months before then.

Q Okay. So in spring of 2009?

A That might be reasonable.

Q Okay.

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

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

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

Q Okay. Did it become something else?

A It became a product liability case.

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

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

Q So the medical malpractice case went away?

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

Q Were you in a jury trial for the products

liability case?

A For Michael Washington?

Q Yes.

A Yes, sir.

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

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

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

Q And these were specific to the product liability case?

A That's correct.

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

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

the Southern Nevada Health -- their final investigation report.

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

A That is correct.

Q And you are not that?

A I am not an epidemiologist.

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

A No, sir.

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

A No, sir.

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

A Oh --

Q -- in San Francisco?

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

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

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

Q Okay. In your practice as an anesthesiologist,

have you ever been sued for medical malpractice?

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

Q Okay. Were you ever sued for medical malpractice?

A For medical malpractice?

Q Yes, sir.

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

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

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

Q Are you a dentist?

A I am not a dentist.

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

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

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

A That's correct.

Q And you settled that case for money?

A That is correct.

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

testified or worked on a case involving propofol?

A Not that I can remember.

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

A Not that I remember.

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

A None that I remember.

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

A No, sir.

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

A That is correct.

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

A That is correct.

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

A That is correct.

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

A That is correct.

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

A That is correct.

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

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

REDIRECT EXAMINATION

BY MR. STAUDAHER:

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

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

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

A No.

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

A No.

Q --- epidemiology --

A No, sir.

Q -- anything like that?

A No, sir.

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

A That is correct.

Q Is that fair?

A That is correct.

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

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

THE COURT: Yeah, that's sustained.

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

THE COURT: You can rephrase the question.

MR. STAUDAHER: I'll rephrase it.

BY MR. STAUDAHER:

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

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

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

THE COURT: The intubation?

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

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

BY MR. STAUDAHER:

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

A Right.

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

A Pharmaceutical.

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

A And the --

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

A And the biological, which was the Botox.

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

A Absolutely not.

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

A That is correct.

Q Now, one of the other things. What size

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

A A 20 cc syringe.

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

A Yes.

Q Why would you do that?

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

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

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

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

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

cross.

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

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

BY MR. STAUDAHER:

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

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

Q You, did you know?

A Okay. That's what I read --

MR. SANTACROCE: Objection. Still --

THE COURT: No. Well, overruled.

THE WITNESS: What?

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

THE WITNESS: Okay. Yes.

BY MR. STAUDAHER:

Q So you knew that?

A That he had -- yes.

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

A That's correct.

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

A That's correct.

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

A Correct.

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

A That's correct.

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

A That's correct.

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

A The American Association of Nurse Anesthetists.

Q The AASA, what is that?

A ASA, one A, I'm sorry.

Q ASA, I'm sorry.

A The American Society of Anesthesiology.

Q Is that a journal you read or --

A Yes.

Q -- a society you're part of?

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

Q Okay. And CDC?

A The CDC.

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

A Yes, sir.

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

A Yes, sir.

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

A Yes, sir.

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

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

THE COURT: Yeah, that's sustained.

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

BY MR. STAUDAHER:

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

A Yes, sir.

Q Many years?

A Yes, sir.

Q Is this something you were taught in your training?

A Yes, sir.

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

THE COURT: That's fine.

BY MR. STAUDAHER:

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

A Yes.

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

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

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

A Yes. Very much so.

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

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

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

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

MR. STAUDAHER: Nothing further, Your Honor.

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

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

(Off-record bench conference.)

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

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

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

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

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

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

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

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

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

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

THE MARSHAL: Thank you. You may be seated.

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

And Mr. Wright, you may begin your recross.

RECROSS-EXAMINATION

BY MR. WRIGHT:

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

A Yes, sir.

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

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

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

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

A That's consistent with --

Q Is that your correct testimony in the civil case?

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

Q Is that your testimony?

A Yes. I said yes.

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

A Yes, sir.

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

A I'm sorry, say that again?

Q July --

A Yeah, I --

Q -- 2007.

A Seven, yes.

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

A To re-use it?

Q Re-use.

A It is not within the standard of care.

Q In July 2007, not today.

A You mean in terms of what the CDC said?

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

A Right.

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

A Can I read the context of it?

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

was?

"Under these circumstances, yes.

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

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

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

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

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

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

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

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

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

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

THE COURT: All right. Let him finish.

BY MR. WRIGHT:

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

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

A I understand.

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

MR. SANTACROCE: Michael Washington.

BY MR. WRIGHT:

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

MR. STAUDAHER: Objection.

BY MR. WRIGHT:

Q Is that correct?

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

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

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

BY MR. WRIGHT:

Q You don't understand?

A No.

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

A Can I see --

Q Yes.

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

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

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

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

of 77.

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

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

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

A Okay. Okay.

Q On page --

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

Q Okay.

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

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

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

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

THE COURT: Are you finished with your --

MR. WRIGHT: Go ahead, read it.

THE COURT: Oh, all right. Read it.

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

BY MR. WRIGHT:

Q Tell me what I misconstrued.

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

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

BY MR. WRIGHT:

Q Did I misread it?

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

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

A If you wish me to.

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

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

Q Did you say that there?

A Can I read this?

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

A That's fine. That's fine.

THE COURT: You can read them out loud.

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

THE COURT: Oh.

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

BY MR. WRIGHT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Keep reading.

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

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

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

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

"Answer: No.

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

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

"Answer: Under those circumstances, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Question: Do you know or not?

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

Q Okay.

A -- what is there.

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

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

Q Okay.

A I just wanted to read --

Q And before --

A -- what was before.

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

A Yes, sir.

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

A Yes, sir.

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

A Yes.

Q Okay.

MR. WRIGHT: No further questions.

THE WITNESS: Okay.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: I have nothing.

THE COURT: Mr. Staudaher?

MR. STAUDAHER: No redirect, Your Honor.

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

THE WITNESS: Okay.

THE COURT: You are excused at this time.

THE WITNESS: Thank you.

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

THE COURT: Sure.

MR. STAUDAHER: Thank you.

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

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

THE COURT: Start.

MS. WECKERLY: Okay.

THE COURT: The next witness is whom?

MS. WECKERLY: Joaen Syler.

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

JOAEN SYLER, STATE'S WITNESS, SWORN

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

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

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

DIRECT EXAMINATION

BY MS. WECKERLY:

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

Ma'am, how are you employed?

A As a consultant, an independent consultant.

Q In -- in what area?

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

certified coding issues.

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

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

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

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

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

A Yes, I have.

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

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

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

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

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

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

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

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

A Yes, I am.

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

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

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

A Yes.

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

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

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

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

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

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

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

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

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

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

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

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

evaluation --

Q Yes.

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

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

A Yes.

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

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

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

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

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

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

A Are you asking is there common times?

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

A Yes.

Q Okay.

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

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

How is that calculated? Or --

A They do not add --

Q Okay.

A -- minutes for that preop evaluation time.

Q That's included in the procedure?

A Yes.

Q Okay.

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

Q No, that's okay. I think I confused myself. But in -- in terms of anesthesia billing and in terms of your experience in the industry, are you allowed to be billing anesthesia for two patients at the same times, or are you allowed to have overlap?

A One practitioner, one anesthesia practitioner?

Q Right.

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

Q So you're not allowed to --

A Simultaneously --

Q Right. Uh-huh.

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

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

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

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

A Absolutely. One at a time.

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

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

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

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

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

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

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

A Yes.

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

A You mean the insurer?

Q The insurer.

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

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

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

A Yes. I reviewed approximately 140 medical records.

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

A Yes, I did.

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

A Yes.

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

A Yes.

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

hours than there was in the day?

A Yes.

MS. WECKERLY: I'll pass the witness.

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

During the recess you are reminded you are not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Please don't do any independent research by way of the Internet or any other medium. 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 recesses at 5:54 p.m.)

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

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

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

THE COURT: Well, yesterday we had --

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

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

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

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

MR. WRIGHT: I've been telling --

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

MR. WRIGHT: Correct.

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

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

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

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

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

MR. WRIGHT: -- and I get --

THE COURT: All right.

MR. WRIGHT: -- longer sessions.

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

MR. WRIGHT: Longer than I requested.

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

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

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

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

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

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

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

MR. WRIGHT: I don't disagree.

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

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

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

MR. WRIGHT: Nothing further.

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

MR. WRIGHT: Nothing further. Nothing further.

THE COURT: Okay.

MR. WRIGHT: Sorry I took the time.

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

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

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

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

(Court recessed for the evening at 6:02 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.

KARR REPORTING, INC.
Aurora, Colorado

KIMBERLY LAWSON

an expert on --

THE COURT: Well --

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

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

THE COURT: Well, overruled.

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

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

BY MR. WRIGHT:

Q Is that correct?

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

THE COURT: Well, if he knows.

BY MR. WRIGHT:

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

A Let's -- ask it again.

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

MR. STAUDAHER: Objection. Speculation, Your Honor.

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

the answer's obvious.

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

BY MR. WRIGHT:

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

MR. STAUDAHER: Objection. Argumentative.

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

BY MR. WRIGHT:

Q Would you --

THE COURT: Argumentative.

BY MR. WRIGHT:

Q -- answer my question.

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

Q Correct. Are you an epidemiologist?

A No, sir.

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

MR. STAUDAHER: Objection, Your Honor.

MS. WECKERLY: Your Honor --

THE COURT: That's sustained.

BY MR. WRIGHT:

Q Could --

THE COURT: Well, it calls for --

MR. STAUDAHER: Objection.

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

BY MR. WRIGHT:

Q Well do you --

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

BY MR. WRIGHT:

Q Were you --

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

MR. WRIGHT: Okay.

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

MR. WRIGHT: Okay.

THE COURT: -- as a physician.

MR. WRIGHT: Okay.

THE COURT: An anesthesiologist. So.

BY MR. WRIGHT:

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

benefit for you to help here, correct?

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

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

A That's correct.

Q No, I said, did you?

A No, I did not.

Q Okay. That's what I was asking.

A That's --

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

A Yes, sir.

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

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

Those are the three methods.

Q Okay.

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

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

A A dose.

Q Okay.

A A single dose.

Q So you can dose or constant infusion?

A That's correct.

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

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

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

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

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

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

Q Okay. You do mainly infusion?

A No. You --

Q I'm asking.

A There are two ways --

Q That's a question.

A -- in which you have --

Q Which do you --

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

Q I got that.

A -- resuscitation --

Q Which do you do --

A I do the --

Q -- the majority of your practice?

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

Q Got it.

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

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

THE COURT: You mean here in Clark County?

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

BY MR. WRIGHT:

Q No, I said --

A In Las Vegas.

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

A I don't know what they do --

Q Okay.

A -- in terms of Las Vegas.

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

A I'm saying that --

Q Is that correct?

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

Q I asked you if they do that in California?

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

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

A California is a big state.

Q Is that correct?

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

Q Okay. Whether they --

A So I --

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

A That is correct.

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

A I have not.

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

A Yes, sir.

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

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

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

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

A No. I said if they had --

Q Okay.

A -- aseptic technique --

Q Right.

A -- that --

Q My example --

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

Q Yes.

A -- there would be no transmission --

Q Okay.

A -- from a 50 cc vial.

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

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

A Absolutely. It's correct.

Q Okay.

A If the aseptic technique is there.

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

A If there's aseptic technique.

Q Okay.

A That is correct.

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

A That is correct.

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

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

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

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

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

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

MR. STAUDAHER: Objection. Speculation, Your Honor.

THE COURT: Yeah, that's sustained.

BY MR. WRIGHT:

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

A Not me.

Q You.

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

Q Well, just quick --

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

Q Well, tell --

A My practice is --

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

A That's correct.

Q I thought you didn't do that.

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

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

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

A I understand what you're talking about.

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

A Correct.

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

A I put a new needle on it.

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

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

Q With what?

A With the syringe.

Q With a new needle?

A With a new needle.

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

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

A Yes.

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

A It would --

Q Correct?

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

Q I'm not --

A And there's -- no, wait.

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

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

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

A No, sir.

Q Ever?

A No, sir.

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

MR. STAUDAHER: Objection. Argumentative, Your Honor.

THE COURT: Yeah, that's argumentative.

BY MR. WRIGHT:

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

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

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

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

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

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

BY MR. WRIGHT:

Q It's consistent with what the CDC says?

A Uh-huh.

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

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

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

A With all --

Q CD --

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

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

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

Q And you think it adds some safety?

MR. STAUDAHER: Asked and answered, Your Honor.

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

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

BY MR. WRIGHT:

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

A It could always happen.

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

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

Q Okay. Well --

A But --

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

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

wasn't? I don't believe so.

Q I ask the questions.

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

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

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

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

A And one patient. That's correct.

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

A Yes, sir.

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

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

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

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

MR. WRIGHT: Okay. Consist --

THE COURT: That is true, he said consistent.

MR. WRIGHT: I misstated it.

THE WITNESS: So what are you asking now?

BY MR. WRIGHT:

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

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

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

A That would be part of aseptic approach.

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

A It's safe injection practice.

Q Safe injection practice.

A Which is part of aseptic practice.

Q Okay. Aseptic's bigger?

A That is correct.

Q Okay.

A The injection is part of aseptic technique.

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

A That's correct.

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

A Longer than that.

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

A Yes, sir.

Q Okay. For as long as anyone can remember?

A Yes, sir.

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

A That's correct.

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

A Yes, sir.

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

A Didn't follow that one.

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

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

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

Q Okay.

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

Q No. I'm talking one vial.

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

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

THE WITNESS: The way he --

BY MR. WRIGHT:

Q What do you mean, all the contents?

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

THE COURT: Oh.

THE WITNESS: That's what he said.

BY MR. WRIGHT:

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

A Uh-huh.

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

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

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

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

Q Okay. Who's they're?

A That's the CDC --

Q Okay.

A The Centers of Disease Control.

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

A Right.

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

A Yes, sir.

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

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

Q Okay.

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

Q Okay.

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

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

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

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

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

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

Q Okay. But it's --

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

Q Okay.

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

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

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

Q Okay.

A -- or they are using --

Q All the time?

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

Q Okay.

A That's what the literature says.

Q Okay.

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

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

A Correct.

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

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

MR. STAUDAHER: Objection. Speculation, Your Honor.

BY MR. WRIGHT:

Q -- are --

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

BY MR. WRIGHT:

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

MR. STAUDAHER: Objection. Speculation.

THE COURT: Well --

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

MR. WRIGHT: If he can answer it.

THE COURT: If he can answer.

THE WITNESS: I don't know.

MR. STAUDAHER: Your Honor --

THE COURT: Obviously, he doesn't --

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

THE COURT: -- know what individuals --

MR. WRIGHT: Sorry.

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

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

BY MR. WRIGHT:

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

MR. STAUDAHER: Objection.

BY MR. WRIGHT:

Q Does that --

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

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

BY MR. WRIGHT:

Q There's -- there has been --

THE COURT: If there were evidence or...

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

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

BY MR. WRIGHT:

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

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

A It happens. Unsafe practices happen.

