Do bad doctors get sued? Yes. So, I mean, I think I would need to know what's the outcome and is this a large number of medical malpractice cases. As I said, the complaints to the medical board, that

sounds excessive to me so I think that that may be evidence of something.

MR. WRIGHT: I'm going to object to this. I mean before --

THE COURT: I assumed you were.

MR. WRIGHT: Well, I don't -- so there's 31 individual -- I'm asking, 31 individual complaints against Dr. Desai in his individual practice --

MR. STAUDAHER: Yes.

MR. WRIGHT: -- of patients involving endoscopies?

MS. WECKERLY: We -- why can't we just ask, would you hold the same opinion if you knew --

MR. WRIGHT: I think this is a misrepresentation.

MS. WECKERLY: -- you know, about X amount of complaints. I mean --

MS. STANISH: No.

MR. WRIGHT: No, because they are.

THE COURT: That's totally inappropriate to ask it that way --

MR. WRIGHT: I ask -- I asked the question --

THE COURT: -- because now you're putting it out there he's had all these complaints and whatever. So, you know, you can ask him if he was aware of the complaints and, you know, or would it -- would it -- you know, how many complaints has he had, you know, is that -- does that sound

being used for like saline?

A I don't recall at that time discussions of other multi-use preparation; saline, Lidocaine, et cetera. I remember the focus of that exit meeting being the propofol and the observation of the needle change as the most likely mechanism of what happened.

Q Okay. And so the -- it -- it -- after that, aside from the propofol injection policy, if I'm correct, you also went ahead and got rid of like common use saline for starting -- in preop for heplocks and went to individual prefilled saline syringes --

A We did.

Q -- is that correct?

A That's correct.

Q And that was as a result of the investigation and concerns being raised about possible contamination?

A That's right. That -- that occurred during the process. For example, the idea that the flushes that were being used for the IVs or the heplocks, were coming from a single bottle was made to us during the process of that 10 days.

Q Okay.

A And then it's during that time that Jeff Krueger mentioned that to me and said well, you know, you can get prefilled syringes with saline. And I said then go ahead and

get them, so we did that.

Q Okay. And Lidocaine was another medication -- is that a medication or --

A Lidocaine is a -- is a topical anesthetic agent --

Q Okay.

A -- that comes in a large bottle.

Q Okay. So that -- that's what we would call multi-use --

A Yes.

Q -- correct? And so -- and Lidocaine was used by CRNAs to mix with propofol to inject the patient that supposedly removed the sting?

A Correct.

Q Okay. And so based -- based upon -- during that same period of the inspection and concerns being raised, Lidocaine was changed?

A To my recollection we just simply said no more Lidocaine.

Q Okay.

A No -- no -- just forget using it because of the -- as maybe that could be a problem.

Q Okay. So these -- these changes are being put in place by the clinic, correct?

A Yes.

Q There are -- you know -- I'm in mid-January now, okay? You and -- you were designated to be the representative of the clinic to interface with CDC and Southern Nevada Health District; is that right?

A I don't know if it was an official designation, it was sort of a de facto reality --

Q Okay.

A -- so I was there, I took it upon myself to --

Q Okay.

A -- to interact with these representatives, to understand what was happening, to help --

Q Okay.

A -- and participate in discovering what happened and to correct it.

Q Okay. I didn't mean like a official, only talk to him, but you were the representative of the clinic interfacing with them the most?

A Yes.

Q Okay. And as was Tonya and all of the staff that they wanted absolutely cooperated, correct?

A Yes.

Q And you all opened your doors and did everything possible, everything possible to assist in determining what had happened; is that fair?

A That's accurate.

Q And everyone in the -- every employee that was there gave blood tests, you yourself did?

A Yes, sir.

Q That was all to see if it had been employee transmitted in some fashion?

A Correct.

Q And so you have these changes in place or being implemented in mid-January. Do you see anything on the horizon like is going to come and blow up?

A No.

Q Okay. The -- in dealing with BLC the State wrote up a report for you all, correct?

A Yes.

Q Okay. And that was their findings of what they thought was wrong; is that fair?

A Fair.

Q Okay. And the procedure is you all respond to that in writing and correct any infractions or anything they think is wrong.

A Right. During that process and as I was learning how this works because I never experienced anything like this, we needed to prepare a plan of correction, an official detailed plan of correction, in writing, to the Bureau of Licensure in response to their identification of problems or infractions. And we did with the help of Lewis

and Roca, the attorneys to make it professional, but we laid out a plan of correction back to the Bureau of Licensure.

Q Okay. And so for -- and it's literally a document, we will later see it here in the courtroom from BLC, but it lists here's what we found, and then right -- other half of the same page you all respond as to what you are doing to remedy any problems they have, correct?

A Yes, sir.

Q Okay. And BLC was satisfied with that?

A BLC was completely --

MR. STAUDAHER: Objection, Your Honor --

THE COURT: Well, he asked whether or not they were satisfied. That's sustained. You can ask it another way.

BY MR. WRIGHT:

Q Okay. What was -- did the -- what was BLC's response?

A I received a phone call from an attorney at Lewis and Roca telling me that the plan of --

MR. STAUDAHER: Objection to hearsay, Your Honor, at this point.

THE COURT: Well, that's true. It's sustained.

MR. WRIGHT: Okay.

THE COURT: Well, let's -- I was going to take a break in two minutes.

MR. WRIGHT: Okay.

THE COURT: Let's take our break now. Ladies and gentlemen, we're going to take our morning recess until 11. During the morning recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, person, subject matter relating to the case. Don't do any independent research and please don't form or express an opinion on the trial. Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 10:47 a.m.)

THE COURT: All right, if anyone needs a break.

MR. STAUDAHER: I just want to make sure that we're clear that I'm going to object to anything that we're going toward of me giving -- having this witness make any legal conclusion that the BLC somehow --

THE COURT: Right. He can -- I sustained your objection. I mean, he can say after the BLC report we were allowed to continue to operate or, you know, or they gave us additional direction or whatever, but he can't say what their satisfaction level was or anything like that unless he got a letter, we're satisfied, you know. But, I mean, obviously there -- you know, whatever inference that they were allowed to continue to operate. So Mr. Wright, you need to phrase your questions that way, not as to --

MR. WRIGHT: Okay.

THE COURT: -- what they may have been thinking or their future plans or anything like that because obviously the witness doesn't know that.

MR. WRIGHT: Got it.

THE COURT: And if he did he couldn't testify to that. I have a question, just off the record for the State.

(Court recessed at 10:49 a.m. until 10:57 a.m.)

(Outside the presence of the jury.)

THE COURT: All right. If everyone's ready we can see if the jury's ready and get started.

Just so you folks know, I have to do an evidentiary hearing that's been moved in a civil matter Monday morning so we're going to start later. I tried to find -- I just found out about it and I tried to find a other -- another judge to hear it but I can't, so it will be me. So we'll be getting -- we've all been spoiled by these early start days so --

MS. WECKERLY: The -- the -- that's fine. The witness I have scheduled is a doctor so I'd like to give him as much as heads up --

THE COURT: Okay.

MS. WECKERLY: -- and he was set for the morning so --

THE COURT: Oh, I'm sorry.

MS. WECKERLY: That's okay. But if you could just

tell me then I'll submit it.

THE COURT: Okay. So maybe we would start like --

MS. WECKERLY: Just afternoon, is --

THE COURT: -- yeah.

MS. WECKERLY: -- that what you're saying?

THE COURT: Just like 12:30.

MS. WECKERLY: Okay, I'll have him --

THE COURT: No lunch break, we'll start at 12:30.

MS. WECKERLY: I'm going to just have them call right now.

THE COURT: Okay. If there's a problem let me know and I will send out a blast e-mail to all the other judges and see if somebody will pick it up. But my usual -- my usual sources for help are either not here or have said they can't do it.

MS. WECKERLY: Okay.

THE COURT: So --

MS. WECKERLY: But we'd start like at one, do you think?

THE COURT: I would say 12:30.

MS. WECKERLY: Okay.

THE COURT: And then again, no lunch break, we'll just tell them -- bring them in.

(Jury reconvened at 11:01 a.m.)

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

Mr. Wright, you may resume your cross-examination.

MR. WRIGHT: Thank you, Your Honor.

BY MR. WRIGHT:

Q BLC you -- you and your lawyers, the clinic, when I say you I'm talking about the clinic, had prepared a plan of correction and submitted it to the BLC, correct?

A Yes.

Q And BLC could revoke licenses, close the clinic if they wanted to?

A To my knowledge they have that authority.

Q Okay. And after the submission and communication back from your lawyers and your understanding of the position, were you planning to close the clinic?

A No.

Q Okay. So as far as BLC goes, you believed the -- the -- the concerns and issues had been addressed and you all would be going forward, a bigger, better clinic than ever?

A Well, the plan of correction was accepted.

Q Okay. And you didn't see still yet on the horizon what was going to come?

A I didn't foresee this, no.

THE COURT: And I don't know if this is clear, the BLC is what again?

THE WITNESS: The Bureau of Licensure for the State of Nevada.

THE COURT: Okay.

BY MR. WRIGHT:

Q Now, the -- when -- going forward, do you first learn of a plan for notification?

A I first learned of the plan for public notification at a meeting at the Health District office and I apologize, I do not remember the date of that meeting. But that was a meeting that was called by the Health District to report its -- its findings and recommendations. When they departed they didn't make recommendations or formal findings but this -- they said we'd get back to you in a number of weeks. And this -- this was a meeting that was called by them to discuss the situation.

Q Okay. And so when -- when they departed, the exit interview, for lack of a better word, after being there 10 days, informally they said we see these as issues; propofol, syringe use and you all responded as you've already testified to, correct?

A Correct.

Q And -- but you were still waiting for a final conclusion of what the -- of the Southern Nevada Health District, correct?

A Yes.

Q How about CDC, did you lump those two together in your mind?

A In my mind they were lumped together.

Q Okay. And so the -- finally -- do you recall it -- it would have been in early February approximately?

A Approximately, yes.

Q Okay. And so early February you're called to get the results from the Southern Nevada Health District?

A Yes.

Q Okay. You go and who else?

A To my recollection at that meeting it was me, and Tonya Rushing from our practice, Brian Labus, Dr. Sands, the Director of the Southern Nevada Health District, another representative from the Southern Nevada Health District and I believe a representative from the Bureau of Licensure was there.

Q Okay.

A It's hard for me to remember.

Q And so run through that meeting generally.

A That meeting was a meeting to inform us of the findings and the conclusions of the evaluation investigation. And during that meeting Brian Labus and Dr. Sands were predominately the people who were communicating to us. We were told that --

MR. STAUDAHER: Your Honor, I'm going to -- since we have those witnesses coming in I'm going to object to this at this point for hearsay purposes.

THE COURT: All right. What's the purpose you're offering it for that's nonhearsay.

MR. WRIGHT: To put in context what they then did.

THE COURT: All right.

MR. WRIGHT: I mean, the witnesses are going to come in here.

THE COURT: All right. Well, some of this you can ask, you know, a different way based on what they told you, what did you do but, you can go ahead and kind of give us the gist of the meeting.

THE WITNESS: Well, the gist of the meeting was that it was concluded that indeed the propofol and the needle change was the mechanism by which the hepatitis C transmission had occurred. And the gist was --

THE COURT: Who made that to you -- I'm sorry.

THE WITNESS: Brian Labus --

THE COURT: Okay.

THE WITNESS: -- and Dr. Sands.

THE COURT: All right.

THE WITNESS: And that since they could not determine how far back this practice went, they were planning to inform all patients who had ever had a procedure at our surgical center, from 2004 forward, that you needed to be tested for hepatitis A, B and C and for HIV. And that they were going -- since it was unlikely to be effective by mail only, that they

planned to do a public announcement, a date to be ascertained.
BY MR. WRIGHT:
Q Okay. And was that the -- the first you had heard of any such proposal like that?
A Yes, sir.
Q Okay. And what was your response?
A Well, my response was fear and shock because I understood that that meant that there were going to be approximately 50,000 people in this valley notified that there was a potential foreign infectious transmission and that testing needed to be done. And I -- I protested, I didn't think that was reasonable.
Q Okay. And did you suggest at that time, at that meeting or later alternatives?
A Yes.
Q Okay. And what -- what -- at this time are you, yourself, investigating vigorously and devoting your time to trying to find out what could have happened like on September 21st?
A It's hard for me to remember when I really started to do that.
Q Okay.
A It was in and around that time where I started to try to get the information myself, understand who was scoped that day, what the schedule was, who -- who are these

patients who acquired hepatitis C. I had -- I had started the process of looking in to this.

Q Okay. And so the -- were you concerned that they were incorrect in their determination?