Q Okay. And that's an unsafe practice?

A Yes.

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

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

Q Okay. Because?

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

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

A There was no hypothetical --

MR. STAUDAHER: Objection, Your Honor.

THE WITNESS: -- in your question.

MR. STAUDAHER: That was the hypothetical.

THE COURT: All right.

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

BY MR. WRIGHT:

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

A Yes, sir.

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

A Yes, sir.

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

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

Q Okay. Distinguish between the two for me.

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

Q Says on the what --

A The second one says single patient use vial.

Q Okay.

A That is a big difference.

Q Okay.

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

specifically says that on the vial.

Q That it says what on the vial?

A Single patient use vial.

Q Okay. Isn't that --

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

BY MR. WRIGHT:

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

A Not necessarily.

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

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

Q Okay.

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

Q I understand that.

A -- is the human link.

Q And so --

A We've also talked about the fact --

Q We're human.

A -- we're human.

Q I understand that.

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

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

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

Q Go ahead.

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

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

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

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

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

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

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

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

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

MR. STAUDAHER: Sitting out there.

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

THE CLERK: I said, Oh, good.

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

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

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

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

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

Secondly, to the extent it may even be privileged,

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

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

MR. WRIGHT: Thank you.

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

(Outside the presence of the jury.)

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

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

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

THE COURT: Can you read --

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

THE COURT: Yeah.

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

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

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

MR. STAUDAHER: Yes.

THE COURT: All right.

THE MARSHAL: Rise for the jury.

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

THE MARSHAL: Thank you. Everybody may be seated.

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

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

CROSS-EXAMINATION (Continued)

BY MR. WRIGHT:

Q Dr. Friedman.

A Yes, sir.

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

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

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

Q Okay.

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

Q I didn't --

A -- use --

Q -- I'm sorry.

A Okay.

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

A Well, that's --

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

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

Q Right.

A And we should make no mistake of that.

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

A That's one of the reasons.

Q Okay.

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

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

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

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

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

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

THE WITNESS: That is correct.

THE COURT: Okay. But then somebody could use a

dirty needle and a dirty syringe in any other bottle.

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

THE COURT: Because it --

THE WITNESS: -- people.

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

THE WITNESS: That's one.

THE COURT: Is that fair?

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

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

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

THE COURT: All right.

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

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

THE WITNESS: Yes.

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

BY MR. WRIGHT:

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

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

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

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

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

BY MR. WRIGHT:

Q Correct?

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

THE WITNESS: Okay. Ask -- ask again.

BY MR. WRIGHT:

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

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

A Yes, sir.

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

A It says single patient.

Q -- or single dose?

A It says single patient use.

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

A No. It should never be used.

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

A The smaller it is, the safer it is.

Q Okay.

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

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

MR. STAUDAHER: Objection. Speculation, Your Honor.

THE COURT: Yeah. It's sustained.

BY MR. WRIGHT:

Q You know what? Oh, I'm sorry. It's sustained. Shouldn't have been sold to the clinic, correct?

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

Q Okay.

A There is -- there is equal --

Q Okay.

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

Q Okay.

A -- do quality control --

Q I understand.

A -- etcetera...

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

A It says single use.

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

A That's what you asked.

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

A This --

Q Wasn't that your testimony?

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

Q It wasn't, was it?

A It was not front and center.

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

A It was.

Q Isn't that your testimony?

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

Q What's that mean?

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

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

Q Okay. And you have --

A And it is single-patient-use vial.

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

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

Q Was that your testimony?

A Yes. Yes.

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

A It makes no difference.

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

A It didn't --

Q And why was it confusing?

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

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

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

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

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

MR. STAUDAHER: Objection. Facts not in evidence.

BY MR. WRIGHT:

Q -- on notice, correct, sir?

MR. STAUDAHER: Journals nobody reads?

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

MR. WRIGHT: Okay.

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

BY MR. WRIGHT:

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

A Which testimony?

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

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

Q Okay. I thought --

A You're saying that.

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

A I have not read the entire pamphlet --

Q Okay.

A -- that's correct.

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

A I do not get it.

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

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

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

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

MR. WRIGHT: I'm reading in something.

MR. STAUDAHER: Reading what?

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

MR. WRIGHT: In this deposition.

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

MR. WRIGHT: Page 116.

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

MR. WRIGHT: Yes.

THE COURT: All right. Go ahead.

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

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

MR. WRIGHT: Yes.

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

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

THE COURT: All right. That's fine.

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

BY MR. WRIGHT:

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

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

Q Does it make a difference?

A Yes, sir.

Q You testified differently in different cases?

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

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

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

BY MR. WRIGHT:

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

A Uh-huh. Thank you.

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

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

BY MR. WRIGHT:

Q 117 there?

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

THE COURT: To yourself.

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

BY MR. WRIGHT::

Q Okay.

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

THE WITNESS: Or you can read it --

BY MR. WRIGHT:

Q No, you read it.

A -- if you'll read --

THE COURT: Okay.

THE WITNESS: Okay. I'll read it.

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

THE WITNESS: All right. Here it is.

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

So, Mr. Wright, apparently you --

MR. WRIGHT: Go ahead.

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

MR. WRIGHT: Yes.

THE COURT: All right. Go ahead, Doctor.

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

"I disagree with that statement.

"And why do you disagree with that statement?

"The reason is that I" --

THE COURT: Can you go question/answer,

question/answer.

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

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

THE WITNESS: Question -- okay, right.

THE COURT: Question, blah blah blah.

THE WITNESS: I understand. I understand.

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

MR. WRIGHT: Start again.

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

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

"Answer: I disagree with that statement.

"Question: Why do you disagree with that statement?

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

BY MR. WRIGHT:

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

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

THE COURT: Well, sir. Okay.

THE WITNESS: Okay. I'm sorry.

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

THE WITNESS: Okay.

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

THE WITNESS: Okay. I apologize.

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

THE WITNESS: That's fine.

THE COURT: And so --

THE WITNESS: Okay.

THE COURT: -- just read it verbatim.

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

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

THE WITNESS: Yes.

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

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

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

That's what I said.

BY MR. WRIGHT:

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

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

A That's what I said.

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

A I think it is not a fair --

Q Okay.

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

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

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

MR. WRIGHT: Out loud.

MR. STAUDAHER: Is there a question pending?

MR. WRIGHT: Right.

THE WITNESS: Where would you like me to --

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

THE COURT: Is it -- all right.

MR. WRIGHT: Yes it's inconsistent.

THE COURT: If it's -- I -- I'm going to trust you.

THE WITNESS: Where you would like me to start, sir?

BY MR. WRIGHT:

Q Well, you read 116, 117.

A Right.

Q I'll read the question and you finish the question and --

A That's fine.

Q -- then go question and answer. I'll start it for you.

A Okay.

Q "All right. Again, the question was, and then I'll wrap it up. Safe injection practices"...

A "Have been well established as well as widely publicized. You disagree with that statement?"

And I said: "Wait, okay, let's now." And the -- Mr. Sharpe says, "Do you have" -- Mr. Sharpe is the --

Q Questioner.

A "Do you have a page number that you can reference if you're reading on there?"

Mr. Couric says: "It's a general statement."

Mr. Sharpe: "You're reading it off the report. I mean, you don't want to show him the report?"

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

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

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

You want me continue, right?

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

A Okay.

Q I don't want to tell you wrong.

A That's all right.

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

A Okay. Okay.

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

these individuals read; is that a fair characterization?

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

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

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

Q Okay.

A But the information --

Q Do you read epidemiology journals?

A I have enough to read with just --

Q Okay.

A -- reading anesthesiology.

Q And so it's public --

A And that's why --

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

A I never used the word obscure. But --

Q I said would --

A But I don't read it.

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

A I --

MR. STAUDAHER: Objection, Your Honor.

THE WITNESS: No, we do not.

BY MR. WRIGHT:

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

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

Q Okay.

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

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

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

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

Q Well, have you --

A We --

Q -- previously testified --

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

Q Did you --

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

Q If I suckem to the temptation, or whatever that word is. Succumb?

THE COURT: Succumb.

BY MR. WRIGHT:

Q Succumb. I didn't do fancy.

THE COURT: Glad you clarified that.

BY MR. WRIGHT:

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

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

Q Because of human error, correct?

A Correct.

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

A We know my --

Q Did you testify to that?

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

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

THE WITNESS: Oh, was I --

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

BY MR. WRIGHT:

Q Do you think you testified that way?

A Ask the question again.

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

A Certainly Mr. Washington would not have gotten infected.

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

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

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

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

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

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

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

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

A You give one dose.

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

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

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

A You can call it what --

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

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

Q Even though I call it single-dose vial?

A Whatever. That is correct.

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

A It is from my standpoint. Yes, sir.

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

A Can I see it, please?

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

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

Q I don't want to show you yet.

THE COURT: Well...

BY MR. WRIGHT:

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

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

THE WITNESS: I don't know.

BY MR. WRIGHT:

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

A That's why I want to see it.

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

THE WITNESS: I said I don't know.

BY MR. WRIGHT:

Q Do you have --

THE COURT: Okay, you don't know.

THE WITNESS: Without seeing --

THE COURT: That's not what you said.

THE WITNESS: I can't recall.

THE COURT: Okay.

THE WITNESS: I can't recall without looking.

BY MR. WRIGHT:

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

A I don't remember.

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

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

Q Okay. Exhibit N1. Ever seen that before?

A Yes, sir.

Q Where did you see it?

A I see it right here.

Q I said have you seen it before?

A I have seen it before. Yes, sir.

Q And where did you see it before?

A It was in my possession.

Q Did you testify about it?

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

Q I can't either, at the moment.

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

Q Is that a correct definition?

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

Q Sure.

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

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

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

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

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

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

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

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

Q Do you --

A -- absolutely nothing --

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

A But they --

Q Did you testify to that, sir?

A Yes.

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

A I did not know it until we reviewed this.

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

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

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

Q Okay. Well, now you remember it.

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

Q I can't find it.

A Because --

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

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

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

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

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

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

MR. WRIGHT: Okay. Thank you.

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

MR. WRIGHT: Got it.

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

MR. WRIGHT: Pages again?

MR. SANTACROCE: 149, 150.

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

BY MR. WRIGHT:

Q Little tiny writing.

A Where do you want me to start?

Q It starts --

A With Mr. Madden?

Q Mr. Madden.

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

"Answer: But this is from California.

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

"Answer: That is correct.

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

"Answer: I do.

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

"Yes -- "answer: Yes.

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

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

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

Q Okay.

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

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

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

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

THE COURT: Well.

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

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

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

BY MR. WRIGHT:

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

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

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

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

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

A Relative to the safety issue; that is correct. It's --

Q So, what you --

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

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

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

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

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

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

MR. STAUDAHER: Objection.

THE COURT: Overruled.

MR. STAUDAHER: Mischaracterizes his testimony.

THE COURT: Overruled.

BY MR. WRIGHT:

Q Correct? Is that correct?

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

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

A I would have to see it.

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

MR. STAUDAHER: Could -- could I come up and see what he's looking at, Your Honor?

THE COURT: Of course.

MR. WRIGHT: Yes.

BY MR. WRIGHT:

Q I said from there to there.

A I just wanted to see where you took it from.

Q Come out of my notes.

MR. STAUDAHER: Are these your notes or are these -- what is this?

MR. WRIGHT: Those are my notes quoting things. I want to know if he has seen that.

What are you looking at?

MR. STAUDAHER: I'm just trying to find out what the document is you're handing him.

MR. WRIGHT: Says --

MR. STAUDAHER: I have a right to look at whatever he's handing the witness, Your Honor.

MR. WRIGHT: Okay. Well, what I asked the witness to do was --

THE COURT: Okay. Excuse me. Mr. Staudaher has a right to look at whatever Mr. Wright is showing the witness and should be given an opportunity while he stands there for all of you to look at it together or what have you.

MR. STAUDAHER: What he's doing to the document.

THE COURT: Okay. Well, the only thing relevant for you to look at, Mr. Staudaher, is that portion of the document which Mr. Wright is showing the witness. If the witness has had an opportunity to see any other portion of the document, then Mr. Wright, you are directed that you must show that portion of the document to Mr. Staudaher.

MR. STAUDAHER: So we're --

THE COURT: So, basically, if he viewed anything other than that little folded-up part up there, then you have to show the entire thing to Mr. Staudaher.

MR. STAUDAHER: I just want to know what this is that we're looking at. Because it's not a paper. I thought it was a paper he was showing me or some sort of article.

MR. WRIGHT: It isn't.

THE COURT: For the record --

MR. WRIGHT: Do you want me to tell you what it is?

MR. STAUDAHER: Well, no. What is this document you're folding up?

THE COURT: What is the document?

MR. WRIGHT: What is the document I'm folding up? It's my legal memo on --

MR. STAUDAHER: Well, I know -- he's showing him his legal memo?

MR. WRIGHT: I have a quote -- it --

MR. STAUDAHER: To refresh his memory?

MR. WRIGHT: I have a quote in there out of a journal.

THE COURT: Okay. Show me what you're -- okay.

MR. WRIGHT: Jeez.

THE COURT: So you're showing a memo that you wrote to yourself or Ms. Stanish that --

MR. WRIGHT: Quotes --

THE COURT: -- quotes the CDC. Okay. So you want him to read this quote, which you're maintaining here today is an accurate quote from a CDC source, and then you're going to say, okay, you've read a quote. Is that --

MR. WRIGHT: I'm going to ask him if he's familiar with that -- if it identifies with the publication and where it is.

THE COURT: Okay.

MR. WRIGHT: That's how I started with him.

THE COURT: So before you can -- Okay. Doctor, I'm going to show you this part here. I want you to read it quietly to yourself. All right.

The question is: Are you familiar with that as being a quote from a publication or the CDC?

MR. STAUDAHER: May I look at it also, Your Honor?

THE COURT: Of course.

THE WITNESS: I'm -- I have not read this particular CDC release, but I am --

BY MR. WRIGHT:

Q Okay. Well, then --

A -- if that's -- if you want me stop there, I'll stop there.

Q Well, I don't -- I don't --

A That was your question, have I seen this.

Q Correct. That is my question.

A I have not seen this before.

Q Because I can't -- if I can't establish what it is and you're not familiar with it, then I don't get to question you about it.

THE COURT: He can't ask you about it.

BY MR. WRIGHT:

Q So I didn't want you to go on explaining it.

A Thank you very much.

Q I'll take that.

A Okay. Thank you.

Q I think I'm almost done, sir.

MR. WRIGHT: Thank you.

THE COURT: All right. Does anyone need a break before -- everybody's good?

All right. Mr. Santacroce.

MR. SANTACROCE: Thank you.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Dr. Friedman, you testified that you were employed by plaintiff's counsel in the civil cases; is that correct? Some of them?

A Yes, sir.

Q And can you tell me the cases that you were employed in, of the -- specific -- let me rephrase that. I don't want you to go through a whole bunch of them.

I only want to talk about the relevant ones in this case. That might save us -- if you look on this chart here, were you retained in -- for Kenneth Rubino?

A No, sir.

Q Lakota Quanah?

A Yes, sir.

Q Rodolfo Meana?

A Yes, sir.

Q Somnia Ariano [phonetic]?

A No, sir.

Q Gwendolyn Martin?

A Yes, sir.

Q And Nguyen Huynh?

A Yes, sir.

Q How about down here, Stacy Hutchinson?

A Yes, sir.

Q Patty Aspinwall?

A No.

Q Carol Grueskin?

A Yes, sir.

Q So of these people on this list, everybody except Rubino, Grueskin, and it was one other one.

A Aspinwall.

Q Okay. And then for the infection on July 25th, 2007, Michael Washington; is that correct?

A Yes, sir.

Q And with regard to Michael Washington, when were you retained by the plaintiff's law firm on that case?

A I'd -- I'd have to go back and look at the files. I would say...

Q Well, if I -- if I help you out and tell you you gave a deposition in that case in July of 2009, would that help you?

A I was pegging it that it was done a couple of

record your time, are you recording it the same regardless of who the insurer happens to be?

THE WITNESS: Yes.

THE COURT: So you bill out your time the same, and then the billing people worry about is this Medicare, is this Blue Cross Blue Shield, what have you; is that -- is that correct?

THE WITNESS: Yes, ma'am. That's correct.

THE COURT: Okay.

BY MR. STAUDAHER:

Q So the time that you record actually does not change, it is always the same?

A That's correct.

Q And so when you go to these classes and they tell you these things or instruct you on it as far as that's concerned, what is the purpose of that, those kinds of classes? How do you stay in compliance?

A Well, it's just to make sure that if there are any regulatory agency changes, that everybody knows and everybody does it the same way within a department. But we have new people that come all the time. We have people who have been there 20 years. Those people usually know that unless there is a change, that this is the way we've been doing it all the time. But regulatory changes occur all the time, but most of the time they don't occur very much when it

comes to billing.

Q So the times issue doesn't get changed very much; is that correct?

A I can't remember in all the years of practice since 1982 in anesthesia that there has been any change, that this has always been the standard.

Q Meaning the face-to-face time calculated to put down the time as it is?

A That's correct.

Q And we're talking about to the minute kind of thing?

A To the minute.

THE COURT: I have a question. Do you do it the same regardless of whether you're in a hospital, an outpatient or an ambulatory -- well, you said you haven't been in an ambulatory surgical center in roughly ten years; is that true?

THE WITNESS: That is correct.

THE COURT: And then what about an outpatient center, when was the last time you billed in an outpatient center?

THE WITNESS: Within the last five years.

THE COURT: Okay. So most of your recent work has been in the hospital setting?

THE WITNESS: Yeah. If you want to say I do mostly in the hospital setting than in the outpatient facility.

THE COURT: Is that because of the type of procedures

you're doing?

THE WITNESS: It's because everything in my life has been high risk patients.

THE COURT: Right.

THE WITNESS: That's the way I've been trained.

THE COURT: Okay. So are you doing simple -- I'm just curious. Are you doing simple procedures on high risk patients, or are you doing higher risk procedures on high risk patients; meaning, I'm assuming, open heart surgery is more risky than, you know, a colonoscopy generally?

THE WITNESS: That's correct. But usually if I'm asked to do an outpatient, it's a high risk patient in a procedure that usually is low risk, or it's a VIP patient who I have done somewhere because of all the years I've been there, they want me to do that procedure. And that turns out to be in an outpatient facility.

THE COURT: Okay.

MR. STAUDAHER: Two documents --

THE COURT: Do you have follow-up to that line of questions?

MR. STAUDAHER: Just for a couple. I've probably got three, four minutes and that's it, Your Honor.

THE COURT: That's fine.

MR. STAUDAHER: I'm going to show you a couple of documents now. Okay. The first is Exhibit 82.

THE COURT: Is that admitted Exhibit 82?

MR. STAUDAHER: It is admitted 82.

BY MR. STAUDAHER:

Q And this is, I'll represent to you, from the clinic. And the part that I want you to -- can you see that on your screen?

A I can.

Q Okay. And if that's hard for you to read [inaudible] need to at any time, you just draw on the screen [inaudible].

MS. STANISH: Excuse me. May we see the exhibit?

MR. STAUDAHER: While counsel is looking at that one, I'll look at another one, Your Honor. And this is 86, by the way.

I'm going to show you a highlighted version of --

MS. STANISH: Can we see that too? I'm sorry. We don't have them memorized for copies. Thank you.

THE COURT: Maybe we should go to lunch. I need a break actually, not just to eat. We were in session, as I told you, ladies and gentlemen, I don't want you to think that when we have late starts, you know, we're all reading gossip magazines and eating donuts. We're actually in session on hearings on unrelated, you know, matters. We have hundreds of cases and sometimes we have to handle our other matters.

So we obviously had a break, but it's been a long

morning for us and so we're going to go ahead and take our lunch break now. Ladies and gentlemen, it's now 12:30. We'll be in recess for the lunch break until 1:50.

During the lunch recess, you are reminded you are not to discuss the case or anything relating to the case with each other or with anyone else. You are not to read, watch, listen to any reports of or commentaries on this case, any person or subject matter relating to the case by any medium of information. Please do not do any independent research on any subject connected with the trial, and please do not form or express an opinion on the case.

I know you all want letters for your employers. We'll get that to you today. Some of you have given letters from your employers to me. We're not able -- well, I am ignoring you, but I'm not in my head. I am aware of these issues. I'm trying to address them, so just be aware of that.

I am told that we should be concluding prior to the 4th of July holiday. I know there were questions about that if we went past the 4th of July holiday, if you could take a Friday off. I told Kenny I promise we won't be there, but if we are, that will be a majority vote of the jurors if people wanted to take it off, then I'm fine with that.

So those are to answer some of the issues that I know you've been talking to Kenny about. Any other issue you need brought up to me, please, he's always available to all of you.

So having said that, notepads in your chairs, and follow the bailiff through the rear door.

(Jurors recessed at 12:31 p.m.)

THE COURT: Doctor, we are going to excuse you for the lunch break.

I don't know if you want him available to talk to you folks.

So you're free to go to lunch, whatever you want to do. Just be back --

THE WITNESS: Just be back, 1:50.

THE COURT: Yeah. Be back before 1:50.

THE WITNESS: Okay.

THE COURT: If anyone needs to use the facilities, do that. My staff and I need to take a quick break, then we'll come back on the record to address what has come up with the witness, as well as the lab fee memorandum.

(Court recessed at 12:33 p.m. until 12:39 p.m.)

(Outside the presence of the jury.)

THE COURT: All right. Out of the presence of the jury, we're on the record.

Mr. Wright, you indicated you wanted to go on the record at the bench --

MR. WRIGHT: Yep.

THE COURT: -- regarding the qualifications of the expert.

MR. WRIGHT: Yep.

THE COURT: Go ahead.

MR. WRIGHT: Yes. I move to strike his testimony regarding billing, because I had -- he isn't listed as a billing expert. All I've read, and I --

THE COURT: I had asked for this previously, but I never got it to my knowledge, is a copy of the expert -- you might have given it to me or I've seen it, a copy of the -- but I may have given it back, a copy of the expert disclosure. So as these issues come up, I can see what the disclosure was and whether I think it was --

MR. WRIGHT: Well --

THE COURT: -- sufficient notice.

MR. WRIGHT: -- I'll -- I'll read it --

THE COURT: Just read it.

MR. WRIGHT: -- I'll read it to you.

THE COURT: That's fine.

MR. WRIGHT: Numbers -- Expert No. 63. "Dr. Arnold Friedman, anesthesiologist, is expected to provide testimony including, but not limited to, his direct involvement, review of records and analysis of the victims in this case, as well as proper anesthesia procedures, standards of care, proper use and administration of anesthetic agents, anesthesiologist supervision of certified registered nurse anesthetists, proper aseptic technique, proper use an documentation of anesthesia

records, pre- and post-operative anesthetic care of patients and ongoing procedures and related topics."

THE COURT: Well, he can -- I don't know what the State's going to say, but to me the anesthesia records can be -- this is how I write down my time. I don't write down 31 minutes for every single patient I see. I write -- and which he actually has already testified to, I think, in response to something I may have asked, trying to figure out if he had knowledge to testify.

I think he can testify this is how I write down my time. I write it down according to the time I spent with my patient and that's how I would make an anesthesia record. I think that's within the disclosure.

I think, you know, how it's --

MR. WRIGHT: He's an expert at that?

THE COURT: Well, any doctor --

MR. WRIGHT: From -- did he insert -- can I make my argument?

THE COURT: Well --

MR. WRIGHT: He's at Cedars-Sinai; he's -- he's brought in here as an expert. All I've read, and I've read his depositions, everything in the case, never has he said a word about billing. Okay.

THE COURT: Which, if you'd --

MR. WRIGHT: Or his time.

THE COURT: Okay. Wait a minute.

MR. WRIGHT: And --

THE COURT: If you hadn't interrupted me, Mr. Wright, I would have said I think he can say how much time he puts on the record. I haven't seen anything about billing the time.

MR. WRIGHT: Okay.

THE COURT: If you hadn't interrupted me --

MR. WRIGHT: I'm sorry. Then my motion to strike is granted?

THE COURT: Well, I don't know what he said about billing so far. I mean, because you -- you objected on the foundation and Mr. Staudaher tried to lay a foundation. So what is there to strike?

MR. WRIGHT: All of his testimony about his insurance companies, the word Medicaid, Medicare, Med -- he --

THE COURT: I don't remember him getting there.

MR. WRIGHT: He -- he testified to all that.

THE COURT: What did he say?

MR. WRIGHT: I want to have it played back, then. Because he testified --

THE COURT: Well, no, you tell me you remember --

MR. WRIGHT: He --

MR. SANTACROCE: He testified as to base units, he testified to additional units of 15-minute increments, he testified that this was CMS standards, start and stop time.

MR. WRIGHT: Start time, stop time, CMS, Medicaid, anesthesia billing every 15 minutes --

THE COURT: Well --

MR. WRIGHT: -- base unit different with Medicaid, Medicare, how private insurers do it, they follow state by state. I do it, although you don't -- no, that's my voir dire that he knows nothing. You take a guy who's an anesthesiologist and his expertise is in California in his hospital he changed -- he appears at an annual refresher course. And so then he researches online so he can come in here as a billing expert. He has no expertise in billing. His records, anesthesia records, we have no idea what they look like and they're -- if they're anything like the records that are used here in Nevada or anything else.

THE COURT: Well, that to me is cross. I mean, I think the -- just, look, the issue is basis of knowledge and -- or expertise and sufficiency of the disclosure. On sufficiency of the disclosure, he certainly can testify within that disclosure as to how he records his time, because that's part of the record. So I don't have a problem with that.

Now, you can point out on cross, as you've already done on your voir dire, that this guy hasn't been in an ambulatory surgical center in a decade. And he's only -- it's half a decade since he's been in an outpatient clinic. So he's only been doing this in a hospital setting pretty much.

So, I mean, that's cross.

But, you know, the disclosure was what he does in his record. So the time he puts in his record, I'm fine with that. That was in the disclosure. Now, I'm concerned about the billing, from him to go from that disclosure to billing.

MR. SANTACROCE: And when I approached the bench --

MR. STAUDAHER: Well, and in the disclosure --

MR. SANTACROCE: -- I asked for an offer of proof as to what he was going to be allowed to testify to as an expert. And Mr. Staudaher said, Well, we gave you the disclosure. There's nothing in the disclosure about the --

MR. STAUDAHER: You also said --

MR. WRIGHT: There's not a word --

MR. STAUDAHER: You also said it was going to --

MR. WRIGHT: -- about billing.

MR. SANTACROCE: And not a word about --

MR. STAUDAHER: -- be exactly --

MALE SPEAKER: One at a time.

MR. SANTACROCE: Not a word about billing in the disclosure. And then he takes him on this long path of what billing procedures are for providers and base units and additional units and how anesthesiology is different in billing because they get five base units because some procedures are slower and some are longer and they shouldn't be penalized. I mean, that's absolutely beyond what he was

qualified to be an expert in.

I'm joining Mr. Wright's motion to strike that portion of his testimony.

MR. STAUDAHER: The disclosure said proper documentation and use of anesthesia records. Those records have no other purpose on the time issue than to use for billing purposes. His limited knowledge is all that he's testified to. His experience in how that is important, why he goes and -- and takes these classes, so that he can be in compliance when he's filling out those records and submitting them for billing purposes.

THE COURT: Okay. He can testify what he puts in the record, you know, if he tries to be accurate, why he tries to be accurate. In terms of how it's all billed, I think that's beyond the disclosure. But he can certainly, I think within the disclosure, say this is how I record the time, this is why it's important for it to be -- I mean, there are other reasons they record the time, frankly.

Medical malpractice issues, you know, they need to show that they were in attendance with the patient, they didn't walk out of the room while this surgeon's there. Because, as we've learned, and many of us knew before, you know, they're responsible to make sure the guy's breathing.

So, I mean, there's other reasons they accurately record the time that have nothing to do with billing. Now,

that's, of course, probably a primary area. But I'm sure there's other reasons relating to claims -- later claims and medical negligence and things like that. So they have to document for a number of reasons. Some of which maybe their carriers even care about.

I mean, they're -- I don't know. But I think, you know, certainly the way he records it, why he's, you know, accurate, what he does to see what time it is, anything like that, I think is fine. I think beyond that, you know, you know, what do you, you know, he can say, Is this the only record you submit to your billing department regarding compensation?

MR. STAUDAHER: The only thing I'm going --

THE COURT: Yes. Okay.

MR. STAUDAHER: -- I'm not asking him any further questions if I've asked it.

THE COURT: How the gal bills it -- gal or guy, I shouldn't be sexist -- bill it out from there I think is beyond the disclosure.

MR. STAUDAHER: I mean, then, he clearly within his knowledge with those anesthesia records that the time is -- is 15-minute increments. That's what he does. I mean, that's not without -- that's not outside the scope of what we're talking about. The reason to keep record time is to actually document the time for billing purposes. That's what he told

-- testified to.

MR. WRIGHT: If the Court can't recall his testimony, I want it played back. We went into question after question, read them off, Mr. Staudaher. If the guy's out in the recovery room and then a question is asked, Is it proper? No, under CMS you can't. If it's face to face, No, you can't under CMS. He even said under the law you can't. That's a quote. Under the law you can't. And if -- if they come in and ask you a question, can you, No.

Anesthesia's different than other things, under the law, if you call your doctor, he can bill for it. If someone comes in and asks me a question in recovery room, I can't bill for it. That's the law. He testified for 15 minutes on this. I want it stricken. That had nothing to do with time, 15 minutes, how I fill out my record.

He acknowledges he is not an expert. He has no expertise, he has no billing. He had to go do some research to come in and answer the questions that obviously Mr. Staudaher told him, Here's what I'm going to ask you about. I want to go into billing and whether you can do these things. With no notice to us.