A Well, I was very concerned that the determination was incorrect and I made several suggestions -- alternatives to them about how to move forward.

Q Okay. And what -- what were those suggestions and to whom?

A I suggested at the time to Dr. Sands and to Brian Labus and the other participants that perhaps -- that it didn't sound reasonable to do this and perhaps it was a better idea simply to -- to do more investigation and to perhaps do a -- a small further study and take a sample of the patients, a random sample of any of the patients from four years and test for hepatitis C, some number of patients, and see if that incidence of hepatitis C in that sample, was any different than the background expected incidents of hepatitis C.

Because like I told you before, we know that there's quote, 1.9 or 2 percent background incidence of hepatitis C or prevalence is better. And if there was an increase, a statistical increase over the background rate, than perhaps then having this testing move forward was reasonable but if there wasn't maybe to reevaluate the conclusion.

Q Okay. I want to be certain this is understood

what your proposal was and background rates, et cetera. The Health District was proposing -- because of this incident on the 21st and -- of September and July 25th, notify 50,000 plus patients, correct?

A Yes.

Q And you were suggesting that let's do random sampling of patients by days or whatever mechanism, have those samples tested for hepatitis C, correct?

A Correct.

Q And see how many of them test positive for hepatitis C, correct?

A Correct.

Q And you -- you read Brian Labus's Southern Nevada Health District final -- final report, which came out at the end of 2009?

A Yes.

Q Okay. And you recognize -- do you -- did you understand that the background rate for the people at the clinic -- at the clinic, because of their age, was approximately four percent expected?

A I remember reading that.

Q Okay. And the -- the rate was -- the expected rate of hepatitis C in the populous of the clinic -- meaning they had it before they ever walked in the door, right?

A Right.

Q Okay. Expected to be four percent and that was higher than like the national average because we're dealing with mainly baby boomer -- baby boomers, elderly people, getting colonoscopies and they're in the group with the higher incidents --

A I think that's reasonable --

Q -- is that fair?

A -- I think that's fair.

Q Okay. So what you were suggesting is we know that the patients in the clinic, four percent of them statistically should have hepatitis C, if you all are right, Southern Nevada Health District, we -- that this was the method of transmission and this has been going on for four years, we can test and see if the patients with hepatitis C have an amount higher than expected, right?

A Well, that's correct except for I didn't say at that time four percent expected. You know, I still understood it to be around 2 percent from -- from understanding and from training. But that four percent number appeared later, in the sub-population from --

THE COURT: When you said the two percent you weren't factoring in the baby boomers and people have --

THE WITNESS: That's --

THE COURT: -- colonoscopies at 50.

THE WITNESS: -- right, that's a national average.

THE COURT: Okay. Young people, super old people, everybody?

THE WITNESS: All the population.

THE COURT: Okay.

BY MR. WRIGHT:

Q Okay. But as far -- as far as the math works, whether it's two percent or four percent, grab one month like from each year, test them and presumably you should have so many with hepatitis C, right?

A Correct.

Q And if there was twice that much there would be an indication that maybe there's a problem and the Health District's right, correct?

A Correct. I didn't say twice, I said an increase.

Q Right. I mean, I'm just trying to explain what it was when you said please do sampling and compare it to the background incidence of hepatitis C.

A That's correct.

Q Okay. And they're -- did you get an immediate response from Dr. Sands or Brian Labus to your proposal?

A Yes.

Q And what was it?

A Well, from Brian Sands -- excuse me, from Brian Labus, the response was no.

Q Okay.

A The response was it doesn't matter because we observed the practice and we don't know how far back it went and we're obligated to inform potential patients that they may have been exposed or have had a transmission. Dr. Sands though --

MR. STAUDAHER: Your Honor, and I'm going to object to hearsay again. I let that last part in because I think that that was appropriate but I -- it's a continuing objection here on this so.

THE COURT: All right. Well, did Dr. Sands indicate whether or not he would do that or consider it or?

THE WITNESS: He indicated he would consider that.

THE COURT: All right.

BY MR. WRIGHT:

Q Okay. And the result of that -- did -- did you then talk to someone else?

A Yes.

Q Okay. And who else did you talk to about the necessity for this -- the breath of the disclosure they wanted versus your targeted test, see if you're right and then more evaluation, who else did you talk with?

A I spoke to the representative from the CDC who had been there during the investigation by telephone.

Q Okay. And did -- did you propose -- discuss the

same type things we've been talking about?

A Yes, I did.

Q Okay. And were you -- obviously you weren't successful because we know the notification went forward, but did you get any relief by talking to them?

MR. STAUDAHER: Objection, Your Honor. Hearsay again.

THE COURT: Well, over-ruled.

THE WITNESS: No.

THE COURT: Let me ask you this: In your plan then, that wouldn't have tested -- or would it have also tested for HIV/AIDS?

THE WITNESS: No. We -- I was -- I was proposing a background evaluation of hepatitis C.

THE COURT: Okay.

BY MR. WRIGHT:

Q Okay. And -- and you were proposing any alternative and asking them for -- to come up with alternative methods, correct? I mean if they wanted to test for HIV also, random, same thing, you would agree to it, right?

A Of course.

Q And are you during this time conducting -- conducting your own investigation trying to verify or debunk their conclusions?

A I began the process of evaluating not with the

intention to debunk really.

Q Okay.

A Not to condemn or to vilify but to understand for myself. I had a desperate need to know how this happened so I began the process and I continued after that meeting to understand what happened here. How did this happen and was it true that this proposed mechanism was correct. Now, it didn't -- it wasn't to hurt anybody, debunk, I wanted to just know how it happened and the truth to properly manage this because I thought that -- that notification was excessive.

Q Okay. And so how did you go about it individually because the health district still wouldn't share the patients with you, correct?

A The fundamental process that I undertook was to gather the names of the patients on our schedule and who had had procedures on that day because that information was available. And I began to separate -- I got a list from our own staff of the patients who had procedures that day, patient X, patient Y, patient Z, patient A, B, C and down the list and began to try to figure out from the patients that were known at the time to have had a hepatitis C transmission or have hepatitis C, where they were in the lineup, when did it occur. And that's when I began to notice some problems in that distribution of the patients.

Q Okay. And what did you -- what caused you

concerns?

A What caused me concern at that time was that at the time there were patients between patients that had an infection that to my knowledge at the time were not infected, were not recognized as having hepatitis C. There were a number of patients between the affected patients who were not and that seemed odd for a -- for this proposed mechanism. And I began to figure out by who the CRNA was because it was listed in our schedule, I began to separate out the two rooms by the CRNAs and I began to understand that it seemed that there were infections in two rooms and I couldn't understand by what the mechanism that was proposed. At the time I didn't understand how it could go from one room to the other. So as I gathered more information about this I decided to go see Brian Labus about it.

Q Okay. And this is still before the public announcement?

A Right. This is before whatever date is agreed upon to the public announcement.

Q Okay. And the -- you go see Brian Labus to express your concerns. Do you take your charts and the information that you have?

A I took my papers and the charts that I had to his office just a few hundred yards away from our office --

Q Okay.

A -- on Shadow Lane.

Q And your concern was that the method of transmission that they were believing you -- you were still skeptical of it at that time?

A Correct.

Q Okay. And so you -- did you lay all of that out to him in greater detail than what you just told us?

A Yes.

Q Okay. And what was his response?

A He told me that that was interesting and I laid it out just like I laid out for you but in much more detail and he said it didn't matter. It didn't matter because of the -- what was observed with the changing of needles and the propofol bottle not being used completely for one patient but being used for the next was sufficient. The observation alone was sufficient that no matter what I'm presenting, no matter what the -- an alternative is or no matter -- it didn't -- it didn't fit, it didn't matter --

Q Okay.

A -- that still this public announcement had to be made.

Q Okay. And it -- and basically the -- they had -- the Southern Nevada Health District had observed what they determined to be unsafe injection practices with the propofol application, correct?

A Well, I have to say that that phrase, unsafe injection practices, was never uttered to me and to anybody to my knowledge until the public announcement.

Q Okay. Well, maybe that's where I got it but I was just trying to -- they had observed things, which were contrary to aseptic technique, right?

A Correct.

Q And because of those observations, like reuse of syringe on a patient, a second time a CRNA injects patient first dose, takes the same needle and syringe, takes out a brand new sterile needle, puts it on, goes back into propofol reinjects, right?

A Correct.

Q Okay. Those type of observations were such that there is a potential that there could have been a -- a method of transmitting blood born disease, fair?

A That's a fair statement.

Q Okay. And you -- what was being told to you was the -- the hepatitis C outbreak is what got us in there to look and what we saw causes this notification regardless of how the people got hepatitis C, correct?

A Correct. And my understanding was the observation alone of these two factors that you just described was sufficient to make the notification.

Q All right.

A He even said that.

Q Right. Even if no one had got -- got hepatitis C, just seeing that is what caused this notification?

A Yes. He even said to me at that meeting that I went to him that had this observation been made without any transmission of hepatitis C, it still would have been sufficient to make a notification.

Q Okay. And the -- so basically your trip to Brian Labus to try to explain that they may be wrong about this was to no avail because it was going forward because of the -- what they saw, right?

A Right.

Q Okay. So it's going forward. Do you call other people other than Brian Labus to enlighten them about your findings that there -- it may be questionable on the method of transmission?

A I'm not sure who you mean by other people.

Q Anyone at the State? Did you make the same presentation you gave to Brian Labus to anyone else?

A Yes, I did. I made a presentation just like that to the -- who I believe is the chief epidemiologist of the State of Nevada, whose name I don't remember.

Q Okay.

A But I did do that by -- through a television hookup and I'm sorry that I don't remember the date --

Q Okay.

A -- but I did the same type of presentation.

Q Okay. Was it pre-announcement?

A I believe it was. Again --

Q Okay.

A -- it's just hard for me to remember the dates.

Q Okay. And you're -- once again you were unsuccessful?

A Yes.

Q So the announcement's going to go forward, correct?

A Correct.

Q Okay. And that's being planned and you, despite disagreeing, the clinic is still cooperating with the Southern Nevada Health District, correct?

A Absolutely.

Q All right. So okay, we don't think you should do this but we're on board and we'll cooperate, correct?

A Yes.

Q And the -- were alternatives suggested like you all -- you all setting up call centers and arranging for the testing for the patients and everything?

A Yes.

Q Okay. And what were those proposals?

A We had proposed that once this -- this

announcement was going to be made that we, the practice, would set up a call center for the patients to call in to us about what had happened and what needed to be done. And the idea was that I would man it and Dr. Carrera who speaks fluent Spanish would man it. We also thought that we would try to pay for the testing of any individual who wanted to be tested. And I even made phone calls to Quest to find out if we could buy a bulk of tests because we're talking of 50,000 people to do -- to do that to -- to help out in this situation.

Q Okay. Those proposals were made and rejected?

A They were rejected.

Q Okay. And so you -- you -- you all continued to cooperate, correct?

A Yes.

Q And it comes to the date it's going to be announced?

A Yes.

Q And that is late in February?

A Yes.

Q And the -- when it's announced was that at a press conference?

A Yes, it was at a press conference.

Q Okay. Once -- once it's announced what happens?

A Well there's an immediate media attention to it. Media outfits come to our facility. It's been reported and

then the subsequent newspaper articles and then the subsequent news reports and then the cascade of events that have been occurring for five years.

Q Okay. And the -- after the news broke, did -- did there come a time shortly thereafter where the clinics were closed?

A Yes.

Q Okay. Had the BLC closed the clinics?

A No.

Q Okay. Had the Southern Nevada Health District?

A No.

Q Okay. CDC?

A No.

Q Okay. How did that come about?

A The clinic was closed by none of those organizations. It was closed by the city of Las Vegas Business Department. It began with a tardy fee payment and that was what was used to initiate the closing of our office.

Q Okay. And by closing I mean the doors were closed, correct?

A The doors were closed. We were quote, shut down.

Q Okay. And you were shut down -- not only the endoscopy clinic but also the medical offices, correct?

A Yes.

Q And -- and do you recall pleading with the authorities to not close the medical offices for what had occurred on the -- allegedly on the endoscopy side?

A Yes.

Q And the reason for that was what regarding the patients?

A The reason for that was when they closed the medical side we had no way to communicate with our hundreds and hundreds of patients about illnesses, medications, renewals of medications, biopsy results, therapy moving forward. The patients were lost, they were absolutely cut off from us. So I pleaded with the authorities who had shut us down to not close the medical side and to let us take care of the patients to no avail.

THE COURT: What division of the city shut you down, if you know?

THE WITNESS: I don't remember.

THE COURT: Okay. And I have a related question. I think at some point you said there was also an office in Henderson?

THE WITNESS: We had an office in Henderson.