I've fully expected to hear this witness testify about aseptic practices and multi-use of vials and everything else. Because that's what -- that's what the discovery is on him. And there's nothing about billing.

THE COURT: In any of his --

MR. STAUDAHER: When we were up at the bench we said specifically that before we started questioning that witness that we were going to ask him about start and stop times and things like that.

THE COURT: I said start and stop times are fine.

MR. STAUDAHER: Yeah, and that's what --

THE COURT: That's fine. That's part of the record.

MR. STAUDAHER: So how do you define it?

THE COURT: And that's something he does as a doctor. I'm fine with that. The -- and I think that's encompassed in, ironically, civil expert disclosures are much more comprehensive than criminal expert disclosures, which makes no sense to me. But I think that that's sufficient under, you know, as an expert disclosure for him to talk about the time, because it says records and what they're used for.

You know, you can ask him, if you want, you know, Is this what you turn over? Do you turn over any other records to your billing department to bill your time? Beyond that, I think you need a billing person, not this guy. It's not disclosed.

MR. WRIGHT: I -- I want his testimony, all I'm talking about on the billing, Can you bill for time spent with patient? What about liability, is liability larger than the time? Yes. Under CMS or CMT, whatever he's talking about.

THE COURT: Well, they're talking about malpractice liability, I'm assuming.

MR. WRIGHT: But he -- he's not a billing expert, Judge. He went into you cannot overlap. A billing -- according to the billings guides by CMS, you can't be treating three patients or five patients at the same time. That has nothing to do with his records and what I got notice of.

THE COURT: Sure it does. I mean --

MR. WRIGHT: That -- that the law says he can't do that?

THE COURT: Well, okay. Here's the thing. I mean, he can say, I can instruct them that this witness is not here as a legal expert. Any testimony he gave regarding the law is to be disregarded.

MR. WRIGHT: And billing.

THE COURT: But he can say, as a physician, if somebody comes in and asks a question, he doesn't bill for that time or -- or they're not allowed to do that. Because it's what he fills out.

MR. WRIGHT: Why? Why is he not allowed to do that?

THE COURT: Well, he doesn't do that or whatever.

MR. WRIGHT: Well, why is that relevant what he does in a hospital practice at Cedars-Sinai?

THE COURT: Well, how else are you going to get into it? I mean --

MR. WRIGHT: They can call an expert --

THE COURT: -- that's all any --

MR. WRIGHT: -- on billing, Judge.

THE COURT: I said they had to -- that he can't talk about billing and how it's done. He can say what kind of a record he makes.

MR. STAUDAHER: And -- and why he makes the record. I mean, that's -- that's the -- if he has knowledge of that, that's the -- that's the --

THE COURT: Yeah, but --

MR. STAUDAHER: -- documentation --

MR. WRIGHT: Hearsay.

THE COURT: -- okay.

MR. STAUDAHER: -- and use of the item.

THE COURT: Looking up CMS today or yesterday isn't why he makes the record. Because if -- if he knew why he made the record, he wouldn't have to look up the CMS prior to coming in to testify. I -- I mean, if it's something that's part of your general basis of knowledge, hey, the billing gal told me to do it this way, or, Hey, my senior partner did it this way, or I've always done it this way, or I learned in med school to do it this way, then why's he looking up the CMS?

I mean, so I'm comfortable, you know, saying he can't make -- he's not -- here's a legal expert.

MR. STAUDAHER: We have no problem with that.

MR. WRIGHT: And --

MR. SANTACROCE: Or billing.

MR. WRIGHT: And --

MR. STAUDAHER: No. No and.

MR. WRIGHT: -- I want to strike his testimony. That's my motion. He's -- he was called as an expert. He himself says he's not an expert.

THE COURT: Well, he's given --

MR. WRIGHT: Therefore the information he provided that he learned in classes once a year and that he looked up is hearsay. It doesn't come in through a nonexpert. He is not an expert. It's hearsay.

MR. STAUDAHER: It is -- how he fills out --

MR. WRIGHT: It's inadmissible.

MR. STAUDAHER: How he -- I'm sorry.

MR. WRIGHT: And -- and I don't care how he writes down his time has nothing to do with all he testified about. CMS out in recovery, if the patient's just a little farther away in an ASC setting. He's never even been in a setting, or billed in the HACHA [phonetic] setting.

MR. STAUDAHER: It is clearly within his knowledge that he cannot deal with two patients at the same time. That's what he's testifying to --

THE COURT: Well, that's what I said. He's fine --

MR. STAUDAHER: -- and it has to --

THE COURT: -- to record -- to testify how he records his time. That as a physician he can't deal with two patients at one time. To me, that's physician stuff. The gal in the billing department can't say it's unethical or it's not good procedure to run out into the recovery room when you've got a patient on the bed. That's medical testimony. That's a physician. And I'm fine with him doing that.

That would be inappropriate testimony for a billing gal, some gal in billing is going to say, Oh, yeah, the doctor has to stay with the patient and he can't -- I mean, come on. That is medical testimony and you need a medical doctor to say it. That is not billing testimony. So I'm fine with him saying that about he doesn't write down the time, his duty is to the patient in -- in the procedure room. That's medical stuff. If they tried to put it onto a billing person, you'd be standing here saying, Well, that's medical standard of care --

MR. WRIGHT: Well, I would not.

THE COURT: -- test -- well, I'd be wondering why you weren't saying it, then.

MR. WRIGHT: Saying -- saying I cannot bill if I have three people under my care in -- in a -- in a prenatal unit --

THE COURT: No, he said they weren't really under his care.

MR. WRIGHT: -- if I have four babies, I can bill for

all four of them. I tried the damn case. Don't -- I understand there are different rules of procedures on when you -- he had a word for it. It wasn't -- started with a C, about when you can do it. Anesthesia's different. It's not like other things. Because there are procedures where you can bill co -- whatever the hell the word is, coterminously at the same time. And -- and I am responsible for more than one.

And he's given a legal opinion that you cannot do that, because anesthesia's different. And that isn't medical. That is billing. I move to strike it.

THE COURT: I -- okay.

MR. WRIGHT: His billing testimony. And if then he wants to say -- and -- and an instruction that how he fills out his records and then it's -- the correct time, his start time, stop time, I don't care about. What I care is he gave a lecture to the jury, turned, looked to them and said, And furthermore, if I'm in the recovery room -- he gave them eight -- you have to have them written down in your questions to ask him. And they -- they made hypotheticals that call for legal conclusions. And he gave them. And he's not qualified.

THE COURT: Well, why didn't we get a contemporaneous objection? Objection, calls for a legal, not a conclusion?

MR. WRIGHT: Because I'm moving to strike. Because I thought he was an expert. And that's why I took him on voir dire. Because I'm thinking, what's going on here?

THE COURT: Well, why weren't you looking at your expert disclosure saying, Wait a minute, this stuff wasn't disclosed to me, what's he doing? Objection. Exceeds the scope of his expert disclosure. Then I would have hauled everybody up here and said, Gee, let me read this. Oh, you know what, it says --

MR. WRIGHT: I thought --

THE COURT: -- nothing about billing.

MR. WRIGHT: I thought --

THE COURT: I don't know, why not, Objection, exceeds the scope of the expert disclosure?

MR. WRIGHT: My fault.

THE COURT: Objection, beyond the disclosed area of testimony. I don't know, that's not that hard to me as opposed to now trying to remember what exactly he said and we want to do an instruction and not cut out the stuff that he can say and cut out only the stuff he wasn't supposed to say. I don't know, to me a contemporaneous objection, objection, they haven't laid a foundation as to this type of testimony. Like I said, to me, the obvious. Objection, exceeds the scope of the expert disclosure. Then I can read it. I can say, Gee, Mr. Staudaher, I don't see anything in here about billing. You're blindsiding the defense. Why didn't you do that instead of now sitting here trying to write some kind of instruction to admonish the jury --

MR. WRIGHT: How --

THE COURT: -- to make the State look bad?

MR. WRIGHT: How tough is it to strike?

THE COURT: You know, I mean, this could have been rectified --

MR. WRIGHT: The motion was to strike.

THE COURT: -- and we could have saved, you know, 20 minutes of testimony.

MR. WRIGHT: The motion is to strike. It wasn't to instruct.

THE COURT: Strike what?

MR. WRIGHT: His testimony regarding billing only.

THE COURT: Well, then they're going to --

MR. WRIGHT: Billing practices and what the law is on it. And I took him on voir dire and said, I'm going to want to address this. And he said, You'll get the opportunity. Okay. I'll wait. And then it's -- Wait, you should have been -- we should have been doing it sooner.

THE COURT: Well, no. You took him on voir dire and then Mr. Staudaher --

MR. WRIGHT: Right. And then -- and then --

THE COURT: -- tried to lay a foundation, and then --

MR. WRIGHT: Well, right. I --

THE COURT: -- I said let's go to lunch. I mean --

MR. WRIGHT: Okay. So I --

THE COURT: So that's my memory of what --

MR. WRIGHT: My motion is to strike.

THE COURT: Mr. Staudaher?

MR. STAUDAHER: Your Honor, he's an anesthesiologist. You just said yourself that he -- that's his medicine side of things, whether he can treat multiple patients at once, whether he is able to do any of those things has nothing to do with billings, per se. Although that's the ultimate result, that he is able to either not bill or bill. The anesthesia record was disclosed. How that record is used was disclosed. That record is used for the purposes of billing and it has very specific parameters by which it comes into existence and how it's used and whether or not you can start a new one when you've got one going on another patient, or you can start three when you've got one going on a patient. All of that, I believe, is subsumed within -- in the notice.

We disclosed up at the bench we were going to be talking about start and stop times. That's why it's important to even talk about start and stop times. Because if you have a stop time, then you have a stop time. If it -- if it's squishy and it goes on forever, you have no end time. And that's what the issue here is in this case. That if there's no end time, then you can bill for or five, six patients. That was -- we talked about that at the bench before his testimony started.

THE COURT: All right.

MR. STAUDAHER: There was no issue.

THE COURT: Here's what I --

MR. WRIGHT: Let me -- can I tell you, our -- our next billing expert coming on. Let me tell you the notice they gave us. "Joaen Syler expected to provide testimony including but not limited to medical record auditing, coding compliance, documentation standards, auditing for documentation to support charges billed to insurance company, coding, healthcare financing guidelines and regulations, provider insurance negotiation." This was the billing expert. This was the notice, the next witness coming up. You tell me that's the notice under Mr. Friedman.

THE COURT: I already said, Mr. Wright, why do you keep fighting with me and screaming and yelling and carrying on --

MR. WRIGHT: I talk loud.

THE COURT: -- about stuff that I've already agreed with you? First of all, it's a waste of time, and second of all, it's stressful for everyone concerned. And third of all, in my view, it's completely unnecessary. So I don't know why, when I've said it wasn't an adequate disclosure for billing, why you have to keep saying it's not an adequate -- yeah, I agree. It's not an adequate disclosure for billing.

In my view it is an adequate disclosure for how time

is recorded. I mean, records, what other records are we talking about? There's, you know, the record, on cross you can point out, is this the type of record you use? You've never practiced in Nevada, you've only practiced in California. You know, you haven't been in an ambulatory center in 10 years? I mean, that you can, you know, bring up on cross, that he's not really competent. I am willing to give an instruction to the jury that they are not to consider the last witness's testimony, this witness's testimony regarding any legal conclusions. As to what is legally permissible, as he was not, you know, he's not a legal expert.

I'm also willing to say that they can't consider his testimony as to what he looked up on CMS, or what was told to him in the annual billing classes or whatever. Beyond that I'm not willing to do anything else. I will tell Mr. Staudaher that he can't talk about how, then, his time is billed out because he wasn't disclosed to do that. He can only talk about how his time is recorded, you can ask him, you know, how do you do it, do you synchronize your watches, what do you, you know, when -- when do you start recording your time, what about if you interview the patient, do you record that, blah blah blah. That, I think, is permissible. All right. That's what I'm willing to do.

MR. WRIGHT: That's what I'd like.

THE COURT: State, anything else on the proposed

instruction to the jury?

MR. STAUDAHER: No, that's fine, Your Honor.

THE COURT: From this point forward, Mr. Wright, I would like a contemporaneous objection. Objection, exceeds the scope of the disclosure. Objection, you know, I think that's pretty easy, exceeds the scope of this witness's knowledge, you know, if you don't want to call him an expert. Exceeds, you know, the parameters of his knowledge or expertise or whatever. Then we can maybe get a contemporaneous ruling and save us all a bunch of time.

MR. WRIGHT: Yes, Your Honor.

THE COURT: Mr. Santacroce, you're standing up.

MR. SANTACROCE: I'm ready to go to lunch.

THE COURT: Yeah. You and I, you know, who would have thought that...

MR. SANTACROCE: Like minds, you and I.

THE COURT: All right. Oh, before we go to lunch, I'm sorry, Mr. Santacroce. As badly as my head is aching, I want to bring up another issue. This whole disclosure thing.

Basically, according to this, you know, I'm not that uncomfortable with releasing it to the lawyers here, because the defense in some of these endoscopy cases had already gotten it. The insurance defense, I don't remember, was Teva all of them. But they had it. So it's been disseminated.

The important stuff in here, when I first read it, I

thought, Oh, no, this is all contrary. But when you get to the end of it in my view, it's even worse about Dr. Desai when he testified to. The important thing is it doesn't mention that it was disclosed to Mr. Mitchell. It does mention that it was disclosed to Mr. Labus, who received this. So I don't know what was turned over from the what the Health District had about this or not, but it says that it was given to Mr. Labus. How it got from him to the civil lawyers, I do not know. And that's not clear from the motions or anything.

Also, a few things that are different is he says he was called several times by Geraldine and Lisa Falzone encouraging her to call the CDC, or the Clark County Health District. And then he says he spoke to Geraldine four or five times and Maggie Murphy three or four times. He also says -- this is just I'm telling you what I remember as being inconsistent with his testimony -- he began overcompensating for the loss of self-esteem after his wife -- wife's death by verbalizing his sexual liaisons to staff in both the procedures rooms and in the common area, and that he no longer was a team player based on his depression and -- depression is my word.

So, other than that, I think that it's pretty much the allegations consistent with what he testified to, and sometimes even, like, worse than what actually came out. So I'm going to re -- re-look at the briefing on the civil stuff.

But I think the gist of it was that the privilege belongs to the client, not to the attorney. So if the attorney makes an unauthorized disclosure, that doesn't mean that the client can't still assert a privilege that he didn't intend any disclosure to be made.

I think in this case, since it, you know, may have impacted the Health District's investigation, I think that the defense is right to be apprised of witness statements and things like that, supercedes any privilege right that Mr. Chaffee has, particularly since I've seen it, Mr. Labus has seen it according to this, the civil lawyers have all seen it. So it's not like there's some secret document that people haven't seen.

So that's it.

MR. WRIGHT: So we get it?

THE COURT: Well, I'm just going to look over the briefing again.

MR. WRIGHT: Okay.

THE COURT: But that's my initial impression. Because, like I said, there's no big secret here and I think, since the civil lawyers have all seen it, I don't see why the criminal defense lawyers and the DAs can't see it when the Health District's gotten it, maybe Metro's gotten it, I don't know.

MR. WRIGHT: Okay.

THE COURT: Somehow it got distributed. I'm really curious how it got distributed from --

MS. WECKERLY: He says his lawyer, his first lawyer sent it.

THE COURT: Is that who gave it to Labus?

MS. WECKERLY: I think he gave it to other lawyers.

THE COURT: Other lawyers in the civil case? Because what wound up happening, it looks like, is his criminal lawyer is different than who's Ms. Johnson, who's ultimately representing him civilly. And that's who starts asserting the privilege, as I understand it. So.

MR. WRIGHT: More to put on the record, Your Honor. On Shibonles Balducci [phonetic], that -- this redacted document.

THE COURT: Correct. Right.

MR. WRIGHT: Margaret and Mr. Santacroce attested they hadn't read it. I read it. I didn't realize this was the same -- this -- when I went up there and stood and read the whole thing --

THE COURT: Right.

MR. WRIGHT: -- I'm not going to use what was blacked out. But I just wanted to tell you I did read it and that's what I was talking about when I said, you know, this is where she got all this stuff. So.

THE COURT: Okay. But it wasn't from the lawyer.

MR. WRIGHT: Correct. I was focused on this.

THE COURT: Right. Then --

MR. WRIGHT: But I did read that.

THE COURT: You read the memo --

MR. WRIGHT: Because I --

THE COURT: -- from the lawyer --

MR. WRIGHT: Right.

THE COURT: -- but --

MR. WRIGHT: I didn't know.

THE COURT: Okay. Well, that's fine.

MR. WRIGHT: Okay.

THE COURT: You can't unrace --

MR. WRIGHT: But I won't talk about it.

THE COURT: You can't unrace your memory, don't talk about it, you've now got a redacted copy and suffice it to say it wasn't the lawyer coaching her about her testimony or anything like that.

MR. WRIGHT: Correct.

THE COURT: Correct? Okay.

MR. WRIGHT: Yes.

(Court recesses at 1:09 p.m., until 2:00 p.m.)

(Outside the presence of the jury.)

THE COURT: They'll be in in a minute.

MS. WECKERLY: Can I -- can you please read the instruction you're going to --

THE COURT: I was just going to say something like, Ladies and gentlemen, you must disregard any legal opinions offered by this witness, as he is not an expert in legal matters. Additionally, you must disregard any testimony as to what this witness read on the CMS Web page or what he was told at the annual billing classes.

MR. WRIGHT: Is it possible to add that you can consider the balance of his testimony or -- you know, so it's not they --

THE COURT: Right. Okay. You --

MS. WECKERLY: You can --

THE COURT: -- are free to consider the remainder of his testimony and may give it the weight to which you deem entitled.

MS. WECKERLY: Yes, please.

THE COURT: That's fine. I kind of ad-libbed that, so I hope I remember.

MS. WECKERLY: It sounds right. I think I've heard that somewhere.

MR. WRIGHT: Who is that? Is that your daughter?

THE COURT: Bring them in.

THE MARSHAL: Ladies and gentlemen, rise for the presence of the jury.

(Jury reconvenes at 2:01 p.m.)

MR. STAUDAHER: Do you wish me to get the witness,

Your Honor?

THE COURT: I'm sorry?

MR. STAUDAHER: Do you wish me to get the witness?

THE COURT: Sure.

THE MARSHAL: Everybody may be seated.

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

Ladies and gentlemen, before we continue with the testimony of the last witness, I have a -- an admonishment to give you.

Ladies and gentlemen, you must disregard any legal conclusions given by the last witness, as this witness is not an expert in legal matters.

Come on back up.

You must also disregard any testimony regarding any information the witness saw on the CMS Web page or what he was told at the annual billing meetings. You are, however, free to consider the remainder of his testimony and give it the weight to which you deem it entitled.

All right. Sir, you are, of course, still under oath.

And Mr. Staudaher, you may resume your questioning of the witness.

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION (Continued)

BY MR. STAUDAHER:

Q Just a couple of items. Showing you what has been admitted as State's 82. And the highlighted portions of this are mine, just so you know. But I want to go through this with you a little bit. I'll represent to you that this came from the clinic.

In reading the highlighted portion, can you do that, or would you like me to bring the document up to you and make it easier?

A Could I have the document?

Q Just take your time and [indiscernible]. Are you done? Now, that passage there delineating some of the things we've talked about, in comparison with your experience and practice in anesthesia, how you calculate your times, you know, and the like, is this the -- the formula, or is this how you do it, essentially?

A Yes, sir.

Q To your knowledge, is this the way you've always done it?

A Yes, sir.

Q I'm going to show you State's 86, and again, the highlights are mine on this, this particular document.

MR. WRIGHT: What was that previous exhibit, Mr. --

MR. STAUDAHER: Previous -- previous one was 82.

MR. WRIGHT: Thank you.

MR. STAUDAHER: And this one is 86.

BY MR. STAUDAHER:

Q Now, also, as you can see, the title of this is Gastroenterology Center of Nevada Instructions to Post-Anesthesia Charges. It appears as though this is the way that it -- this is what the document shows is how it was done, at least at this center.

MR. SANTACROCE: I'm going to object to leading.

THE COURT: Overruled. It's kind of foundation.

BY MR. STAUDAHER:

Q With regard to where it's listed here where it's talking about to figure units for time, calculate how many 15-minute increments there are, a portion should be rounded off to the next 32 minutes, that would be -- it gives an example of that being three units; do you see that, 32 minutes would be three units?

A Yes, sir.

Q Now, if this was the -- if the practice of the clinic was based on that, would that comport with the 15-minute billing that you're talking about, if the insurance carriers accepted that, for example?

MR. SANTACROCE: I'm going to object.

THE COURT: Sustained.

BY MR. STAUDAHER:

Q Would it be three units of anesthesia as depicted here in this record?

MR. SANTACROCE: Objection. Foundation.

THE COURT: I don't understand -- I don't understand the question.

BY MR. STAUDAHER:

Q In the -- this is -- I'm -- I'm representing to you that this came from the clinic. It's entitled -- it's titled at the clinic; do you see that?

A Yes, sir.

Q And where it's talking about the figuring of 15-minute increments and what 32 minutes would be, would that, based on this comport --

THE COURT: Is that how you did it? Is that your question?

MR. STAUDAHER: I'm -- that's one of them. But I'll -- we can ask that one first.

BY MR. STAUDAHER:

Q Is this how you would do it?

A No, sir.

Q Okay. How would you do it?

A Well, again, it was -- it strictly is the time. In other words, the beginning and end time.

THE COURT: So you -- I'm sorry to interrupt. So you didn't compute the units? You would just say I started the patient at 10:00, I finished the patient at, say hypothetically, 10:37, and you'd write on your chart, you

know, 10:00, 10:37; is that --

THE WITNESS: That's correct.

THE COURT: -- fair? Okay.

BY MR. STAUDAHER:

Q In doing your work, would you -- regardless of procedure, would you just put down a -- a time? I mean, like a set time like that?

MR. SANTACROCE: Objection. Vague, ambiguous.

THE COURT: Do you understand the question?

THE WITNESS: Would you repeat it again?

BY MR. STAUDAHER:

Q In doing your normal anesthetic times, and I'm talking about for procedures like endoscopies or -- or anything like that, when you -- when you put down your time, is it the actual time or is it just some arbitrary number that you just put down?

A It's the actual time.

MR. STAUDAHER: I pass the witness, Your Honor.

THE COURT: All right. Cross, who would like to go first? Mr. Wright?

MR. WRIGHT: Yeah.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q By the way, my name is Richard Wright. I didn't introduce myself previously. I represent Dr. Desai.

Let's talk about your practice and experience in California. Have you ever practiced in Nevada?

A No, sir.

Q Okay. And after Air Force, your specialization, you end up -- I don't -- end up, I don't mean derogatorially, you land at Cedars-Sinai in California and you've been there about ever since?

A Yes, sir.

Q Okay. And you're an anesthesiologist and specialize in what area?

A Well, most of the area has been in cardiovascular anesthesia. It has been in critical care medicine. But it also means taking patients who have cardiovascular problems and doing anything on them. That can be abdominal surgery, it can be a hip, it can be endoscopy, it can be a catheterization. It's just taking a subset of high-risk patient through any surgery or procedures at Cedars.

Q Okay. And so the vast majority of your anesthesia practice is what -- and I don't use all the correct medical terminology -- high-risk difficult procedures at -- no, patients?

A Not all of them. I -- before I -- as I said, because I've been there a while and I've developed a reputation, I have a lot of VIP patients who I take through what most people would say is just ordinary surgery, who are

not high-risk --

Q Okay.

A -- but they want to have a safe anesthetic.

Q Okay.

THE COURT: So if Barbara Streisand calls you, that's -- you would -- that --

THE WITNESS: I wouldn't say no.

THE COURT: Okay.

BY MR. WRIGHT:

Q Do anything with Michael Jackson?

A I do not -- corporate compliance --

THE COURT: He doesn't want to touch that.

THE WITNESS: -- does not allow me to discuss any of these natures with the patients.

BY MR. WRIGHT:

Q So we don't have a yes or a no.

THE COURT: He isn't allowed to answer that question.

BY MR. WRIGHT:

Q The -- I -- I guess the endo center, what we call the Gastroenterology Center here in Las Vegas that's the subject of this criminal case, it was -- Dr. Desai was the majority owner of --

THE COURT: Oh, keep your voice up.

BY MR. WRIGHT:

Q I guess -- I guess the gastro center here in Las

Vegas that Dr. Desai was a majority owner of in the Endoscopy Clinic of Southern Nevada would -- would fall within the ambulatory surgical center category of your classifications?

A Yes, sir.

Q Okay. And have you ever practiced anesthesia in an ambulatory surgical center?

A No, sir.

Q Okay. And you have in what you call outpatient clinics, correct?

A Yes, sir.

Q Okay. And -- and when's the last time you did a endoscopic procedure, like in an outpatient clinic?

A Within 5 to 10 years.

Q Okay. Now, you have familiarity with this case, correct?

A Yes, sir.

Q Okay. How -- how did you end up being here as a witness?

A How? I assume, I don't know this for sure, but I was involved in the trial with plaintiffs against Teva and against Baxter and I got -- I got a phone call from one of the lawyers whose patients I represented, and she told me that I would get a call from the district attorney's office.

Q Okay. And who -- who is that, first of all, Teva, Baxter, who are they?

A They are the generic manufacturer and the distributor -- and Baxter is the distributor of propofol, the generic brand.

Q Okay. And you represented -- or not represented. You were involved in the civil litigation on behalf of plaintiffs in civil litigation arising out of these circumstances of this case?

A Yes, sir.

Q Okay. And who was -- who was the lawyer who contacted you?

A It was Nia Kellebrew.

Q Okay. And did -- did she -- you had been -- let me back up on that.

You had been retained as an expert for how many of these cases?

A Well, I can't -- I can't tell you the total percentage, because it had settled out. I did represent the -- any of the plaintiffs that were from the Bernstein law firm and from the Gillock Law Firm, which was Ms. Kellebrew.

Q Okay. And by represent, you mean as an expert witness?

A Yes, sir.

Q Okay. And did you have to get some -- some type of waivers or something to be able to go to work for the district attorney's office?

A No, sir.

Q Okay. I presume you -- are you being paid by the district attorney's office?

A To be quite honest with you, I never discussed the payment at all, so I have no knowledge of that.

Q Okay. Well, the -- how many cases -- so you're doing it pro bono?

A I have no -- as I said, I don't know.

Q Okay. So when -- when Ms. Kellebrew called you she asked you to help out the district attorney's office?

A No. She said you will be getting a call from the district attorney's office about this case.

Q Okay. And did you say for what?

A Well, I said that and she just said that this is for the trial for Dr. Desai. And that's all I discussed with her. That was it.

Q Okay. Well, are those other law firms paying you?

MR. STAUDAHER: Your Honor, I'm going to object this point to --

THE COURT: Overruled.

THE WITNESS: No.

BY MR. WRIGHT:

Q Okay. Well, the -- I mean, you -- you charge a lot, correct?

A I have in the previous cases, yes.

Q Okay. And, like, how much do you charge?

A Well, it depends what it is that I do. The usual and customary for a malpractice case, which is what I'm usually involved with, is $400 an hour.

Q Okay.

A And that's to review the case. Then it depends whether I go out of town or not.

Q What did -- what did you charge in these, I'll call them the endoscopy Las Vegas cases?

A Well, that's what I charge. I charge $400 an hour.

Q Okay. And -- and you said that's your standard and customary rate?

A Yes, sir.

Q Okay. Do you do this for a living?

A No, sir.

Q Okay. I mean, being an expert witness?

A No, sir.

Q Okay. So this is, like, your first occasion on these cases?

A No, sir.

Q Okay. Second?

A No, sir.

Q Fifth?

A No, sir.

Q Tenth?

A No.

Q Twenty?

A No, sir.

Q Higher?

A Yes.

Q This is a hobby?

A No, sir.

THE COURT: What percentage of your income would you attribute to expert fees, whether it's a file review or a deposition or testifying at trial or doing a malpractice affidavit or whatever?

THE WITNESS: Less than 1 percent.

THE COURT: Of your total income?

THE WITNESS: Yes.

THE COURT: Okay. And I'm assuming that's annual?

THE WITNESS: That's annual. Yes, ma'am.

THE COURT: Okay.

BY MR. WRIGHT:

Q Less than 1 percent of annual income. How much did you make off the Las Vegas endoscopy cases?

A The total amount of that, I can't tell you exactly, but I'll give you an approximation, at least $50,000.

Q Total in all of them?

A Yes, sir.

Q Okay. So $50,000 is 1 percent of what? Boy, you're rich.

A No. I think the judge said when you allocate this over a 30-year period, this was -- this was the most amount of money by far.

Q I didn't hear her say anything about allocating it over a 30-year period.

A She said annual --

THE COURT: Perhaps it was a poorly phrased question.

THE WITNESS: She said annual. So obviously, the one year I got that amount of money was not 1 percent of my salary. But if you go ahead and add 30 years of doing this, it was less than 1 percent when you allocate it --

BY MR. WRIGHT:

Q Okay.

A -- over a 30-year period.

Q And you -- you've testified in many cases?

THE COURT: We can't hear --

BY MR. WRIGHT:

Q You've testified in many cases? Many, M-A-N-Y.

A No.

Q Not mini, M-I-N-I.

A No.

Q Many cases. No?

A No.

Q Okay. You examine the cases, do depositions, and then they normally settle?

A That is correct.

Q Okay. So the cases actually going to, like, a civil trial are a rarity?

A That is correct.

Q Now, the -- the theory, the lawyers who directed you, the district attorney's office, the theory of their civil --

MR. STAUDAHER: Objection. Directed him?

MS. WECKERLY: Can we approach?

THE COURT: All right.

MR. WRIGHT: The -- I'll rephrase it.