THE COURT: Was that shut down as well?

THE WITNESS: Yes.

THE COURT: Okay.

BY MR. WRIGHT:

Q If -- at -- literally it was an avalanche in a flood gate, correct?

A An avalanche in a flood gate. Every single one of our offices was closed.

Q It was a race between the cities to see who could close you the fastest, correct?

MR. STAUDAHER: Objection, Your Honor.

BY MR. WRIGHT:

Q Is that your impression?

THE COURT: Well, sustained. That's sustained.

MR. WRIGHT: Okay.

THE COURT: Go on.

BY MR. WRIGHT:

Q Well, it went like dominoes, correct?

A Yes.

Q And so then with every clinic and every medical office closed, what then happened?

A Some -- some time in that process another event occurred in which the FBI came in to all of our offices on a -- apparently on a warrant and searched and seized all our records from all the offices.

Q Okay.

THE COURT: Was that before or after you'd been shut down by the city of Las Vegas?

THE WITNESS: It's hard for me to remember.

BY MR. WRIGHT:

Q On -- on the day of the search -- and the evidence will show it's March 9th, using that of 2008 -- using that as a -- the date, at that point the authorities -- law enforcement comes in, takes everything, correct?

A Yes.

Q Computers?

A Yes.

Q Records?

A Yes.

Q Tens of thousands of boxes of patient files in storage?

A Yes.

Q Okay. All of the patient files in the clinics, in the medical offices?

A Yes.

Q Okay. And all of it taken so that you -- you all had no access whatsoever to any of it, correct?

A Correct.

Q Okay. And were you -- were you shown a copy of the order that allowed this to happen?

A I was -- no, we were not and I have never seen it.

Q Okay. Were you told why?

A No.

Q Okay. Were you told it was sealed?

A Yes.

Q Okay. Were you told it was sealed because you all were shredding records?

A I don't remember that. I wasn't told this directly, I heard that that was the reason, that there were records being shredded.

Q Okay. At that time were you shredding records?

A No.

Q You all were cooperating 100 percent, correct?

A Yes.

Q Do you have any knowledge of anyone shredding records, destroying evidence?

A No.

Q The -- that -- that ended the clinics -- the partnership or practice as it then existed, correct?

A It effectively imploded, it just ceased to exist.

Q Okay. And then the litigate -- the lawsuits started, correct?

A Yes.

Q And your Rexford case was still pending, right?

A Yes.

Q Okay. And the Rexford case is where you had been sued in a malpractice suit by a former patient, correct?

A Yes.

Q And you were preparing to vigorously defend that case, right?

A Yes.

Q Okay. Because in your judgment what you had done was right, proper, correct and you had experts all lined up to testify?

A That's correct.

Q And you -- file didn't go forward, right?

A Right.

Q Okay. Why not?

A Well, despite having experts who were going to testify that what I had done was --

MR. STAUDAHER: Objection, Your Honor. First of all, relevance to that whole issue; and secondly, that's a single person's opinion as to what the status of the case was and we have specifically not --

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

BY MR. WRIGHT:

Q The -- the case you believed was defensible, correct?

A Yes.

Q And the case was settled and payment of money made, correct?

A Yes.

Q And the case was settled why?

MS. WECKERLY: Objection.

THE COURT: Well, I mean, why did you -- did you agree to the settlement --

BY MR. WRIGHT:

Q Why did you agree to settle the case?

A I agreed to settle the case for a number of reasons. One was that the complaint, which was initially an -- alleging missing a colon cancer, was amended to include all of this hepatitis C material. It was a new complaint now. So now it became much more complex and frankly, I was petrified, terrified that there was no way that I could defend this now that -- with all of this media attention to what had happened. And on advice of counsel he agreed, there was no way to -- to ensure a successful defense and the punitive damages were added to the complaint. So it was in my best interest --

THE COURT: Yeah, don't get in to what your lawyer advised you --

THE WITNESS: Okay.

THE COURT: -- or what your insurance carrier may have said --

THE WITNESS: But it was I -- I believed it was in my best interest, though I thought it was defensible to settle it.

THE COURT: All right.

BY MR. WRIGHT:

Q Okay. And you believed because of the notoriety of you and the clinic that you could not get a fair trial, correct, sir?

MR. STAUDAHER: Objection, Your Honor.

THE COURT: Okay. So --

BY MR. WRIGHT:

Q Well, let's see what you told the grand jury.

MR. STAUDAHER: The same issue that we have addressed before this Court in --

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

THE COURT: Counsel, come back.

(Off-record bench conference.)

BY MR. WRIGHT:

Q I'll show you page 80 -- page 90 of your grand jury testimony --

THE COURT: Well, he hasn't said he didn't remember.

MR. WRIGHT: Oh, go ahead.

THE COURT: He hasn't been inconsistent --

MR. WRIGHT: Sorry.

THE COURT: -- I don't believe.

BY MR. WRIGHT:

Q I got mixed up on it. You settled the case

because of your belief you would never --

THE COURT: I'm sorry, Mr. Wright. May I see counsel bench again on a scheduling --unrelated issue?

(Off-record bench conference.)

THE COURT: All right. Mr. Wright, try your question again.

BY MR. WRIGHT:

Q Did you settle that case in which you did nothing wrong because of your belief you would never get a fair trial?

A Yes.

Q Thank you. I want to talk about anesthesia, billing for anesthesia issue. Okay?

A Okay.

Q You were unaware until let's call it OCDC after January, 2008. Okay?

A Okay.

Q You were unaware of anesthesia billing being tied to time; is that correct?

A That's correct.

Q Okay. And because doctors -- medical offices have all kinds of billing, correct?

A Correct.

Q Okay. We -- we have capitation billing?

A Yes.

Q Okay. And like capitation billing, would that be like flat fee?

A Yes.

Q Okay. So that a capitation type billing with the government or insurance companies would be I get $90 for a procedure or an act or doing something regardless of the amount of time spent; is that right?

A It's a bit inaccurate.

Q Okay. It's complex, correct?

A Complex, yes.

Q Go ahead explain it.

A Capitation is a -- is a billing -- capitation is a payment concept in which an entity like a group of doctors, a hospital, whatever the entity is, agrees to manage a set number of patients for whatever problem exists for a set amount of money on a per patient basis for all comers in that population. They're very common.

Q Okay.

A That's distinct though from a set fee for an individual procedure at hand.

Q Okay.

A So a capitation contract involves all the population. So the group accepting that -- that contract bears some risk to that because there may be patients who are quite expensive or quite involved in their care in which it's

possible that the capitation rate is insufficient for the care of those patients. Whereas a fee per item, for agreed item, say an upper endoscopy, we agree to accept this amount of money is different than capitation, it's an agreed upon fee.

Q Okay. So there may be -- like if we're talking about anesthesia --

A Yes.

Q -- per like HPN or Sierra Health, there could be a flat fee for anesthesia services?

A Yes.

Q Okay. It could be like $90, correct?

A Correct.

Q And it would be a flat fee regardless of whether it's a 11-minute period or a two-hour period, correct?

A Correct.

Q And the -- in -- in -- is it true that before January 2008 you were under the impression that there were some flat fee anesthesia billings?

A Yes.

Q Okay. Like HPN and Sierra Health Services and PacifiCare?

A Yes.

Q Okay. And even on your medical side, gastro, where you see a -- you were talking about the consultation for the patients. Okay?

A Yes.

Q That first time visit before they're going to get their colonoscopy you see the patient, you bill for that, right?

A Correct.

Q Okay. And you fill out something called CPT codes?

A Yes.

Q Okay. And there's all this coding where you just put down numbers for the service you did for the patient, right?

A Yes.

Q Okay. And when you see someone and it's a pre-colonoscopy consultation, what would you call that?

A Yeah, a consultation.

Q Okay. And so you're -- you are reimbursed for that, right?

A Yes.

Q And you bill it and that is a flat fee billing, correct?

A Correct. We -- whatever I think the service requires I bill for that and that is sent out as a -- we charge a fee. What is paid to us varies upon contracts.

Q Okay. But it's the -- you put it down and it's going to be paid regardless of the time you spent with the

patient, right?

A Correct.

Q Okay. So, I mean, we're not talking about flat fee. You're going to get that much whether you spend 10 minutes or 30 minutes on that consultation because it's graded by CPT code by the complexity of the issue?

A Correct.

Q Okay. And during the last six months of 2007 do you recall that there was also billing going on for propofol?

A Yes.

Q Okay. Now this is -- and the billing for propofol, that was a flat fee, correct?

A Correct.

Q Okay. And the billing for propofol is once again, it's like a Pc-ode on the CPT code?

A Yes.

Q Okay. And that -- that's where -- I'm on the endoscopy side now, right?

A Yes.

Q And on the endoscopy side the clinic makes money on a given patient assuming they're insured. Okay?

A Okay.

Q There's -- there's a billing for a facility charge --

A Yes.

Q -- right? And then there's a billing for professional charge?

A Yes.

Q Okay. And we know there's an anesthesia charge, correct?

A Correct.

Q And those are the three components --

A Yes.

Q -- am I right?

A Right.

Q If I'm wrong correct me on it.

A That's correct.

Q Okay. And so for the last six months of 2007 you -- you recall that there was also billing on the facility portion of it, propofol?

A Yes.

Q Okay. And was that discontinued?

A Yes, it was.

Q Okay. Why?

A It was discontinued in December of 2007 because it became clear that the billing for the propofol itself was not a covered item or an acceptable covered event for almost all insurances. They didn't recognize that as a reasonable charge. So there was -- it was very little reimbursement for the cost of the propofol to the ambulatory surgical center so

it was discontinued.

Q Okay. And the -- if someone -- no insurance or anything came in and guy's just going to pay credit card or cash, cash customer for a colonoscopy. Okay?

A Okay.

Q The -- what was the anesthesia fee?

A I don't know.

Q Okay. Do you recall that there was a flat fee, $150 for uninsured patients?

A I do recall something like that, yes.

Q Okay. And the -- so that -- and that would be just what someone has no insurance or anything is billed for the anesthesia piece?

A Yes.

Q Okay. Once again, it's a -- it's flat and it doesn't matter if it's 46 minutes or six minutes, correct?

A Correct.

Q In the -- go back, the clinic management partnership type of stuff, going back to the year 2006. Okay? Was there a discussion at the time for partnership meeting about the retirement -- or putting in place a running of the business if Dr. Desai retired?

A Yes.

Q Okay. And was there -- how did that discussion come about?

A Well, the discussion came about because Dr. Desai had mentioned the possibility of retiring --

Q Okay.

A -- and wanted to make sure that if that occurred there was a smooth transition in managing very complex large business like this.

Q Okay.

A So there convened a meeting of the partners to actually discuss and vote upon a successor if indeed Dr. Desai retired.

Q Okay.

A That meeting occurred and I was considered for that possible position as was Dr. Vish Sharma. So the vote occurred and Dr. Sharma was elected or proposed as the successor in the event that Dr. Desai retired.

Q Okay. And did you have discussions with Dr. Desai about he not being sure one person could take -- could assume his position --

A Yes.

Q -- and that it may take two because of the growth, the expansion of the business and all that he did?

A Yes.

Q Okay. Now, at -- at the -- meeting occurred and it's a partnership meeting so there's voting --

A Yes.

Q -- and you were considered and Vish Sharma, correct?

A Correct.

Q Okay. And Vish Sharma was elected, got the most votes, and then became -- in waiting if Dr. Desai retired and he also became co-manager, correct?

A Yes.

Q Okay. And -- strike that. I forgot to ask you something when we were talking about the patient numbers, patient numbers in the clinic. You testified yesterday that there were times when Dr. Desai would -- would come over to the medical side trying to round up additional upper endoscopies; is that correct?

A Yes.

Q Okay. And the -- you would presume or maybe you understood that's because there weren't enough patients like to fill out the day, cancellations or something; is that right?

A Yes.

Q Okay. So it was -- and by coming over from the endoscopy side, he's coming over to the medical offices, right?

A Correct.

Q And -- and -- and he is asking if there are -- and it would have to be an upper endoscopy, correct?

A Correct.

Q Okay. So we're not talking colonoscopies?

A Correct.

Q Because for an upper endoscopy there's no prep, correct?

A Correct.

Q And so there are patients in there -- would this be in the afternoon, late morning or what?

A The times varied; it's hard for me to say.

Q Okay.

A But it would generally be in the -- in the late morning.

Q Okay. And what -- what he was asking was if any of the patients there are available, and if they want to, they can have their upper endoscopy done today rather than rescheduling, taking off work or something and doing it later, correct?

A Correct.

Q And the -- some patients may want to do that, correct?

A Yes.

Q And it would have to be that they have to have a driver available, right?

A Yes.

Q Okay. So if a patient or someone could call and

say, can you pick me up, mom, right?

A Right.

Q Okay. So they'd have to agree, they need a driver available. And what else would be necessary if someone said, gee, I have to have an endoscopy, you mean I can have it right this afternoon and get this all done and I'll call my dad to pick me up, what -- is there anything wrong with what I'm talking about?

A Well, the -- what would be required, what would be necessary to make it a safe event, well, it would be that there would be no liquid intake for the two hours prior, no food intake for the eight hours prior, a person -- a responsible adult to drive home --

Q Right.

A -- and importantly, no use of Coumadin, a blood thinner, for five days prior.

Q Okay. And so -- and all of those things can be asked, correct?

A Yes.

Q Okay. And someone could say I didn't eat yet and I'll -- I'll wait two hours because I -- from when I last had a drink of water -- if they wanted to get it done, correct?

A Correct.

Q And I -- I -- I think that's -- that's what -- I

mean, is that your understanding of what Dr. Desai was proposing if there were any patients available who want to do this, we have some spaces open?

A That's my understanding.

Q You testified yesterday a little bit about what I put on my notes as problems with preps for colonoscopies. I think we were talking about colonoscopy.

A Yes.

Q And the -- the problem with preps is someone drinks all that stuff the night before so that they can evacuate and be clean, right?

A Yes.

Q And then they can't eat or drink, right?

A Right.

Q Okay. So then you come in for the colonoscopy and if -- if -- if there's a long wait, say they're being done in the afternoon, even if they religiously follow all of the procedure, there ends up being some type of build up?

A Yes.

Q Okay. What's that -- put that in medical terms.

A If a period of time passes -- so that a patient who had prepared the evening before has a colonoscopy toward the afternoon, there's a build up of liquid and residue in the colon naturally so that the inspection of the lining of the colon is not -- is not adequate to detect polyps.

Q Okay. And you -- you brought up and addressed this issue with other physicians, correct?

A I -- yes.

Q Okay. And you also had to talk to the CRNAs about it, correct?

A Yes, I did.

Q Okay. And your -- your suggestion was why don't we have some people prep in the morning so when they have an afternoon appointment they will be cleaner --

A That's correct.

Q -- right? And other physicians agreed it was a good idea, right?

A Yes.

Q And the CRNAs agreed it would work because they have their own rules about how long to wait, right?

A Correct.

Q And in fact it was implemented, correct?

A Yes.

Q And that was your idea, solution, and you put it in to place?

A Best I recall that's true.

Q Okay. And as best as you recall, you didn't even talk to Dr. Desai about it?

A I don't remember --

Q Okay.

A -- if I did or not.

Q Talk about CRNAs going room to room. Okay?

A Yes.

Q And of course we're talking about a date like -- at Shadow Lane like September 21st or a date when both procedure rooms are operating. Okay?

A Okay.

Q And so we would have two CRNAs, right?

A Right.

Q And one's assigned to each room?

A Yes.

Q Okay. And we would have two doctors but not the same doctors, switching off among the doctor?

A Yeah. Sometimes there would be two doctors, sometimes there'd be one.

Q Okay. The -- per room?

A Sometimes, again, there'd be one doctor per room and sometimes there'd be one doctor for both rooms --

Q Okay.

A -- going back and forth.

Q Okay. But on -- on a day when both procedure rooms are operating with two doctors. Okay?

A Okay.

Q Because that -- that -- that -- that's September 21st, correct?

A What do you mean?

Q That the example I just gave you, both procedure rooms were going with different doctors in each, right?

A No. On September 21st --

Q Yeah.

A -- the day began with a single doctor, me, starting out the day alone, moving back and forth from room to room, like I described yesterday until around 10:00 or 10:15 when I got relief and I exited to do the office. From that moment forward to the end of the day, there were two doctors.

Q Okay. And -- and -- and you recall when you did -- on -- when I say, when you recall, you may not recall the exact procedure but you've studied that day, correct?

A I did.

Q And so you -- you did Mr. Rubino, correct?

A Correct.

Q And turns out he was the source patient, correct?

A Correct.

Q Okay. And you -- I mean, you -- you knew that because you were treating him for hepatitis C, correct?

A Correct.

Q And so you completed Mr. Rubino's colonoscopy and were done --

A Yes.

Q -- and you were intending to go to the next room to start a new colonoscopy with a new staff and CRNA, correct?

A Yes.

Q And when you went you saw that Dr. Desai had already come in to relieve you, right?

A Correct.

Q Okay. And Dr. Desai was already in the process of conducting the colon -- the procedure, right?

A To my recollection that's true.

Q Okay. And then you were done for the time being?

A Yes.

Q Okay. Didn't participate at all in that next procedure?

A Right.

Q Went back to the consultations, back to the medical side?

A Correct.

Q Okay. And then did you ultimately come back a couple hours later?

A A couple hours later when I was done seeing patients and I had an assignment to do the hospital next door I stopped by to lend my hand like I always did, to see if I -- any cases needed to be done that I could help with on my way to the hospital.

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 12

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that we're so traumatized by this that the policy was discard it. It doesn't matter, just discard it and that's why I had a problem because it was that part wasn't being done.

Q Okay. And so the -- you -- you thought you saw it, brought Jeff Krueger in, double check, he looked, verified it --

A Yes.

Q -- and so it was march her upstairs and fire her?

A Yes.

Q Okay. And she was crying?

A I think she was tearful.

Q Okay. And then you had told Dr. Desai?

A Yes.

Q Okay. And then Dr. Desai said -- and she had been a long-time employee, correct?

A Yes.

Q And Dr. Desai said no or he overruled you?

A At some point he did.

Q Okay. And -- and you knew that he required retraining?

A Yes.

Q Okay. Through OSHA and then had her go to the Burnham Clinic.

A Yes.

Q And do you disagree with that treatment of Linda?

A Personally because -- because this had occurred and we were so traumatized and hurt by what was happening and because we wanted this to be without any potential breach at all ever, we had asked that any unused portion of propofol be discarded. And we had them sign off on it. So for me I would have preferred termination but I deferred to Dr. Desai on this. Just personally.

Q I just want to be clear. So did you think the decision of retraining her and not terminating her was okay?

A I didn't think so but it was -- I deferred.

Q Okay. You recall -- you thought it was okay at the grand jury?

A I don't recall that.

Q Page 93 -- tiny writing. I don't get the big one. Page 93.

A Yes, I see that.

Q Okay. Is that --

A All right. Again, deferring. If Desai felt it was okay, then okay.

Q If you stated, I didn't think she would do that again and she didn't use the propofol the way it was specified I thought okay an OSHA course, okay and that she would definitely do what she was supposed to. I mean, I read that

as that you were okay with --

A I was deferring -- yes, I was deferring to his judgment that that was okay. When you asked me what I would have preferred, I answered it that way.

Q Now, your -- do you know how many patients a day you all -- procedures -- how many procedures a day was the average?

A Depends on what year. I mean if it was in 2007 or 2004, they were different.

Q 2007.

A I would say around 50 to 60 a day.

Q Okay. Would -- is this 53?

A I would say -- I mean, I'm guessing now --

Q Okay.

A -- an average of around 53 to 55 in there.

Q Okay. The -- did you tell the grand jury that the average for 2007 was 53 procedures per day?

A I'd have to see it. I don't remember.

Q Do you recall?

A No.

Q Would that be right?

A I think that would be within the range, yes.

Q Okay. Well, we've heard all kinds of numbers about 80's, 90's, 70's, 75 -- 91, where it's yellow.

A Okay, yes.

Q Is that correct?

A Yes.

Q And there's really no need to constantly keep speculating about the number of procedures that were done because they are all of record, correct?

A Right.

Q In fact, if we want to know how many procedures on September 21st, 2007 --

A Yes.

Q -- all of the records are there, correct?

A Correct.

Q And if we want to know precisely the number of procedures from oh, October 2007 when Dr. Desai had his first stroke, up until the clinic closed, all of those records, every procedure, schedule and number per day are all in existence, correct?

A Yes.

Q And we can simply add up every procedure for the month, for the year, divide by the days open, we'll know how many procedures, right?

A You can determine an average, yes.

Q Okay. It really isn't necessary to bring people in and have them speculate on the numbers per day, correct?

MR. STAUDAHER: Objection. Speculation.

MR. WRIGHT: That's not speculation.

THE COURT: Well, overruled. He can answer.

BY MR. WRIGHT:

Q Is there any reason why an exercise like this would go on when all of the records are here?

THE COURT: Well, that's not a proper question.

MR. WRIGHT: Okay.

THE COURT: If you wanted to find out how many patients per day, you could look at the records, divide by the number of days and come up with an average, correct?

THE WITNESS: Yes.

THE COURT: So we don't have to rely -- I think where Mr. Wright's going, we don't have to rely on people's memories.

BY MR. WRIGHT:

Q Okay. Or you could just count them up for every day because they're -- every record is there, correct?

A Right, until the practice had -- was closed --

Q Right.

A -- we kept a logbook of procedures performed and you could -- you could simply go to the logbook and see.

Q And who has those logbooks?

A I believe Metro Police still has them.

Q Okay. You know Detective Whitely?

A I know Detective Whitely, yes.

Q Okay. Those -- all of those were taken at the

time of the search, correct?

A Yes.

Q So from that time until now, all of these answers could be known about how many procedures on a given day, right?

A If you had the logs, yes.

Q So we would be able to determine exactly when after Dr. Desai's stroke, return and your first day and you reduce it to 60 scheduled --

A Right.

Q -- procedures Shadow Lane Clinic --

A Yes.

Q -- we can go right to the date and figure out when that happened, right?

A You could -- I think so, I don't know where the schedules are but the logbook is a log of procedures performed.

Q Okay. Schedules -- and of course with the 60 we're talking about scheduled?

A Correct.

Q And that you'd drop off 10 to 12, meaning 48?

A Correct.

Q Okay. And if 70 were scheduled you're doing like 58?

A Correct.

Q And when we talk about the average of 53 procedures, we're not talking about scheduled, we're talking about the actual procedures per day, correct?

A Correct.

Q On -- strike that.

MR. WRIGHT: Can we approach the bench, Your Honor?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to go ahead and take our evening recess at this point. We will reconvene tomorrow morning at nine a.m. During the evening recess you are reminded that you are not to discuss 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. Don't do any independent research and please do not form or express an opinion on the trial. If you would all please place your notepads in your chairs and follow the bailiff through the rear door and we'll see you back tomorrow.

(Jury recessed at 3:23 p.m.)

MR. STAUDAHER: At what time, Judge?

THE COURT: Nine a.m.

MR. STAUDAHER: Nine, okay.

THE COURT: And Dr. Carrol, once again, please don't discuss your testimony during the evening recess.

THE WITNESS: Judge, is it possible to have a sense of how much time I will be needed here tomorrow?

THE COURT: It's not up to me. How much longer for cross, Mr. Wright, do you think?

MR. WRIGHT: Through the morning.

THE COURT: So until lunchtime roughly at noon, so another three hours?

MR. WRIGHT: Yes.

THE COURT: And then obviously, you can't know how much redirect based -- because you don't know what's going to come out, but based on what we've heard so far, how much redirect do you think?

MR. STAUDAHER: Probably 20 minutes.

THE COURT: Okay. So maybe a total of an hour or so of redirect? So that's four hours and we've got a few juror questions so that usually probably will generate maybe another 20 minutes, 15 to 20 minutes. And then there may be some recross. So, you know, I'd bank on mid to late afternoon, late afternoon being five. You know, mid to afternoon being like right now.

THE WITNESS: Does anyone think this will go to Monday?

THE COURT: I doubt it, no.

MR. WRIGHT: No.

(Court recessed for the evening at 3:25 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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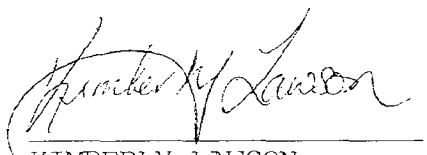

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TRAN

CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA, Plaintiff, vs. DIPAK KANTILAL DESAI, RONALD E. LAKEMAN, Defendants.	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT NO. XXI **TRANSCRIPT OF PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 17

FRIDAY, MAY 17, 2013

APPEARANCES:

FOR THE STATE:	MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys
FOR DEFENDANT DESAI:	RICHARD A. WRIGHT, ESQ. MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN:	FREDERICK A. SANTACROCE, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

I N D E X

WITNESSES FOR THE STATE:

CLIFFORD CARROL

E X H I B I T S

LAS VEGAS, NEVADA, FRIDAY, MAY 17, 2013, 9:12 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: All right the jurors are all now here, but before we bring them in a couple of thing on the record, includes you Mr. Wright.