THE COURT: I mean, I think that's sustained. That's the lawyer who contacted you and told you you would be contacted by someone from the DA's office.

MR. WRIGHT: Correct. Well, it --

BY MR. WRIGHT:

Q Fair to say it appears some lawyers had a conversation with the district attorney's office about --

MR. STAUDAHER: Objection. Hearsay, Your Honor.

THE COURT: Well, that would be speculation. I mean, unless...

BY MR. WRIGHT::

Q Well, does Nina [sic] Kellebrew of the Bernstein Law Firm --

MR. STAUDAHER: Objection. That's not her law firm.

THE COURT: That's correct.

MR. WRIGHT: Okay. Wrong --

THE COURT: It's -- it's Gillock Kellebrew, I think.

MR. WRIGHT: Okay.

BY MR. WRIGHT:

Q What firm is it? I misstated it.

A What is your question? Repeat your --

Q What law firm is --

THE COURT: Is Ms. Kellebrew with?

BY MR. WRIGHT:

Q -- Kellebrew with?

A Gillock.

Q Gillock. Gerold Gillock Law Firm.

A That's correct.

Q Ms. Kellebrew just called you and said expect a call from the district attorney's office?

A That's correct.

Q Okay. Did that lead you to believe there had been some discussions that took place --

MR. STAUDAHER: Objection. Speculation.

BY MR. WRIGHT:

Q -- with the district attorney's office?

A I have no --

MR. STAUDAHER: Objection. Speculation, Your Honor.

THE COURT: Well, were you then contacted by someone from the district attorney's office?

THE WITNESS: Eventually, I did get an e-mail from Mr. Staudaher.

THE COURT: Mr. Staudaher? How long after the conversation with Ms. Kellebrew did you receive that e-mail?

THE WITNESS: Probably within a week.

THE COURT: Okay. And -- and you spoke telephonically with Ms. Kellebrew?

THE WITNESS: She called me, yes.

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

BY MR. WRIGHT:

Q Did -- did you talk to Ms. Kellebrew after you got the call from the district attorney's office?

THE COURT: E-mail.

THE WITNESS: No.

BY MR. WRIGHT:

Q Okay. Now, the cases of the Rawlings Law Firm, you were an expert in their cases?

A I'm not familiar with the Rawlings Law Firm.

Q Or, like, I keep -- I can't keep it --

THE COURT: Edward and Bernstein I think was the firm. Did you deal with --

MR. WRIGHT: Gillock. Gillock.

THE COURT: Oh.

MR. WRIGHT: God. Jerry Gillock's law firm.

BY MR. WRIGHT:

Q Were you an expert in their cases?

A In the -- in -- if we're talking about the propofol trial, yes.

Q Okay. Which -- who was the plaintiff in that?

A The -- well, the one -- the only jury trial that I had was the Michael Washington case.

Q Okay. Michael Washington. And that was hand -- that's the Gillock Law Firm?

A No. That was the Bernstein.

Q Okay. Gillock Law Firm had some of the plaintiffs arising out of this, right?

A That's correct.

Q You were an expert for them?

A That's correct.

Q Those cases settled as a result of trials?

A Well, they eventually settled, yes.

Q Okay. And the -- the ferry by which those cases were going forward was what?

MR. STAUDAHER: Your Honor, at this point, legal conclusion and relevance to this?

THE COURT: Well, if he -- if he knows or he can talk

about what he was assigned or asked to do as an expert.

MR. STAUDAHER: But that has nothing to do with the theory that they had.

THE COURT: Well --

MR. STAUDAHER: It has to do with what he was asked to review.

THE COURT: -- as it relates to his testimony, if he knows.

THE WITNESS: Okay. Would you please rephrase the question?

BY MR. WRIGHT:

Q What were the defendants being sued for?

A Product liability.

Q Based upon what?

A The way in which they had large vials and how it might have led to the transmission of the virus, how they had a mini spike that might have led to using the drug on multiple patients, and the fact that a large vial is -- in an area such as an ambulatory care center that does endoscopy which has short procedures, a 50 cc vial should not be in that area.

Q Okay. We'll get back to all that. But is a -- a predicate, a basis for the lawsuit --

MR. STAUDAHER: Objection. Legal conclusion, Your Honor.

THE COURT: Well, overruled. Again, he can -- you

know, don't give us any legal conclusions or speculate or opine as to legal, you know, decisions that may have been made by the lawyers. As it pertains to what you were asked to do as an expert or your understanding of the, I guess, interface between the claims made against the manufacturer, medical claims that you were consulted on or opined on, you can certainly testify as to that. Okay. I don't know if that makes sense to you.

So, Mr. Wright, within that sort of parameter, he -- you can ask him the questions.

BY MR. WRIGHT:

Q A factual predicate, or a -- before the manufacturers could be sued in the manner in which they were sued for product liability, it was necessary that there be a determination that the hepatitis C of Mr. Washington had been transmitted by propofol use, correct?

A For inappropriate -- for unsafe injection practices of propofol; that's correct.

Q Okay. So that -- that was a necessary basis, meaning if -- if the hepatitis C transmission had been caused by some other mechanism, like dirty scopes, whatever the alternatives were, then you couldn't sue the manufacturers, right?

MR. STAUDAHER: Objection. He doesn't -- he's not the one suing the manufacturer. He's asked if he'd come in as

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 31

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INDEX TO APPENDIX VOLUMES 1 through 41

But I'm just saying we've heard what the issue is. We'll have the people bring in what they relied upon to make those assessments.

THE COURT: If it's not their memory.

MS. WECKERLY: Right. Right. Sure. And then there shouldn't be a problem.

MR. STAUDAHER: The Court is ordering those witnesses, in case there's some issue with them trying to find them, if they have to go up to corporate counsel or whatever, that the Court's ordering them to produce that stuff.

THE COURT: Yeah, whatever they're going to need to rely on to discuss the -- how much they paid out. And I mean, you know, the one where they were all lumped together, it's really not much of an issue, because you've got ten people there for your theft.

MS. WECKERLY: Right.

THE COURT: It's more the ones where they're separated. But even so, you got to get it over the 250 you've pled, and so yeah. You know, if they can't do it, if they need to rely on something to do it, then --

MS. WECKERLY: We'll inform them.

THE COURT: -- whatever it is they need to rely on they need to bring.

MS. WECKERLY: Okay. We'll do that, but they won't be tomorrow.

THE COURT: And that's --

MR. SANTACROCE: Can you just remind me who tomorrow is?

THE COURT: Can I see counsel -- well, it's just us. Off the record.

(Court recessed for the evening at 5:36 p.m.)

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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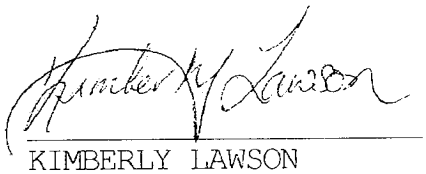

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA, Plaintiff, vs. DIPAK KANTILAL DESAI, RONALD E. LAKEMAN, Defendants.	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT NO. XXI **TRANSCRIPT OF PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 35

THURSDAY, JUNE 13, 2013

APPEARANCES:

FOR THE STATE:	MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys
FOR DEFENDANT DESAI:	RICHARD A. WRIGHT, ESQ. MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN:	FREDERICK A. SANTACROCE, ESQ.
Also Present:	Christian Balducci, Esq.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

I N D E X

WITNESSES FOR THE STATE:

LAS VEGAS, NEVADA, THURSDAY, JUNE 13, 2013, 10:56 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: The jurors, some of them have little mini vacations, so they wanted to know if they had to work on the 5th. But, you know, we're hoping to be done before that, so it won't even be an issue. We'll be done before the 5th.

Yeah. I mean, if they're deliberating, I don't care when they deliberate, because, you know, if they want to be on vacation on the 5th and come back, sure. If they -- you know, I don't really care. I mean, you know, we're pretty flexible with that.

All right. Apparently there is a lawyer here who wishes to be heard on something. So sir, can you state your name and your bar number for the record.

MR. BALDUCCI: Yeah. Christian Balducci. My bar number is 12688.

THE COURT: All right. And you represent whom?

MR. BALDUCCI: I represent HealthCare Partners of Nevada.

THE COURT: All right. That's one of the insurers in this case; is that correct?

MR. BALDUCCI: Yes, Your Honor.

THE COURT: And my understanding is, pursuant to a court order based on some testimony that came out yesterday

with a different insurer, Ms. Weckerly or Mr. Staudaher --

MS. WECKERLY: Well, it's the same insurer as --

THE COURT: Oh, it's the same insurer. Okay. We asked that some documents be produced that apparently the witness had viewed prior to her testimony; is that correct, what you asked?

(No audible response.)

THE COURT: And we needed her to produce those documents. Basically we told her when she got back from her vacation to produce them to the State so that they could produce them to the defense. So is there a concern or...

MR. BALDUCCI: I actually have two issues, Your Honor.

THE COURT: All right.

MR. BALDUCCI: If you don't mind if I address those.

THE COURT: Go ahead.

MR. BALDUCCI: I'm sure I'm not the first attorney to actually miss something in this trial, so.

THE COURT: Well, so far it's been the plaintiff's lawyers.

MR. BALDUCCI: May I approach, or...

THE COURT: You may. You can just stand in the well of the courtroom or stand at the podium, wherever you're comfortable.

MR. BALDUCCI: The podium, please.

THE COURT: That's fine.

MR. BALDUCCI: It's come to my understanding that yesterday during testimony, Patty Shibona, the director of operations for HealthCare Partners of Nevada, I guess there were some notes or something of that sort that she had with her.

THE COURT: Right. Basically she had said, Can I refer to my note -- I'll tell you exactly what happened. You know, essentially she said, Can I refer to my notes, or something, and she had a yellow folder with her and she opened it up and she started reading something. And I said, For the record, what is it that you're reading? And then the lawyers said, can we just see what she's looking at, and I said fine.

And basically, the long and short of it is she had made some notes. She had reviewed some documents. She had written some things down, and she had reviewed some things over the Internet in order to prepare for her testimony and to, you know, I guess, record some -- I did not look at whatever it was she was looking at. So that's essentially what happened.

MR. BALDUCCI: And that exactly, that last part is my concern. One of the things she had with her was it's actually an email from me to her.

THE COURT: Okay. I don't believe the lawyers read the email; is that true, Ms. Stanish?

MS. STANISH: That's correct, Your Honor. I was only -- I only focused on her handwritten notes. I didn't even know it was from a lawyer.

THE COURT: The handwritten notes concerned figures and things she had referred to. I know one was the CMS rules off the Internet, that specifically. And I don't remember the other two things she had referred to.

MS. STANISH: Some numerical figures.

THE COURT: Yeah. They were figures that she had needed to calculate how much the difference in the anesthesia charges would have been. Mr. Santacroce, I believe you also approached. Were you able to read that email?

MR. SANTACROCE: I saw it was an email and she had handwritten notes on it, but I don't -- I didn't read the content of it.

THE COURT: Okay. Well, I'm fine then if, you know, she doesn't have to produce the email. We're fine with that.

MR. BALDUCCI: Okay.

THE COURT: All she has to do is produce the documents that we said, which would be, you know, the contract with the gastro center or the, you know, endo center, the policy, what the chart was for in terms of reimbursement rates and how that was calculated.

Was there anything else we needed from her?

MS. STANISH: The redacted --

MR. WRIGHT: I got a question.

MS. STANISH: -- email with the notes would be fine.

THE COURT: Yeah. Just she can cross out, you know, in black marker the email, just so that we have her handwritten notes that had those figures on it because she did refer to those in her testimony.

MR. BALDUCCI: Certainly, and I actually do have a copy of a redacted version here.

THE COURT: Okay.

MR. WRIGHT: I've got a question.

THE COURT: Mr. Wright.

MR. WRIGHT: I want to be sure your email to her was simply legal advice and you didn't tell her any information, facts that she --

MR. BALDUCCI: It was an attorney-client privilege conversation.

MR. WRIGHT: No. My question is did you --

THE COURT: But you didn't say testify to this or testify to that or --

MR. BALDUCCI: No.

MR. WRIGHT: Did you give her any factual information?

MR. BALDUCCI: No.

THE COURT: Like the figures, numbers, anything like that?

MR. BALDUCCI: No.

THE COURT: Okay. That's fine. You said you have a redacted version?

MR. BALDUCCI: Yes. Would you like to --

THE COURT: Sure.

MR. BALDUCCI: -- review it, Your Honor?

THE COURT: Can you --

MR. BALDUCCI: If I may approach, please.

THE COURT: Sure, of course.

MR. BALDUCCI: Thank you.

THE COURT: Do you want to just leave that then? Is this my copy?

MR. BALDUCCI: Yes, certainly.

THE COURT: Okay.

MR. BALDUCCI: And the other page behind it, the two pages, one would be the -- it's on a loose-leaf paper.

THE COURT: Right. And that's her own handwritten --

MR. BALDUCCI: The other --

THE COURT: -- notes. All right. What we'll do then is this will be a court's exhibit. I'll also make copies for all of the attorneys, meaning the bailiff will make copies for all of the attorneys. And is that all satisfactory with you?

MR. BALDUCCI: As for that, yes, but --

THE COURT: What's the other issue?

MR. BALDUCCI: The other issue was the contract or

the agreement. HealthCare Partners of Nevada today is different --

THE COURT: Okay. We only care about what was in place at the time the allegedly fraudulent charges were made.

MR. BALDUCCI: And that's the exact issue that we're looking into. It's our understanding at the moment though, we're looking at it further, that the Endoscopy Center's contract was not with HealthCare Partners of Nevada at that time. We're not entirely sure yet. We're still looking into it. We think it may have been with an entity called Pippa [phonetic], which is now bankrupt. So we don't know what --

THE COURT: But she must have had something to figure out, well, how much are we going to pay here, because obviously there was some contract or you folks wouldn't have been paying out on these claims, as I understand.

MR. BALDUCCI: What HealthCare Partners of Nevada did, and of course the [inaudible] that we need a specific time frame, because that's really going to help us. It's our understanding the way it worked was we simply process on behalf of PacifiCare. So whatever the start times or end times of these things, they were a product of PacifiCare. We were, I guess you could say, kind of in the middle.

THE COURT: Here's what I would ask then. If you tell me, if you come back and you say we don't have the

agreement, what I need from you is whatever guidelines, forms, policies your company used at that time to calculate reimbursement. Is that -- that's essentially what we're looking for. I mean --

MR. WRIGHT: And we want to know where it is, I mean if PacifiCare has it or whatever.

THE COURT: Yeah. I mean, there may have been another contract, but your company had to have had something, some documents so that they would know how they're calculating these charges. That's really what we're looking for, and what the agreement was.

So there had to have been some guidelines. Whether they had the full contract or not, you know, it has to go from A to B so that B knows what it's supposed to be doing. Whether that was a memorandum or some other kind of directive from, you know, PacifiCare or whatever, whatever that was, we need it.