Just for the record, when we concluded the cross-examination of the doctor by Mr. Santacroce yesterday afternoon Mr. Wright approached the bench and said he needed about an hour and a half to confer with his client in order to prepare for his cross-examination. At that time we took our evening recess and that was at 3:30 yesterday afternoon. I think it was almost exactly 3:30 when we took the recess because obviously to give him an hour and a half it's 5:00 and that's time to quit. So I just wanted to put that on the record that he's now had the hour and a half plus whatever additional time over the evening break to confer with his client to prepare for his cross-examination.

Correct, Mr. Wright?

MR. WRIGHT: That's correct.

THE COURT: All right. A second issue. Just as I was walking in the door just now, my marshal started informing me that Ms. Booker in chair -- the second chair in the back row, correct?

THE MARSHAL: Yeah.

THE COURT: Believes she knows one of the witnesses. This may be the witness we've already discussed but --

THE MARSHAL: She said that they [inaudible].

THE COURT: Oh, okay. And so Kenny told her to write down what her information was so we could see it. But in a nutshell, what did she tell you?

THE MARSHAL: She just basically said that she went to high school with this gentlemen and that she now worked with him, she doesn't talk to him very much, she didn't even know his last name. So I told her to write down a brief summary of how you know him to the extent and how long and how well you know him and what his full name was.

THE COURT: And did she indicate how she figured this out?

THE MARSHAL: I believe that he talked to her after -- or something like that, sent her an e-mail asking her and she said I don't know what you're talking about and stuff like that. So she didn't -- never said that she was on the jury or anything like that. She just told him that she didn't know what he was talking about.

MS. WECKERLY: We haven't talked to him yet.

THE COURT: Okay. Yeah, I was going to say -- well, let's --

MS. WECKERLY: We wouldn't have recommended that.

THE COURT: Well, you know, maybe he was being

conscientious. He wanted to make sure before we made a big to do about it, it was really her. That explains however -- and I think addresses any issue of misconduct on her part in not disclosing it because she didn't know his last name and that's kind of what we had surmised that, you know, sometimes you know people for years and years and you never really know their name or you certainly don't their last name. It's just somebody you say, oh, hi, how are you. So we'll pursue that later. I just wanted to make everyone aware of it as soon as I became aware of it.

So why don't we then just bring in the jury and we'll -- is -- is the witness here?

MS. WECKERLY: He is, he's just in the anteroom.

THE COURT: Okay. You can just go get him or whatever, bring him in.

(Jury reconvened at 9:17 a.m.)

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.

Dr. Carrol, you are of course still under oath. Do you understand that?

THE WITNESS: Yes.

THE COURT: All right. Mr. Wright, you may begin your cross-examination.

MR. WRIGHT: Resume it.

THE COURT: Oh, I'm sorry. Resume it, you're correct.

CLIFFORD CARROL, STATE'S WITNESS, PREVIOUSLY SWORN

MR. WRIGHT: Thank you.

CROSS-EXAMINATION (Continued)

BY MR. WRIGHT:

Q Good morning.

A Good morning.

MR. WRIGHT: You've just got a secret one working.

THE COURT: Oh, okay. All right. I'll turn off the secret one.

MR. WRIGHT: Everyone else is on.

THE COURT: The secret one has now been turned off.

BY MR. WRIGHT:

Q In preparation for your testimony here, not today but yesterday, did you review anything?

A I reviewed my interview with the detective and I reviewed briefly my testimony to the grand jury, but I didn't review it word for word.

Q Okay. And that -- that would have been the -- the interview with the detectives would have been the interview with Mr. Staudaher, the detectives, prior to your grand jury appearance?

A That's correct.

Q And then your grand jury testimony --
A Correct.
Q -- you reviewed briefly?
A Briefly, yes.
Q Okay. And did you review anything else?
A No.
Q Okay. Did you meet with anyone to prepare?
A No.
Q Okay. Did you meet with the district attorney?
A Oh, yes.
Q Okay. I mean just for a pre -- a prep -- just a -- like where your testimony's going type session?
A Yes, it was a preparation.
Q Okay. Anyone other than that?
A No.
Q Okay. Now I want to talk to you a little bit about -- because you're a specialist in hepatitis C, I want you to answer -- explain to the jury some -- some things about hepatitis C, its transmission, its prevalence in the population, in the community, and the types of it because you -- you're totally familiar with that, correct?
A Yes, sir.
Q And you have given like talks to other doctors or the community about it?
A Yes, sir.

Q Okay. Well, just like this is a community talk, explain to them hepatitis C, what the virus is, how prevalent it is, and how many people have it, those type of things.

A Okay. Hepatitis C is a virus. It's a viral infection that is transmitted from a person to another person or from a tainted blood product to another person. The virus enters the bloodstream and then infects predominantly but not exclusively the liver cells. Hepatitis C used to be call hepatitis non-A, non-B. We've known about it for generations but we didn't know what it was or had a name for it until the technology allowed us to understand exactly what it was and actually measure its level in people's blood. It turns out that hepatitis C virus is a family of viruses.

There are about six different viruses worldwide. It's as if they were a group of cousins in a room, they're all the same, they're related, but they're not exactly the same. In the United States we have predominately type one, type two, and type three and then there are subtypes of even those.

When I was in training we learned that the prevalence of the disease or how many people likely have it in the United States is approximately two percent of the population. So that translates to approximately two percent of 300 million people. The transmission of the virus, when I was in training and practice, is typically by a blood transfusion before 1992, an operation where there may have been a contamination of

surgical instruments, being incarcerated is a risk factor, intravenous use of drugs, heroin use, nasal cocaine use, being incarcerated is a risk factor, and tattoos before about five years ago when tattoo parlors became aware of this.

The principal way that people get hepatitis C is by using intravenous drugs back in the '70s, '80s, and perhaps '90s or blood transfusion before 1992. When the virus is transmitted it can cause no symptoms and only detected years later, that's the most common presentation. A patient goes to the doctor, gets a screening test for hepatitis C and surprisingly it's positive without having any symptoms. Or it can be acute where several weeks after the inoculation the patient will have fever and chills and what we call constitutional symptoms, malaise, fatigue, even fever, yellow -- yellowing of the eyes, dark urine, yellowing of the skin and it may or may not become chronic. Chronic hepatitis C infection is when it persists and it doesn't go away on its own.

There are a number of patients who get acute hepatitis C who clear the virus on their own. Their own immune systems clear it and they don't have a chronic infection. Generally, when I was in training, the -- the information was that once a patient acquired hepatitis C it would be between 15 to 20 years before cirrhosis or scar tissue of the liver would occur. The treatment for hepatitis

C has really evolved. When I was in training in 1992 to 1995 we had one medicine and that was Interferon, which was a medicine that you injected into your own skin once -- Monday, Wednesday and Friday. It caused side effects like muscle aches, joint aches, fever, fatigue, suicidal thoughts, homicidal thoughts, depression, anemia, insomnia and a host of others. And at that time we almost never cured anybody of it. It was about a three percent effective rate.

Then I went into private practice. The next big events in the treatment of hepatitis C was not a new drug but was a drug in addition to Interferon and that's called Ribavirin. So the Interferon was an injection and the Ribavirin is a pill. So the treatment's standard for a good number of years was Interferon Monday, Wednesday and Friday, shots and Ribavirin pills everyday.

Now, the treatment for hepatitis C depends on which one of those types you have. If you have type one, that treatment is generally 48 weeks and if you have type two or type three, it's six months or 24 weeks. And it's -- it's remarkable that one of the types, type one, is the most difficult to treat. It's the one that is the -- is the least responsive to therapy, whereas type two and type three are very responsive to therapy. So with Interferon and Ribavirin we were successful in treating people, that means getting rid of the virus 30 percent of the time and for types two and

three it was about 60 to 80 percent of the time.

Patients didn't like it. It caused all these side effects. They were giving themselves needles Monday, Wednesday and Friday. They had to be in the doctor's office every month monitoring blood tests, monitoring side effects, treating side effects, preventing suicidal thoughts, preventing depression.

The next major event was a change in the Interferon. The molecules changed in such a way that it didn't need to be given Monday, Wednesday, Friday, it could be given just once a week. So now the treatment was once a week Interferon plus the Ribavirin and the efficacy or the ability to cure type one jumped to around 40 percent, 35 to 40 percent after treatment. And I treated many people with type one, type two and type three hepatitis C over the years. And I went to support groups to help people understand what the treatments were.

So for a number of years that was the standard of care treatment. Then the next major event was not a new medication but an additional medication. So now we had a three-drug cocktail. The three-drug cocktail, Interferon, Ribavirin plus a new class of medications that directly kills the virus made the efficacy or the ability to cure the disease in type one go from 30 to 40 percent to around 60 percent. That was about a year, year and a half ago we started giving that treatment.

However, we had some problems because when I talked to you about the toxicity of the prior treatment, this treatment was much more toxic. Now we had a problem with more side effects. One of the medications was associated with a rash that, believe it or not, could kill a person if that rash became out of control, it became a systemic problem. So I treated only a few patients with this regimen for fear of toxicity.

But now we have a revolution in the treatment of hepatitis C whereas we might -- we will have at the end of this year, treatment that does not include Interferon at all, no more needles. There is a new treatment coming out, which is the Ribavirin plus a new molecule that has been shown in trials to be nearly 100 percent effective in type two and three hepatitis C in clearing it and curing it for 12 weeks, just two pills, no more shots.

For type one in 2015 or late 2014 we expect to have a similar regimen with not just -- not two pills but one pill, that's all, no injections, for 12 weeks once a day with a nearly 100 percent effective rate in killing type one hepatitis C. Why? Because these drugs are not like all the old drugs, these drugs are directly virucidal or they kill the virus directly.

So in the world of treatment of hepatitis C, it's all about to change and it's -- it's one of the most remarkable

scientific improvements I have ever seen in practice where we'll go from a treatment that's toxic and difficult to one that has no side effects and is nearly 100 percent effective.

So I'm telling my patients now to hold off and just wait because I'll be able treat them very soon with this regimen.

Q Thank you. Ask you a few questions on it. If I contact -- contracted hepatitis C virus today --

A Yes.

Q -- okay, and as I understand it, I then have -- if I have a sufficient viral load -- you know, I contact enough to where I've got it, okay?

A Yes, sir.

Q I may or may not have symptoms?

A That's correct.

Q Okay. And the majority of the people who contracted do not have symptoms?

A That's correct.

Q But -- but they still have it?

A Yes.

Q Okay. And that -- that's why I believe the majority of the population that has hepatitis C right now doesn't even know it.

A Is it the majority? I don't know, but it's a significant proportion.

Q Okay. And like the baby boomer generation, my generation, doesn't -- like CDC within the past year recommend that every single person in baby boomer age get a hepatitis test?

A That's right. The Centers for Disease Control last year recommended that not only patients who have some risky history of behavior that could make them at risk for hepatitis C get tested, but it's recommended that every American no matter what, between -- born between 1945 and 1965 gets a screening test for hepatitis C. Why? Well, it's just so that the epidemiology tells us that that group of people is at the highest risk for getting hepatitis C. And the CDC recognizes that these -- these new treatments are so powerful and so effective that a potential cure of this disease is on the horizon and no more liver cancer from it or cirrhosis from it.

Q And --

THE COURT: I don't know if you mentioned this, but it can be sexually transmitted as well.

THE WITNESS: It can be sexually transmitted.

THE COURT: That was a question --

THE WITNESS: That's actually a low risk transmission, whereas hepatitis B, a different virus, is almost universally infectious that way. But hepatitis C is not -- is -- can be, but it's a low risk.

THE COURT: Okay.

BY MR. WRIGHT:

Q On -- some statistics I'll ask you about. Are those infected with hepatitis C, about 85 percent end up with the chronic version of this viral illness? In layman's terms that means 85 percent are not symptomatic; is that --

A That means that 85 percent of those people who have had an inoculation or an exposure, will become chronic. Now, it doesn't mean that all 85 percent of those patients didn't have some inkling or some symptom of something wrong. It simply means that the rate at which the virus becomes chronic is 85 percent. In contradistinction to something like hepatitis B, whereas an adult, if I became infected today, my chance of clearing the virus and not having a chronic infection with hepatitis B is 95 percent. So only a five percent risk of a chronic form. So the what the 85 percent refers to is the indolence of this virus, hepatitis C, and that the great majority, 85 percent, will have a chronic form and not clear it on their own.

Q Okay. And in -- in the instances we are talking about at the -- that is the subject of this case, the patients on the 21st of September and the 25th of July, those patients that are on the chart and everything that got hepatitis C, those were chronic patients -- pardon me, used the wrong word, acute patients?

A Yes, sir.

Q Okay. They were symptomatic?

A Yes.

Q And I can -- I can start out -- and if I'm exposed to hepatitis C like at -- at the clinic, if I am going to be acute normally it occurs within how many months?

A The -- the period of time between the inoculation and the development of symptoms varies somewhat but it's generally between four to 12 weeks.

Q Okay. So if I'm exposed at the clinic and I'm -- I'm either going to be non-acute --

A Correct.

Q -- and may not even know it -- about it or then four to 12 weeks on -- generally I would have symptoms and have acute hepatitis C?

A I think that's accurate.

Q Okay. And -- but if -- if we wanted to know if even a person doesn't know it, if we wanted to test every person for three weeks that went to a given clinic that is getting a blood sample and doing specific tests to count the stuff you count, liver enzymes or something?

A Yes.

Q Okay. So you could find out whether someone has contracted hepatitis C regardless of whether they have symptoms?

A Correct.

Q Okay. In the U.S. approximately four million people have chronic hepatitis C. That would be like two percent they're talking about?

A Yes.

Q Around 75 percent of Americans with chronic C hepatitis are unaware of their condition. The -- these are from CDC when they put out the recommendation to get tests for baby boomers. One of every 33 baby boomers, those born between '45 and '65, are living with hepatitis C infection. Those all make sense to you?

A Yes.

MR. STAUDAHER: Just for the record, I don't necessarily object to this but I'd just like to know what the basis of the statistics -- what year it was done and what the information entails.

THE COURT: Would you show that to Mr. Staudaher. While he's doing that, I'm just curious, why -- if you know, is the baby boomer generation at particular risk for hepatitis C?

THE WITNESS: The baby boomer generation --

THE COURT: Is it that crazy behavior of the '70s or what?

THE WITNESS: It's a combination of crazy behavior in the '60s and '70s and lack of knowledge about its transmission

as more invasive surgical procedures, blood transfusions became available.

THE COURT: Okay.

MR. WRIGHT: And the -- just -- just so it's clear for the record, I am talking about statistics and conditions from August, 2012 --

THE COURT: All right. Thank you.

MR. WRIGHT: -- when I'm using these statistics.

BY MR. WRIGHT:

Q Now, when someone -- you talked about a patient having hepatitis C and clearing up on their own?

A Yes.

Q Okay. Explain what that means.

A That means that if I were to be inoculated right now with hepatitis C and I had an acute form of the infection, in four to six weeks from now I became tired, fatigued, my urine turned brown, my eyes turn yellow. I was having acute hepatitis C infection. My liver is inflamed, the liver enzyme test would be elevated. There is a probability or certain percentage of patients whose own immune system reacting to that infection will neutralize it.

Well, how do we know? Well we would test patients, measuring the actual amount of hepatitis C in the virus. We have blood tests that can measure antibodies too, but we also have blood tests that measures the amount, the number of

viruses per milliliter. Those numbers can go in to the millions.

You can have a test result where there's 10 million viruses per cc or seven or eight million. But sometimes that number quickly drops off to under a million, to under a hundred thousand, to under ten thousand suggesting that the immune system is clearing it on its own. There are a certain number of patients who don't require therapy who will clear it and be immune to it or better that particular viral infection is cleared. It's not clear that they'll be immune forever for another infection.

Q Thank you. Now, I want to move on back to the clinic, the endo clinic, when you were there. Tell me about the quality control and certifications that took place. I'm talking about prior to CDC, so like 2006, 2007 time frame.

A They were -- surgical centers are -- well, can be certified to operate by Medicare, by an organization called J-Co or an organization called AAAHC. It's an acronym. If you'll forgive me, I always forget what it stands for. But that's an organization that will accredit an ambulatory surgical center based on a number of quality factors and evaluations.

Our center was accredited by AAAHC twice. And the last accreditation and I don't remember, sir, the exact date of that but it was I think in 2006 or '07. That accreditation

was a three-year accreditation to our organization, which was for them the highest level of accreditation. We had Medicare accreditation and AAAHC accreditation at the highest level for three years.

Q The -- the process -- the most recent AAAHC accreditation, tell the jury about what the process and on-site inspections, exactly how it all worked.

A To the best of my memory, the evaluation occurred with two people. One was an anesthesiologist interestingly and the other was an evaluator. And for a number of days, I believe two or three, these two people evaluated our clinic looking at every aspect -- our surgical center, looking at every aspect of its operation from how patients were processed, how procedures were done, the paperwork, the history and physicals, the way the medications were used, the way the medications were stored, every aspect of the operation was evaluated. For a comprehensive list of -- of those you would have to refer to the -- to that organization.

Q Okay. And at -- at the time they watched procedures, correct?

A Yes.

Q Okay. And looked at all of the books and records?

A Yes.

Q Okay. And do you recall at -- and ultimately there was an ending -- end of accreditation meeting?

A There was a meeting. There was a meeting before these two gentlemen left where they would sit down with us, sort of an exit meeting, and tell us about their -- their observations and their experiences. And I remember one of them saying that not only did we pass and not only would we get the highest accreditation, he called our endo center a model unit.

Q Okay. Did you believe that at the time, correct?

A Yes.

Q And when you were working there, we have heard evidence maybe you have heard from reading the papers, anecdotal stories about feces being all over the walls, on the ceilings and just being a filthy place. Is any -- any of that accurate?

A I don't believe so. I never saw that. I don't believe that's accurate.

Q Okay. Was -- I mean, this was a modern operating up to standard clinic that you were proud of and the other physicians were proud of; is that correct?

A I would say that that's accurate. Was it -- were there other issues? Of course there are issues in any business that need to be addressed, but your statement is

accurate.

Q And was -- was there -- and it was accredited by Medicare?

A Yes, it was.

Q Okay. And how about Quality Care Consultants? Do you know about that?

A You know, I know only a little about that.

Q Okay.

A I know that Quality Care Consultants who I had never met before, was an independent company that purported to accredit or evaluate surgical centers. I know that they were hired. I didn't hire them, but they were hired to evaluate the operations, to give us an independent view of the surgical center.

Q Okay. With AAAHC, do you remember the deficiency they identified?

A There was one deficiency that I recall that they identified and that was -- the only concern that they gave to us was that our history and physical form that we had for the patients before a procedure wasn't consistent. Some patients had a printed out dictated history and physical, some patients had a form filled out in the clinic before the procedure. So they asked that we make that more consistent and as soon as they did I generated a -- a universal form that we could use in response to that one deficiency that was recognized.

Q And -- and do you recall at that time them expressing -- or I'm not sure at that time, do you recall testifying about how impressed and in awe you were of Dr. Despair because of his ability to manage all of that clinic and get that accreditation?

A I do remember that, yes.

Q Okay. And that's true, correct?

A Yes, it is.

Q This is a rigorous national accrediting of the organization that gave you all the highest rating available?

A That's correct.

Q Now, the patient numbers at the clinic -- I'm going to ask you questions about how it operated and the efficiency of the procedures themselves and how you were able to safely accomplish the numbers that were accomplished. I asked you yesterday about your procedures back in Buffalo. Do you recall that?

A Yes, I do.

Q Okay. And that was in -- you were right out of -- well, right out -- right out of a long schooling but you were just getting your feet wet, correct?

A That's right.

Q And you've become better at your practice the more you practice.

A That's true.

Q Okay. And at that time, in Buffalo, on your endoscopy day at the hospital you were doing, I think you said, like 14 to 17, that range?

A That range.

Q Okay. Of procedures, correct?

A Correct.

Q And here -- we're moving up to the 2006, '07 -- or 2007 time frame -- I'm unclear as to the time frame but you, I believe, were doing -- you yourself 24 or 28 to 34 procedures I recall testimony of.

A Correct.

Q Okay. So you were -- you in your room at the Shadow Lane clinic on a given full day, right?

A Correct.

Q Okay. Were doing 28 to 34 procedures, correct?

A Correct.

Q And what -- what is it about the way the clinic operates and is set up and it's equipment and employees that allows that many practicing -- that many procedures to be done and explain why they are safely done?

A Well, it was -- it was set up in a way to be very efficient. So when patients arrived, the intake process was done efficiently, the IV line was placed, the patient was -- by the time I arrived at 6:45 or 6:50 in the morning, usually two patients were already ready to be -- to undergo a

procedure. The sedation is -- acts quickly where -- when I told you yesterday that I used to do Versed and Demerol and give that sedation, that could take three, four, five minutes to work, but propofol can take 15 to 20 seconds to work. So in 15 to 20 seconds the patient is perfectly and adequately sedated so that is a highly -- a high improvement in efficiency. A patient is sedated, comfortable, the sedation is better, the patient's more comfortable so the procedure goes well.

Now, I told you yesterday about using Demerol and Versed when I was first in practice and in training. Doing a colonoscopy that way, I would have to stop and give more and more medication for many patients because it was uncomfortable. But with propofol, patients are very well sedated and comfortable. So that improves the efficiency dramatically.

Also we -- we purchased a -- a system to make a note. Whereas when I was in practice in Buffalo and even in Stony Brook as a trainee we dictated every report. So that means I left the area, I sat down at a table like this, I either used a dictaphone or a telephone and I dictated the entire case. Well, that takes time. We bought a system called ProVation, which was a computer system that as soon as I was done with the procedure, I walked two steps to the computer and with a number of clicks of the mouse a note was generated in real

time and that took a minute to do once you got used to it.

So a patient is sedated quickly, after doing thousands and thousands of procedures and many of the doctors again doing thousands of procedures were quite efficient at this skill. Once the procedure's over the note is generated in a minute and that note is printed and given to the primary care doctor and is part of our record. So when I finish that note I simply walk to the next room, which is a few feet away and the patient is ready to be examined endoscopically. Patient's already been pre-op'd, the patient's already been interviewed, the IV line is in.

So there's -- I look at the chart. I make sure the history and physical's on the chart and if it wasn't I didn't the procedure. It's to make sure I'm doing the right procedure, to make sure the indication's correct, to make sure everything is correct. Then I start that procedure and the process starts again.

Now, while I'm doing that, the other -- in the other room the patient is -- has been wheeled out to recovery and the next patient is being processed to get ready. So in that way the efficiency is very high so I can do, comfortably, four to five procedures per hour that way. Now, an upper endoscopy takes three or four minutes or five minutes. A colonoscopy, like I told you yesterday, varies.

If the anatomy's very easy and the patient is very

comfortable it can -- it can take me one to two minutes to get to the end of the colon. In a patient who's in his 70s or 80s, especially a woman who's had any operations, that could take much longer, it varies. So I could comfortably do four to five procedures per hour. That -- that sometimes changed.

If I had a difficult case it would go down to three. If I had a number of upper endoscopies, it might go to six or even seven in an hour because there's -- there's relatively easy to do technically. Once you learn how to pass the endoscope safely, it's only thick as my pinky, the procedure is -- is only about two or three feet into the intestine so it's very easy. So that's how these -- the clinic was set up to be efficient.

Q Okay. And the -- when you are -- you have completed and you go over to the computer or the ProVation program and essentially you make -- finalize your report and notes and with that are actual photographs and the document all that you are reporting, correct?

A That's correct.

Q And then a -- a report -- I don't know if it's that report or does something else then go to the discharge nurse to talk to the patient?

A That note goes to the discharge nurse.

Q Okay, that note. And the -- you have done -- normal procedure, you or another physician with the practice

would have seen the patient prior to this procedure?

A Absolutely.

Q On the medical side?

A Yes.

Q And that's normally when the history and physical's taken and you were figuring out what -- is a procedure needed and what's the procedure going to be and that's written up and then those records are there waiting when the patient comes in for procedure day?

A That's correct.

Q Okay. And then you do -- do the procedure and then -- of course the patient has been sedated and you don't go out and consult and sit down and go over everything with the patient at that time, you schedule a return visit normally?

A Normally, yes.

Q For the patient to come in, to explain any issues, correct?

A Correct.

Q And so the discharge nurse gives a brief explanation like went okay, whatever, sets up the appointment, correct?

A Right.

Q Now on those -- those procedures and my -- my estimate, 28 to 34 as being an average for you on a day where

you worked full-time --

A Yes.

Q -- there, that's accurate, correct?

A Yes.

Q Okay. And on one day you actually did 50 procedures; is that correct?

A I did, yes.

Q And you were -- you hadn't planned on it?

A No.

Q Okay. It was patients all scheduled and one of the other physicians, who was that?

A Dr. Carrera became acutely ill and needed to go to the hospital. He was scheduled to take over, he couldn't breathe because of asthma and I was -- I had to continue and I continued for an actual full day, from 6:45 until 3:30, 4:00. I didn't stop because these patients were there, they were prepared, it was unfair to have them just be canceled so I -- I was -- I was okay, I did it.