MR. BALDUCCI: So I guess the thing that's most that everyone is looking for is just that says how things get paid out is really --

THE COURT: Well, whatever documents you have -- here's basically what we want. Whatever documents they have relevant to any agreements with the gastro center or the endo center at the time frame in question, any charts or schedules or anything like that, that were utilized to pay claims and

reimbursements. Is that fair, Defense?

MR. BALDUCCI: Yes. I under -- yes.

THE COURT: Defense, is that -- does that encompass what we want?

MS. STANISH: The Court's indulgence.

(Pause in proceedings)

MR. WRIGHT: Right. We need the contract. I mean, we need what you're asking for, but if they don't have it, then they'll say PacifiCare has it.

THE COURT: Yeah. If they don't have it, you need to tell us who does. But what I'm saying, Mr. Wright, is whatever they have, then they have to have something. They don't have the contract, then give us what you have essentially.

And, you know, if you can make a representation as to who, according to your understanding, would have the contract, we'd appreciate that as well.

MR. BALDUCCI: Certainly, Your Honor.

THE COURT: Okay?

MR. BALDUCCI: All right. That really covers it all for me. Sorry. I appreciate the time. Thank you.

THE COURT: No, no problem at all. This came up at the last minute when she started looking at her notes.

MR. BALDUCCI: Yeah.

THE COURT: And then, you know, it's like, okay,

where'd this stuff come from. How long will it take you to find all that, or have your company find all that?

MR. BALDUCCI: A little while.

THE COURT: All right. Here's what you're instructed to do. Coordinate with whatever representative of the State is going to handle this, whether that's Detective Whitely or one of the lawyers or one of their investigators or whatever. Okay?

MR. BALDUCCI: Okay. Great. Spoke with him in the past, it's been a good relationship, so there won't be an issue.

THE COURT: Okay. Good. Thank you.

MR. BALDUCCI: Thank you, Your Honor.

THE COURT: All right. Kenny, bring them in.

MS. WECKERLY: Your Honor, do you want us to try to like get Scott Mitchell up here sometime today?

THE COURT: Between all the other stuff.

MS. WECKERLY: We can take care of a lot of it though.

THE COURT: Yeah. I mean, he can maybe get right to the heart of the matter.

MS. WECKERLY: Yeah. I'll send an email to try to track him down.

(Pause in proceeding.)

(Jurors reconvene at 11:09 a.m.)

THE COURT: Court is now back in session. The record should reflect the presence of the State, the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury. And Mr. Staudaher, please call your next witness.

MR. STAUDAHER: The State calls Arnold Friedman to the stand, Your Honor.

ARNOLD FRIEDMAN, STATE'S WITNESS, SWORN

THE CLERK: Please state and spell your first and last name.

THE WITNESS: Arnold Friedman, A-r-n-o-l-d, F-r-i-e-d-m-a-n.

THE COURT: Thank you. Mr. Staudaher.

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Dr. Friedman, what do you do for a living?

A I'm an anesthesiologist.

Q And how long have you done that?

A Since 1982.

Q Can you give us a little background about where your training and experience have got you to the point where you are today?

A Yes, sir. I started initially after finishing at -- a BS degree at Indiana University, from there I ended up

getting accepted to medical school at the University of Louisville. After that I did a year of internship at Cook County Hospital in Chicago, Illinois. Went into the U.S. Air Force. I was a flight surgeon for two years at Webb Air Force Base. From there I worked in the emergency room in San Francisco at one of the Kaiser facilities.

Then I started my training at the VA hospital in Sepulveda, California. From there I went to Cedars-Sinai Medical Center. I was chief medical resident. I started a cardiology fellowship when they asked me to open up the first medical intensive care unit at the hospital when it opened in 1976.

After that for four years, I cross-trained into anesthesia at UCLA and spent six months at Massachusetts General Hospital. And from there, I then went into anesthesia for open heart surgery and transplants, became the director of the service. And after approximately 20, 25 years, I then moved into the cardiac catheterization lab and electrophysiology lab, as we were developing new heart valves without opening people's chests, and I've done that for six years.

I'm about ready to become the new director of the [unintelligible] procedure, or the pre-anesthesia assessment clinic in the new facility at Cedars-Sinai Medical Center.

Q Is it safe to say that you're familiar with

anesthesia and anesthesia practice?

A Yes, it is.

Q With regard to that, I --

THE COURT: Oh, and sir, we need you to speak up. Some of the jurors can't hear you. See that black box there?

THE WITNESS: Yes, ma'am.

THE COURT: That's the microphone.

THE WITNESS: Okay.

THE COURT: That's better. Thank you.

And Mr. Staudaher, you need to keep your voice up as well.

MR. STAUDAHER: I will try, Your Honor.

BY MR. STAUDAHER:

Q Go through -- I want to go through a couple of things with you regarding anesthesia. Can you tell us what kind of things you do as an anesthesiologist?

A Well, first and foremost, when we first meet the patient, we obviously assess them for their medical problems and do a risk stratification. We talk to them. We try to allay any of their anxieties, answer any of their questions. We start an intravenous under some kind of a local anesthetic like Lidocaine, which is similar to Novocaine that you would go to a dentist for when you are having a procedure.

Then we bring them into the operating room or into a procedure area where we would go ahead and give them medicine

through an intravenous line and they would -- usually you go to sleep. And during that period of time that you get sedated, you have no memory or awareness of what's going on, and the medicine that we use allays any of the pain that occurs.

Afterwards we wake patients up. Obviously between that we take care of any of the problems that occur that could produce an adverse event, and we wake patients up, take care of them either in the recovery room or the intensive care afterwards.

Q So are there different types of anesthetics that get used in different settings; meaning hospital, outpatient, clinic, whatever?

A Yes, sir. In the operating room we tend to do a general anesthetic or a regional anesthetic. A general anesthetic usually requires a breathing tube, an endotracheal tube that's put down into the tracheobronchial tree. Or we can go ahead and do a regional anesthesia.

Let's say if you were coming for a hip replacement or a knee replacement, and for that we would go ahead and put some medicine either into the spinal canal or the area around the spinal canal, in order to go ahead and numb the nerves where the surgeon would be operating on. In the orthopedic example that I gave you, that would be let's say the lower extremities. We would also give you a little something just

to drift off to sleep. That would be a twilight sleep.

If we do something in the procedural areas which would include the ambulatory surgical centers, most of the times what we do is that we would use an -- just individual drugs for sedation and a minimal amount of pain. Because a lot of those procedures don't require an incision, so we're not as concerned usually with extreme pain as we would be in the general anesthetics in the operating room.

Q So let's not -- I want to move away from general anesthetics and go to something short of that. Is there -- I've heard the terms "deep sedation, conscious sedation," things like that. Can you define those terms for us?

A Well, there's planes of anesthesia. If you want to cover everything, it's usually monitored anesthesia care, and monitored anesthesia care means taking you through the simplest thing where a patient might be totally awake for certain reasons to the fact that they would be under deep sedation, which would be a general anesthetic. And between that we have different gradations of sedation.

It depends strictly on what -- how sick the patient is and what their body will tolerate in terms of drugs. It depends upon obviously what kind of procedure you have. An open heart procedure which is obviously going to be a higher risk with a lot of other diseases that a patient has, and they're going to have an incision usually in the sternum,

that's going to require a deep sedation that which includes no awareness and no pain.

As opposed to let's say if we talked about an ambulatory surgical center, the sedation is going to be much lighter. And usually it's just required as a sedation that would be mild sedation, so the patient isn't aware of what's going on, but it doesn't necessarily require much in the way of what we call analgesics or pain medicine.

Q Now, in the setting that you just mentioned, an ambulatory care setting at that level of sedation, is that something where the patient is awake or asleep?

A Most of the times the patients are awake -- they're asleep. It depends what procedure we're doing. If we're doing let's say something in the GI lab, they would be asleep. They would not be cognizant of what was going on around them and they would be moderately sedated.

If we were talking about something where we're looking at abnormal rhythms, which is an electrophysiology lab, that we -- if we make patients too deep, then we can wipe out the ability to go ahead and find what the rhythm disturbance is and get rid of it by burning it. There's other things like putting pacemakers in which is somewhere in between.

So sometimes what we would do is we would do a local anesthetic where the incision is, and then just do moderate

sedation, so a patient doesn't have any anxiety, they're asleep and usually they don't know what is going on, so they have no awareness of the procedure.

Q Are you familiar with the drug propofol?

A Yes, sir.

Q In the settings and the situations you've talked about, when would you use or not use that drug?

A Well, it's used for two things. One is that it can be used as what we call an induction agent, which means you have an intravenous line in and a general anesthetic, higher risk patient, and you want to get them to sleep quickly so that we can then go ahead and put the breathing tube in.

We would give a certain dose of the propofol, and that would be called a bolus, to get them to sleep so we could then go ahead and give them the other things that we need to in order to put the breathing tube in. As opposed to let's say an ambulatory surgical center we would either give a bolus, meaning one drug aliquot; in other words, a dose to get the patient to sleep, and then we would re-bolus them intermittently if we needed to.

We could also give an infusion, which is a constant amount of drug, as opposed to a bolus that we just give at one setting.

Q Now, you mentioned now patient settings. You've also mentioned high risk or not high risk patients. Can you

tell us the types of patients that typically go to an ambulatory care center?

A Well, they tend to be not as sick as the patients that are in the operating room.

MR. SANTACROCE: Your Honor, can we approach?

THE COURT: Of course.

(Off-record bench conference.)

THE COURT: Mr. Staudaher, please proceed with your questioning.

BY MR. STAUDAHER:

Q Have you worked in ambulatory care centers before?

A Yes, sir.

Q Have you worked in hospital settings before?

A Yes, sir.

Q And you worked in this electrophysiology lab that you talked about?

A Yes, sir.

Q So is it fair to say you've worked in different settings giving anesthetic over the time period of your career?

A That's correct.

Q Now, you said your career has lasted in anesthesia for how long?

A Since 1982.

Q So 30-plus years; is that right?

A That's correct.

Q We're in a situation during that time where -- we're in a situation. You were in a situation during that time, if you will tell us, was that pretty much continuous work in anesthesia, or did you take a break and go to Hawaii for years or...

A It was all in anesthesia.

Q In the various settings that we've talked about?

A Yes, sir.

Q Now, with regard to that, I want to go back to the outpatient setting. You mentioned and I want to talk about the types of patients that would go to an outpatient setting; can you tell us that?

A The type of patients tend to be not as sick as the ones that we would do as inpatients; in other words, people who were morbidly obese, people who had sleep apnea, people who had coronary artery disease, people who had poor heart function or they were in heart failure, people who had cardiac valvular diseases.

So again, patients who tended to have a lot of stability and very little what we call co-morbidity or other medical problems.

Q Is that what co-morbidity is?

A That is correct.

Q So a healthier population?

A A healthier population.

Q Now, with regard to those facilities -- and we're not going to be really talking today much about the hospital facilities. We're talking about outpatient level, those types of patients. But before I get there, I want to ask you one other question in general about anesthesia.

Depending if you're doing the same type of anesthesia, general anesthetic, deep sedation, conscious sedation, whatever it is, does it really vary depending on the setting, or is it the same type of thing regardless of the setting?

A Well, again, because of the fact that in the ambulatory care center the patients tend not to be as sick and the procedures are not like what we do in the operating room, where there is a higher risk to the patient like open heart surgery, like lung surgery, like abdominal surgery, the -- we don't need the same degree of anesthetic or monitoring as we would in an operating room setting.

Q Now, with regard to your -- do you use some sort of record during any procedure that you do to document what has happened to the patient and what you've done to the patient?

A Yes. We have an anesthesia record that we fill out during the operating room area. But before that, when

we're assessing the patient, we go ahead and we have a documentation in terms of the preoperative workup, as well as what the assessment is and the fact that we have discussed risks, what some of the alternatives might be if patients want to know.

And then we have at the end of the case, after we put a patient into either the recovery room or into the intensive care unit, we would write our postoperative note, which we would then go ahead and put down the patients are stable, their blood pressure, their heart rate, all their vital signs. And we would do other exams, cardiac, lung exams, neurologically, whether they were mentating okay and they were moving all their extremities.

Q The assessment that you just mentioned, how important is that in doing any anesthetic procedure?

A It's very important, because without an assessment that is appropriate you may have patients who are sent to you who need further workup, in order to go ahead and minimize their risk. So what you're really doing is you're doing initially a risk assessment, and then you're trying to optimize the patient for the peri procedure, whether it's in the operating room or in an ambulatory care center.

Q So describe for us what you do in a typical assessment and does it vary depending on what setting you might be in, say an outpatient setting to an operation in a

hospital?

A Well, most of the times it doesn't vary at all because it's fairly standard. You do a regular history, find out why the patient is there, what is the primary reason they are there for, what is the surgery or procedure that is going to be done, if there's a particular side, which side is it going to be done so that wrong site surgery doesn't occur.

You then go ahead and find out what are the other medical problems that they have that might put them at risk, and whether they've been adequately treated or whether they need to be delayed and worked up further. Like let's say a patient with a heart problem who may have chest pain or angina, that patient may have to be worked up to find out if we need to go ahead and do something else to treat them before we can go ahead and do the procedure or the operation.

After that we do a physical examination, including the fact that we are very interested in the airway because we are intimately involved in taking care of that, which means putting the breathing tube down when you're doing a general anesthetic. But even when you're doing sedation people can lose their airways. So you have to find out whether these are normal or abnormal.

You have to find out what kind of drugs they're on, what kind of surgeries they've previously had, whether they've had an anesthetic untoward event, or whether they've had any

untoward event during surgery. You have to know whether the patients have allergies, because you are giving drugs and you -- almost everything requires an antibiotic, and you want to make sure that they don't have any kind of adverse event there.

After that you have to take a look and see what kind of labs that they have. You have to find out whether there's anything that is abnormal and query the patient about that. We want to make sure whether the drugs that the patients are taking, what they have been given the morning of the procedure or the operation.

And then we want to go ahead and put down what -- discuss with them what specifically is going to be done to them, both from an anesthesia standpoint and at least find out if they have an understanding of what the surgery is, and then we talk about risks.

Q It seems like quite a bit of stuff.

A It is. And in 15 minutes, which is what you usually have, you have to get -- you have to collect all the data off of an electronic information system, and you have to hope that your patient is a good historian.

Q So you have this window of time that you actually spend with the patient before you go back and do anything with them?

A Yes, sir.

Q Now, when you go through an assessment, you mentioned a whole variety of things. I mean, if I understand you correctly, the assessment is essentially you have to do it regardless of whether it's a shorter procedure in an ambulatory care facility or a longer procedure in a hospital; is that fair?

A That's correct. It's just the fact that because the patients will be sicker in the operating room area it will take a little bit longer, because they will have more problems than a person in an ambulatory care center. So statistically, even though you go through the same thing, it just is going to be shorter in an ambulatory care center.

Q When we say shorter, do you truncate it to a degree where you just walk out and say hi to the patient and you're done and you walk away?

A No. It's a matter of going through and asking the same things. It's just the fact that most of the answers will be no rather than yes in terms of the disease states that they have, or whether they have chest pain, whether they've had a heart attack, whether they have shortness of breath.