Q Okay. And -- and you did it safely --

A Yes.

Q -- correct? I mean you were tired and it takes stamina?

A Yes.

Q But you didn't at any time cut corners, skip things or anything like that?

A No.

Q And you -- you never have in the practice, not just on that 50 patient day, but any day, correct?

A Correct.

Q It was -- I can't remember -- you have already testified and I don't remember who was questioning you, but about the different, we call it speed, how fast someone is in performing a colonoscopy --

A Yes.

Q -- or an upper endoscopy and you called it efficiency?

A Yes.

Q And you -- you are very efficient?

A Yes.

Q Okay. Other -- other doctors take longer if we look at it in time to accomplish the same thing?

A Correct.

Q And it depends a great deal on the person's skill and expertise, correct?

A Correct.

Q And you were aware that Dr. Desai has the same skill and expertise in your judgment?

A Correct.

Q And Dr. Desai looked up to you for your expertise and clinical skills; is that correct?

A I believe that's true.

Q Okay. And he manifested that by consulting with you, correct?

A Yes.

Q Asking advice?

A Yes.

Q Referring complex patients -- complex matters to you --

A Yes.

Q -- correct? And not just Dr. Desai but other physicians in the clinic say they had an acute hepatitis C case or some novel issue, they would come to you for assistance, correct?

A Yes.

Q Now, on the colonoscopy, we've heard testimony about the insertion of the endoscope all the way to the end, the cecum, okay?

A Yes.

Q And we heard about using air, water to assist getting it in there, the endoscope, correct?

A Yes.

Q And then it's withdrawn and -- is inspection taking place on the way in too?

A Yes.

Q Okay. So on the way in -- and as you're putting

it in, you're looking at a monitor -- I mean you're actually watching it on the screen, correct?

A Yes.

Q The room at that time is darkened?

A Yes.

Q Okay. And the GI tech would be assisting you and if -- even at times if you needed to move the patient a certain way or apply pressure because you are navigating the colon, correct?

A Correct.

Q And it is -- that -- during that trip pain would be involved, correct?

A Correct.

Q And the -- the patient is feeling no pain because they are under the effect of propofol?

A That's right.

Q And the patient even may be moving around, correct?

A Correct.

Q Okay. So it's -- someone could think like the patient is hurting but the patient is feeling nothing and is -- I mean the patient is not cognizant of any pain.

MR. STAUDAHER: Objection. Speculation, Your Honor.

THE COURT: Well, I mean if -- if you know.

MR. STAUDAHER: The patient -- what the patient's

actually feeling.

MR. WRIGHT: Well, I'm just not verbalizing it well.

THE COURT: Okay. Then maybe say it a different way.

BY MR. WRIGHT:

Q A patient can be moving and twitching in different movements, correct?

A Yes.

Q Okay. And does that mean the patient is hurting?

A Well, that's a difficult question because you're asking about a perception. Pain is a perception. Pain is the generation of an impulse through the nervous system to the brain where it's perceived as pain. So that the stimulus that's causing this problem can be addressed. Either move your hand away from the hot fire or otherwise. So even if a patient is moving or twitching a bit, it's because there's some -- there are still some responses generated in the brain to that stretching of the colon that makes the patient move. But is it an awareness or is the patient cognizant of pain? I believe that that's not the case.

Q Okay. That's what the propofol is for?

A Yes.

Q Okay. And propofol has this amnestic effect that the patient isn't even going to remember -- amnestic, like amnesia, right?

THE COURT: Amnesia. So if they did experience pain, they're not going to remember it anyway?

THE WITNESS: Well, remember that propofol is a deep sedative so when the patient awakens from a deep sedation like that, they'll be -- they'll be no memory of any event that's occurred.

BY MR. WRIGHT:

Q Okay. I -- I may have -- like with an upper endoscope I wouldn't even know it happened but I might like have a sore throat after it happens?

A That's possible but I took pride in never doing it to -- in such a way that the patient had a sore throat.

Q Okay. So -- I mean if -- or if there might be some discomfort or something because I underwent the procedure?

A Right. You might have a little distention in the belly from the air that was used, you might have a little ache from the stretching that had occurred, you might have a sore throat from the scope being passed into the esophagus, yes.

Q Okay. And you testified yesterday and the questions were being asked at the time about giving more propofol at the end of the procedure. Okay?

A Yes.

Q Whether the CRNA should give an additional dose

because this is monitored incremental anesthesia being provided, correct?

A Yes.

Q And you don't want -- I mean you, the CRNA -- the goal is not to overmedicate, correct?

A Correct.

Q Because there -- there can be all those bad side -- or results?

A Yes.

Q Okay. And so you have -- in a colonoscopy you talked about reaching the end and then coming back out, withdrawing the scope. That is the easy part as far as no pain?

A That's right.

Q Okay. Because it was getting it in there, now it's just sliding it out?

A That's right.

Q And so once you are in there and starting to slide it out, you are -- you saw what you saw going in, right?

A Correct.

Q And now you're coming out and you have a good sense as the physician, how close you are to the end of the procedure, correct?

A Yes.

Q And when you testified about you would say to

the CRNA I'm almost done or I'm pulling out or I'm at the end, you all are working as a team?

A Yes.

Q And you -- what you are indicating to him is that you mean no more propofol may be needed because I'm done, I'm going to be finished; is that fair?

A That's fair.

Q And if -- maybe you're partway out, there's polyps or whatever you need to do with the additional procedures, you may say I'm going to be a little bit longer, right?

A Yes.

Q Okay. And a CRNA who is monitoring the patient, the blood, the oxygen, watching the patient, is going to make a determination whether it to addition -- give an additional dose, correct?

A Correct.

Q But as far as communicating to the CRNA, I'm almost done or I'm pulling out, that is a signal that no more propofol is needed?

A That's correct.

Q Now, on the colonoscopy there was testimony of another physician who talked about at the end -- he went like this and talked about looking at the other -- other end of the rectum on the way -- a final look. Do you know what I'm

talking about?

A It's called retroflexion.

Q Retroflexion, that's it. And do -- do some physicians do that at the beginning?

A Well, I don't know. I know that my training and practice was to do that at the end.

Q Okay. Do you know how other older physicians were trained?

A No, I don't.

Q Okay. Now -- while I think of it, you would work at UMC on occasion?

A Yes.

Q Okay. And you all -- were you assigned to a particular hospital to be on call or did you go to various places if you got a call when you're not working in the endo clinic?

A When we were on call we had beepers at that time, at 5:00 if I was on call, then that meant that I was on call for every hospital that the group covered, every hospital and that could mean when I started eight hospitals, then nine hospitals and then finally 12 hospitals.

Q Okay. And the work that the Gastro Center of Nevada did for UMC, you were aware of you and Dr. Desai and the other doctors treating the uninsured and indigent patients at UMC; is that correct?

A Yes, sir.

Q Okay. And you're aware that that went on from 1981 approximately, all the way up to the closing of the clinics, correct?

A Yes.

Q And that was something that you as a partner and the clinic undertook at UMC to provide that care and that was -- free care on your part, correct?

A Yes.

Q And do you recall in 2007 an award being given and a clinic being recognized for that service?

A I don't remember that.

Q Okay. Do you recall going to a meeting with the UMC -- what were they called, Internal Medicine Residency Program with Dr. Wahid and yourself and Dr. Carrol --

A Well, I'm Carrol so --

Q I'm sorry. You guys all look alike.

A I know, we all look alike.

Q Yeah. Do you recall a meeting where you went and it was a discussion of recognition for you all for giving this free treatment and a -- a thank you for the teaching practices that you all were doing?

A We had a number of meetings at that time. It's important to understand this. It's hard to understand, but we were a private practice, we were not hired by UMC, University

Medical Center. University Medical Center is -- at that time, was the only hospital in this valley that had residents and taught medical students from Reno. Dr. Desai had started a relationship with UMC long before I arrived that was very solid and very strong in which even as private practitioners, we took those residents on and every month had an assigned physician to take those residents on a GI service and see consultations no matter what the insurance, it didn't matter.

So the students and those residents were taught by us and it was a very valuable part of UMC's residency program. They have to have cardiology and pulmonologist and gastroenterology services to be accredited program. We provided all that care in the middle of the night, a patient with complex problems, no matter -- and independent of the insurance. Of course, the University Medical Center was pleased and happy with that because we provided such a service. We even went to their -- their free clinic and provided service and we were available 24/7, 365 to that hospital.

So, yes, there was recognition for that from UMC and we had many discussions about how to make it better and how to improve the teaching. And I even came up with a GI jeopardy idea to teach the residents in a game show format so they could learn GI very well. We were proud of that. Was it difficult? It was terribly difficult. Did I grumble? Did

people grumble when a host of patients with no chance of ever reimbursing us occurred? Yes. But we did it because Dr. Desai had established this relationship.

Q Thank you.

THE COURT: Those were students out of University Nevada Reno Medical School?

THE WITNESS: Yes, residents, students, interns.

BY MR. WRIGHT:

Q Now, you testified yesterday about after Dr. Desai's first stroke and -- and I'm focusing in on October -- October, 2007. Okay?

A Yes.

Q And he had gone to India for vacation, correct?

A Yes.

Q Okay. And then he was -- didn't come back as expected?

A Right.

Q Okay. And you all learned that there -- that he had had a stroke?

A Yes.

Q Okay. And the -- I want to be clear on the -- first, I'm going to talk about the time frame of it. You testified about a meeting that was called, correct?

A Yes.

Q And that was -- do you recall which doctor

called the meeting?

A To my recollection Dr. Nayvar was adamant that we needed to have such a meeting to clarify the situation and to understand how to move forward if Dr. Desai was ill and incapacitated.

Q Okay. And so that's -- and that meeting -- it -- it's given in the records that the stroke occurred on September 29th, 2007. Okay?

A Okay.

Q So using that as a benchmark, when he ultimately returned it would have been into October, 2007. Okay?

A That's right.

Q And you had the meeting -- and that's the meeting that Dr. Nayvar called and that's the meeting you testified about in which he stated, if I get this correct, that he -- he appeared and he didn't look healthy, correct?

A Correct.

Q And he stated that he expected he would be out for three to six months?

A That's the best of my recollection, yes.

Q Okay. And it was at that meeting that he assigned yourself to Shadow Lane, correct?

A Yes.

Q And Dr. Sharma to the new Rainbow clinic?

A Yes.

Q Dr. Mason to Burnham. Did I get that right?

A Yes, you did.

Q Okay. And thereafter -- so if -- if -- if this -- do you recall if this mid-October, do you know?

A I don't remember the date.

Q Okay.

A I think it was early October but I don't remember the date.

Q Okay. And thereafter, for a period of about two weeks, you were managing the practice, running Shadow Lane?

A Yes.

Q Okay. And then you testified that Dr. Desai returned, correct?

A Yes.

Q And he incrementally came back into the practice?

A Yes.

Q You testified about him rebuking you because of some of the changes you had made, correct?

A Correct.

Q And when he came back, first it was a period of only seeing patients, correct?

A That's right.

Q And I -- I think that was -- do you recall that time frame?

A I recall that he came back, he began to see patients in the clinic but was not ready to do endoscopy because of the weakness in -- as I recall the right hand.

Q Okay. And I -- I think the time frame is that within eight weeks from the meeting he -- he was back full bore; is that fair?

A Well, I think it's fair. Again, it's hard for me to remember exactly this -- these weeks that passed but I think that that assessment is accurate.

Q Okay. And so -- and -- so we would be early December? I mean if this was -- started in October, October, November, by December 2007, by being fully back, I'm talking about he's back working the way he had been before, correct?

A That's accurate.

Q Okay. And aside from -- aside from all of his management of the practice, he also carried a full load as a partner, correct?

A To the best of my recollection he -- he resumed a full load.

Q Okay. Now, I'm talking about before his first stroke and after.

A So just be a little bit more specific.

Q Okay. I just want it clear that even though he was managing the entire practice, on top of managing the entire practice he was working just as hard as you were?

A I think that's reasonable.

Q Now, I want to move to the CDC coming in and that's January, 2008. Okay?

A Yes.

Q Now, you all -- all the physicians, everyone at the clinic had no idea of any hepatitis C transmission or issues, correct?

A That's absolutely correct.

Q Okay. However, certain patients of the clinic had come into the clinic with hepatitis?

A Yes.

Q Okay. And these were patients that turned out had had a procedure like on -- on September 21st, right?

A Right.

Q Okay. And then they became ill, symptomatic, and their physicians referred them to the specialists --

A Which were us.

Q -- and so you were seeing -- and I don't mean all of them, but a few patients that had turned out were September 21 patients, right?

A Yes.

Q Did you answer?

A Yes.

Q Okay. The -- and still there was no recognition in any of that by you or anyone that it was any -- their

having hepatitis C may be connected to your clinic?

A Yes. To be clear, those patients -- some of those patients did come back to our practice because, like I told you, we were experts in the management of hepatitis C. None of those patients though came back to me personally --

Q Okay.

A -- but they did come back to the practice and to my knowledge there was no recognition that these few patients that came back with acute hepatitis C had had the transmission at our facility.

Q Okay. And so we come to January and once again it's -- it's of record that January 9, 2008 was the day CDC knocked on the door. Okay?

A Okay. I'll take -- that's true.

Q And you were at the clinic or at the Gastro Center?

A Yes.

Q Okay. And it was in the afternoon?

A To the best of my knowledge I think that's true, in the afternoon.

Q Okay. And what -- how did you first learn what was happening?

A I first learned what was happening through a phone call on my cell phone from Dr. Vish Sharma telling me to go -- please go see Tonya Rushing because there are some

representatives from the Health District and from the CDC there, in her office on the fourth floor, and he told me then and there that they say that there may have been a hepatitis C transmission at the Endoscopy Center so please go see what's happening.

Q Okay. And so you immediately went?

A I went up to the office.

Q Okay. And it was Tonya Rushing, she's the Chief -- COO, the business manager; is that fair?

A That's fair.

Q And at that time in the meeting there were a number of people, correct?

A Correct.

Q And they were representatives from the Southern Nevada Health District?

A That was one, Brian Labus.

Q Okay, Brian Labus. There were how many from CDC?

A I think there was just one.

Q Okay.

A A female. And then there was a representative from the Bureau of Licensure, to the best of my recollection.

Q Okay. And we've called that the BLC in here.

A Okay.

Q And tell me what you recall about that meeting.

A That meeting was to tell us that this had -- this had possibly occurred and Brian Labus said that there was evidence that one patient had had a transmission of hepatitis C on July -- July 25th, 2007 and that three patients had had a transmission on June -- excuse me, September 21st, 2007. And we were informed that the -- they needed to do an investigation and an analysis of the -- of the practice to try to understand what happened.

Well, you can imagine, I was shocked and I didn't believe it because I never heard of that before. Remember, I went through all the risk factors of hepatitis C. I had never heard of a transmission in an endoscopy center before. But we immediately agreed. I said of course you can look. And they -- they said they'd be back tomorrow to start the process.

Q Okay. And were -- do you recall that you were skeptical that the transmission was related to the clinic?

A I was initially skeptical, yes.

Q Okay. And do you recall questioning them about -- are -- I mean they -- they were reporting acute hepatitis C cases they were talking about, right?

A Yes.

Q And do you recall questioning them about are you sure? What tests, you know, how did you verify and confirm that?

A I don't recall using that phraseology.

Q Well, that's my phrase.

A I don't recall asking what tests were used to -- to acquire that information. I do remember saying are you sure.

Q Okay.

A I didn't believe it.

Q And at -- at that initial meeting before -- you agreed we're going to completely cooperate, correct?

A Of course.

Q And who else was present on the clinic side; yourself, Tonya Rushing?

A There was -- to the best of my recollection, I mean this is five years ago, it was me and Tonya Rushing.

Q Okay. Do you recall Jeff Refuge being there?

A I don't recall that.

Q Okay. Do you recall that at that meeting an overview was given of the clinic to the reviewers?

A I don't recall that. What do you mean by overview? Of how -- how it operated?

Q Correct.

A By the people -- the CDC and the Health District?

Q No --

A Or that we gave it to them?

Q Right, like by Jeff, Tonya and yourself

explaining to them what the clinic was, the procedures, and how you all did it?

A I don't recall that, sir, at the first meeting. I could be wrong, I just don't remember that.

Q Okay. Do you recall the -- at -- at the first meeting discussing propofol?

A No.

Q Okay. Let me show you something and see if it can refresh your recollection.

A Sure.

Q Dorothy Simms interview. I'm going to let you read this to yourself.

MR. STAUDAHER: Your Honor?

THE COURT: Yes.

MR. STAUDAHER: He's going to use another witness's interview to refresh this witness's recollection?

THE COURT: He can use anything if his recollection -- you can look at it and then see if your recollection is refreshed. If it's not refreshed by this other person's interview --

MR. STAUDAHER: And that's a hearsay statement that he's --

THE COURT: Well, he's not seeking to -- I mean, it's the old plate of spaghetti example from law school. You can show him anything to refresh his recollection but then,

Doctor, you don't have to say your recollection's refreshed if it's not truly refreshed. Do you understand?

THE WITNESS: Yes.

THE COURT: So look at it and then Mr. Wright will ask you --

THE WITNESS: If it is you have to say it is.

THE COURT: Well, he has to tell the truth, whatever that may be. So look at it and Mr. Wright's going to direct you somewhere and then he'll ask you if your recollection is refreshed by looking at that.

BY MR. WRIGHT:

Q I'm going to show you pages nine, 10 and 11.

MR. STAUDAHER: Is this of the grand jury or the Metro?

MR. WRIGHT: The Metro interview.

MR. STAUDAHER: Okay.

BY MR. WRIGHT:

Q And grand jury pages 38 to 43, Dorothy Simms, of the BLC. Would you --

THE COURT: Just read that over quietly to yourself.

BY MR. WRIGHT:

Q Right. This is simply the cover page so that you know and then the grand jury testimony about the interview --

THE COURT: Well, just let him look at it, don't, you

know, you don't need to explain it all.

And just to be clear for the record, Mr. Wright, you're showing him statements that another person made, correct?

MR. WRIGHT: That's Dorothy Simms from the BLC.

THE COURT: All right.

THE WITNESS: Okay, I've read this.

BY MR. WRIGHT:

Q Does that refresh your recollection at all?

A I still don't remember this interaction occurring that we talked about propofol at that first meeting.

Q Do you recall at a later meeting?

A Yes.

Q Okay. Do you recall that you all, the clinic, told them you multi-used propofol?

A No.

Q You don't recall that?

A Recall telling them that we multi-used propofol?

Q Correct.

A I -- I personally don't remember that.

Q Okay. You -- you -- at any meeting?

A That I attended? No, that I remember.

Q Okay. You knew you multi-used propofol.

A When did I know this?

Q At this meeting.

A Which would be the second meeting?

Q You tell me which meeting.

A I never knew --

Q Okay.

A -- that we quote multi-used propofol. I didn't understand that term --

Q Okay.

A -- or that concept until this event occurred. So the answer is no, I did not know that there was any unusual or any -- any unacceptable, quote, multi-use of propofol.

Q Okay. I didn't say unacceptable. I was just asking, were you there when Jeff Krueger stated that we use propofol multi-use?

A I don't remember that.

MR. STAUDAHER: Objection. Hearsay, and that's an improper --

THE COURT: Well, he's already said he doesn't remember. I think maybe Mr. Wright was trying to get him to acknowledge that he adopted that or something like that. The witness has said he didn't remember that occurring. So Mr. Wright's going to move on.

BY MR. WRIGHT:

Q Okay. I'm done with that. Okay. Now, at the --

THE COURT: So the evidence is that that didn't --

there's no evidence that it ever occurred because he doesn't remember. That's the state of the evidence right now.

MR. WRIGHT: I understand.

BY MR. WRIGHT:

Q The -- I want to proceed with the CDC. Okay?

A Yes.

Q So you are -- they come in and they are investigating and inspecting, correct?

A Yes.

Q And that's BLC, CDC and SMHD, right?

A Correct.

Q And it goes on for about 10 days?

A Yes.

Q And the -- you yourself also start trying to investigate, correct?

A Well, not yet.

Q Okay.

A I didn't do anything formally, I didn't look at records yet.

Q Okay.

A I just -- I just -- I just did what they asked us to do like everybody else during their investigation.

Q Okay.

A But there was -- there came a time when I did begin to look at how the patients were distributed on that day

once the information started to come in. It's hard for me to recollect the time frame.

Q Okay. Okay. Well, first of all, you wanted to know the patients, correct?

A Yes.

Q Okay. Because they're telling you patients from your clinic have hepatitis C and they are investigating to see if they got it there, right?

A I remember that and I asked who are these patients.

Q Right. And you told them that you needed to know because imperative is quick treatment, correct?

A Yes.

Q Okay. I -- I mean and that is true that the faster you can get on top of it, the -- the better -- the less the risks, the better the possible outcome?

A That's correct.

Q Okay. And you -- you expressed that, maybe not those words, but you wanted the identities of your own patients.

A They were our patients. I wanted to know who they were because in acute hepatitis C, it's a rare event by the way, it's very rare to have acute hepatitis C, in those patients who are identified as acute hepatitis C, the literature suggests that if you can identify them quickly and

treat with Interferon alone you have a 90 percent chance of clearing the virus if you treat them. So I said I want to know who these patients are, they're our patients.

Q And their response?

A Sorry, we won't give you that information because it's a HIPAA violation.

Q Okay. Even though they're your patients --

A Right.

Q -- they wouldn't tell you who they were and you expressed the need to get them treatment?

A I think I did.

Q Okay. And that -- that -- that posture or that stance, that position by Southern Nevada Health District continued? The we won't share, correct?

A Correct.

Q And the -- you were -- were you aware that more patients were identified as hep C positive incrementally as the month went on?

A Yes, sir.

Q And you -- you learned that because you were getting reports, briefings, shared information from CDC and Southern Nevada Health District?

A I learned that there were other patients in addition to the quote three that had been reported that first meeting, not by any transmission of information from a CDC or

Health District representative but on my own --

Q Okay.

A -- from getting the information from other doctors in our group calling me and saying, you know, patient X has hepatitis C, did that patient have a procedure on September 21st? And by that mechanism I was able to identify the other three patients.

Q Okay.

A Not by any other means.

Q Okay. So they -- they -- the authorities, rather than saying all of the agencies that were there dealing with you, they did not prepare -- they did not share and provide the information other than there were three at the beginning, right?

A Correct.

Q And you learned like over the month of January -- I mean intermittently you would learn of other hep C patients, you would find out who they are from one of your partners.

A Correct.

Q And then you'd look at September 21 and bingo, you found additional ones who were hep C positive and had come in to you all for treatment.

A That's correct.

Q And utilize -- now I'm going to stop there and

go back to what was going on with Southern Nevada Health District, CDC, there came a point -- and BLC. There came a point after like 10 days or so where they were done on-site inspection, right?

A That's correct.

Q And they -- did they have exit interviews or just how did that work?

A There was one exit interview. I can't recall if it was the day they left but there was an exit interview up in Tonya's office at which time I first heard the concept of the needle change on a syringe as a possible mechanism by which this had occurred.

Q Okay. And that -- and that would be coming from like Brian Labus or CDC?

A Brian Labus is the one who communicated that to me. He said that it had been observed by the CDC representative.

Q Okay.

A I asked are you sure; he said yes.

Q Okay. And did they tell you -- give you recommendations going forward as to what -- what you should change and do differently?

A I remember that there was a discussion and a recommendation from Brian Labus, the epidemiologist to make a policy to address this and to make it so that no needle

changes occur and new syringe each time.

Q Okay. And it's in that discussion where Brian Labus or CD said do you have a policy?

A That's correct.

Q And what we're talking about is do you have a policy on injection practices for anesthesia, correct?

A Correct.

Q And they were talking about a written policy in place, do you all have that, correct?

A That's correct.

Q And the answer was, no, we don't, correct?

A Yes.

Q And you're -- and it was because -- or you tell me what you told them as to why it happened.

A Well, the why not is that I never heard or thought or had any inkling that such a policy was necessary. It's like saying there's a policy on how to turn the knob on the endoscope. Well, there's no policy for that because we spent years training on how to do that. So there's no policy on how to do an injection toward a professional individual who spent years and has a master's degree in how to do that.

Q Okay. Because just like you don't have a policy in place in writing on how to do the endoscope --

A Correct.

Q -- and you are responding CRNAs are the trained

experts and, no, we don't have a written policy on how -- how they're supposed to use a needle and syringe, correct?

A That is correct.

Q And Brian Labus suggested that you should have one?

A Yes, he did.

Q As a recommendation.

A Yes.

Q Okay. And that's what prompted you to go ahead and write it up and have everyone's -- the CRNAs sign it, correct?

A Correct.

Q And that was the one bottle, one needle-syringe, one use of needle and syringe anytime it's used at all for entry, toss it?

A Yes.

Q And one bottle of propofol will be used per patient?

A Correct.

Q And never -- and then tossed if it's not completely used?

A Correct.

Q Okay. And other recommendations -- I mean, do you recall other things like discussions about multi-use of -- when I say multi-use, I'm talking about a -- a common vial