So when you go through a lot of noes pretty quickly, it doesn't take long. And a lot of the time, since you already have the medicines that they're taking in front of you, you already have a little bit of an idea from that. And also the surgeon or the interventionist is required to have a

history and physical on the chart already before you even get there, and that gives you an idea that you can go through things a little bit quicker.

Q Do you review that before you talk to the patient?

A Yes, sir.

Q In the setting -- and I'm going to move to the outpatient type ambulatory care sort of situation. In those settings, the type of anesthetic, and we're -- and the procedures that I'm going to ask you about primarily would be like a colonoscopy, endoscopy, things like that, that type of a procedure. What would be the anesthetics that would typically be used with those?

A Well, for those you're usually talking about two different types of anesthetic on average. One would be the use of propofol, period. The other would be a narcotic and what we call something to allay anxiety, which is a benzodiazepine. We call it Versed or midazolam.

The narcotic which would be short acting would be something like fentanyl, which is like morphine, but it's a hundred times more potent and it's quick acting, and it's a shorter time period so that the patients can go home earlier.

Q So those are the two sort of options you have?

A Well, you have more options, but those are the two main options. The other option is that if you find that

you have a problem with an airway, you might have to go to some other form. Like a person who has sleep apnea who is overweight, that kind of a patient, you can lose an airway very quickly. You may have to convert them to some other form of an anesthetic.

And that would be something as opposed to putting a breathing tube down, which is the ultimate in general anesthesia, we have something that is called a laryngeal mask airway. What it is, is that we put something that goes down, and it ends just above what we call the larynx. It doesn't go down into the tracheobronchial tree.

But by sliding it so that it slides along the tongue and it stops, we can give a general anesthetic. And that can be very, very effective more so with a colonoscopy than an esophageal gastroscopy, because you're sharing an airway there. That becomes a little bit different.

Q Okay. So but in the typical procedure of a colonoscopy or upper endoscopy, do you typically have to put a tube down somebody's throat?

A No.

Q So the anesthetic that you would use in those situations would be what, if you had your choice?

A There have been studies to show that propofol is much preferred to the narcotics and benzodiazepines by patients. You get a much more complete sedation. You get

less awareness that occurs with it. And because of the fact that the side effects are much less and it wears off very quickly in terms of getting out of your system, your ability to go home is much quicker.

The problem is, is that the narcotics can affect the brain center and affect your ability to breathe well. You can get nausea and vomiting to a much higher degree with a narcotic than you could with propofol. The benzodiazepine like Versed, the problem is, especially as you get older, you can have a patient have a delirium just from a small amount, especially if they're older or if they have central nervous system problems.

Q So propofol, you said you were familiar with it?

A Very much so.

Q Have you used it much in your practice?

A I use it almost every day.

Q Is this over the time period that it's been in existence essentially?

A Yes.

Q Now, before propofol was around what did you typically use?

A Well, you would -- initially what we would have to do is we would use the other alternative agents. At that -- before propofol, we certainly had the fentanyl or we had morphine, some kind of narcotic, and we had some form of a

benzodiazepine which could have been Versed or midazolam. It could have been Ativan.

They're all related to the drug that people were taking orally which was Valium, which we could give. Each one of them have a different footprint. But you would have to give a much higher dose and it would stay in your body much longer.

Q With regard to propofol, you said every day. I mean, does that equate with -- I mean, can you give us a general estimate in a year how many times you use that drug?

A Well, again, I told you that it can be used either for complete sedation or just to get the patient to sleep. I would say on an average, I probably do a thousand cases a year where propofol is involved in some fashion.

Q So you've done a lot of them?

A A lot.

Q Now, with regard to an in and out patient sort of setting with a procedure like a colonoscopy or so forth that's relatively short in duration, did you mention that you could just use propofol alone as the anesthetic agent?

A Yes.

Q In the situations where that would be the case, how would you use it, in your experience?

A Well, in my experience we would usually give a bolus, meaning we would give a certain amount of drug based

usually on body weight, and the patient would go ahead and approximately within 30 to 45 seconds the patient would drift off to sleep. Most of the time their airway, they would spontaneously breathe once we had a little distribution of the drug, and you could go ahead let's say in a colonoscopy or what we call an EGD, the esophagogastroscopy, the patients could go ahead and tolerate that.

There are only usually two discomforting things on average with those problems. With the colonoscopy the problem is, is that in order to get good visualization there's a lot of air, to go ahead and inflate the bowel so you can go ahead and take a look and see if there's any lesions or not. That distension can be very discomforting. That's for a colonoscopy.

For the esophagogastroscopy, it's just the initial insertion, because of the fact that you have to get past the airway you would gag. So you need to go ahead and actually need initially to get a little bit more sedation to put the esophagogastroscopy in as opposed to the colonoscopy. Whereas the colonoscopy -- in other words, once that's down for an esophagogastroscopy, there's not a lot of discomfort, so you just want to go ahead and have a sedation so the patient isn't aware of what's going on.

As opposed to with a colonoscopy, as you get further into the procedure, you get more dilatation of your bowel, so

there's more discomfort. So you may actually need a little bit more at the end of the case, and you may have to supplement that in the postoperative arena, meaning the recovery room.

Q So would it be unusual to have to give some additional medication, propofol, near the end of a colonoscopy case because of those issues?

A It could. It strictly depends on how quick the endoscopist is; in other words, the gastroenterologist. If it is somebody -- and we see a bell shaped curve in terms of how long it takes a gastroenterologist to do the procedure, just like it would any surgeon. Sometimes it's short and sometimes it can be very long.

Q And what factors play into that?

A Well, again, again, some people are more facile doing things than others are. The other thing is that all the sudden they may see that there are problems that occur. They may see polyps where they're going to have to biopsy. They may have a problem where the patient isn't cleaned well enough. Then it becomes very, very difficult for them to do that.

Sometimes there may be certain angulations that don't allow you to get to the places that you want to. It depends on the pathology that they find. So part of it is the operator themselves, and part of it is either the preparation

or the disease state that the patient has.

Q So in those types of procedure -- procedures rather, what is your role?

A Our role is, well, we first of all monitors -- after we go through the assessment, we bring them in. They go into position. We want to make sure that the intravenous line is working well and we put monitors on for safekeeping. Those monitors include a continuous electrocardiogram which determines what the rhythm is and whether it's normal, whether it's fast, whether it's slow.

We go ahead and put a blood pressure cuff on and we have a baseline blood pressure. And then we would get another blood pressure certainly after the propofol, because the patients are sedated and that tends to cause the blood pressure to go down. We want to make sure the patient is breathing adequately, so we have a monitor where we can actually see carbon dioxide that's being exhaled from the lungs and we know the patient is not obstructed.

We have a monitor on the finger that is called a pulse oximeter that measures the oxygen that you have in your body, so a patient doesn't get to a dangerously low level of oxygenation. And so these are the primary monitors that we use.

Q Now, as far as decisions on that type of care, including either withholding or giving additional medication

anesthetic, who makes those decisions in that situation?

A Well, at our hospital where we have anesthesiologists, it's the anesthesiologist that makes that decision. There may be times when the surgeon or the operator, in this case it would be the gastroenterologist, where he might need a little bit more sedation because of the fact that something painful is going to happen, or when patients have the ability to move and they're not paralyzed from neuromuscular blockers that we do so a patient doesn't move, like in an open heart surgery, we might have to give more.

And patients vary. It isn't only their body weight. Part of it is genetically determined in terms of how sensitive they're going to be to the medicine, and that is something we don't know until we take care of the patient and see how they respond to the anesthetic.

Q When you're doing a procedure and you're assessing those things as you go, I mean, are you making adjustments to how much medication you give?

A Yes.

Q Who makes the decision on how much medication to give?

A The anesthesiologist, or in this case it would be the nurse anesthetist would, because that is their scope of practice.

Q So with regard to the surgeon though, or the operator, would they ever enter into the realm with you and start dictating to you how things should be done or not done?

A It would be very, very rare that that would happen.

Q Is there an issue of sort of a person in the room that has to take care of the safety of the patient? I mean, where do you fall into that?

A We are responsible for the safety of the patient, because the surgeon usually is operating room -- operating, and so that's his focus, to do whatever he can and take care of that. We are responsible for everything else in terms of the patient's safety.

Q If you had a situation where a surgeon told you not to give anymore medication and you felt that it was appropriate to do so, what would you do?

A I would do what would be in the best interest of the patient, which is my determination.

Q Now, as far as the -- well, let me ask you a different area. Are you familiar with aseptic technique and safe injection practices, things like that?

A Yes.

Q Is that something that you've been familiar with throughout your career?

A Yes.

Q Has that changed at all for you during your career?

A Very little, except for the fact that we are seeing more and more write-ups in the medical literature about this problem occurring in the medical profession.

Q And you're talking about the problem you're here to testify about today?

A Yes.

Q Now, with regard to -- well, walk us through. What is considered aseptic technique and a safe injection practice in the setting of an ambulatory care facility, a colonoscopy, upper endoscopy, that kind of thing?

A Aseptic technique means that it is a technique in which you want to make sure that there is no microbes that essentially are involved in transmitting to the patient. That microbe can be a bacteria, it can be a virus. And how -- what are those techniques? That includes any of the handling or storage of any of the drugs. It could be the intravenous bags. It can be the equipment, meaning the injection equipment.

It's also the fact that we wear masks, we glove, that we wash our hands for a period of time, that we go ahead and we use alcohol to make sure that nothing enters the system that shouldn't be entering the system and be contaminated. Aseptic technique in some ways includes part of safe injection

practices, which is a much more specific area.

Aseptic technique also includes the fact that when you come for a surgery, obviously we have to go ahead and put something that's going to kill organisms on your body. We put drapes around. So it's the maintenance of an environment that literally has no bacteria or no virus that can go ahead and invade the patient.

The other aspect is safe injection practices, and those are those practices that allow you to give a safe injection of a drug or a solution of without -- and that can be both to the patient and the healthcare provider, like having a needle that is uncapped and sticking yourself, being the healthcare provider, to the fact of the transmission of either bacteria or viruses because of the fact that you haven't used appropriate techniques to prevent that from happening.

Q Can you describe what safe injection practices actually are?

A It's -- safe injection practices can be anywhere from the fact that you don't go ahead and put let's say alcohol over a rubber stopper when you go ahead and you aspirate. It can be the fact that when you inject a drug and the port that you inject it in the intravenous, you don't go ahead and use alcohol. It can be the fact that you take a syringe, let's say from a vial of medication, and you don't --

you don't wear gloves.

It can be the fact that when you take a syringe full of it and you give it to the patient, and then you go ahead and you go back into that vial and reuse the syringe, that can be a problem. You can go ahead and never get rid of the syringe and even use it on the next patient.

You can go ahead and because of the fact that you have gone a second time into the vial with the same syringe, you can go ahead and actually get contamination that can then be transmitted to whatever the remaining contents are in the vial. If you then go ahead, even if you go ahead and use a new needle and a new syringe, and you don't waste any of that medication and you use it on the next patient, you now have a contaminated vial, and then you can go ahead and give that problem, meaning a virus or a bacteria, to the second patient.

So in other words, the thing that you don't want to do is that when you have something where it is a single use vial or a single patient use vial, you never want to use it on more than one patient.

Q Now, in reality, does that happen? I mean, do single use containers of medication get used on multiple patients?

A There is a single -- a single use vial can only be used on multiple patients under only one circumstance according to the CDC and the U.S. Pharmacopeia, who makes all

the suggestions of what is a safe injection practice.

And that is a situation where you have to by law, you have to do it in a sterile area outside of the operating room. There has to be a certain number of air exchanges. You have to be gloved. You have to wear masks so that you aren't going to go ahead and contaminate what it is you're about to do. And these substances are very specific.

They would be like what we call radiation or radiopharmaceutical drugs that are used in radiation. Whether it's primarily let's say for stress tests for your heart where we're using radiopharmaceuticals, it is very expensive. It has a certain expiration date. And so what you might do is that you might take it in this area and you might take three aliquots so that three studies can be done if there's X amount in.

There are certain drugs that we use for oncology, cancer, that are very, very expensive. And the way in which you did it may allow you to go ahead and divide it into three areas. But again, it has to be under certain areas not in the operating room.

They're done in pharmacy under very strict codes, where you have to have certain amount of air turnovers and you are checked by the joint commission to make sure that you are -- and the standards of let's say the state, that you abide by that. Those are the only things that you can do it.

There are certain biologicals, Botox being one of them in the past, where that was another thing where because of the cost of the drug and how much was given by either the plastic surgeon or a dermatologist, which allowed under the circumstances I told you to divide it into certain different syringes. But that is the only time that is allowed, that you can take a single use vial and use it on more than one patient.

Q Now, we know that that's the way it's supposed to be done, correct?

A That is the way it's supposed to be done.

Q In reality, do some practitioners use a single use vial or a single patient use vial on multiple patients in some settings? I mean, in reality does that happen?

A In reality the answer is yes.

Q Now, in a situation where you do what you describe, you take the vial of medication and you draw it up into say three separate aliquots -- or is that -- what is an aliquot?

A An aliquot is a certain dose. So in other words, let's say we just had something -- for ease, let's say we have something where there is 20 milliliters of drug and we want to give 5 milliliters to one drug [sic], and it's obviously a certain concentration, 5 milliliters to another patient, and 10 milliliters to another, that is an aliquot.

And the dose like in propofol is it would be 10 milligrams per ml, milliliter, or 10 milligrams per cc. So if it was giving 10 ml to one patient, that would be 100 milligrams. And that would be what we would use possibly to get the patient to sleep. We might use the 5 milliliters or 50 milligrams as a touch-up, or we might go ahead and give it to a small person. It depends.

In this case we also have 50 cc of 50 milliliters, meaning large vials, so we have much more medicine to go around. So we had a larger number of ability to go ahead and do multiple draws for multiple patients.

Q So if you did that though, if you had a vial and you extracted from the vial with a clean syringe, sterile, hadn't been used on another patient, you did let's say a 50 cc bottle and you had 10 cc syringes, I mean, you could draw five different syringes full, correct?

A That is correct.

Q And then if you kept those separate and sterile and not used by any other patient, theoretically could you use those aseptically on subsequent patients?

A You could do it theoretically. The problem comes in is because, as you alluded to before, there is a significant number of unsafe practices that are occurring. So what you end up doing is, is that you start getting vials that are partially mixed and matched where people go in, they take

out. There's confusion, and so they have the ability to go ahead and infect a second patient, who the first patient was already infected.

So that what's happened is, is that the nature organizations, meaning the CDC, the Centers for Disease Control, the FDA, the Food and Drug Administration, the American Society of Anesthesiology, the American Association for Nurse Anesthetists all believe in one easy standard approach, and that is you have one vial, you have one syringe, you have one needle for one patient.

So the ideal thing would be to take whatever the vial size is and empty all of it into one syringe, throw away the vial. At the end of the case, if you have any left in the syringe that has to be wasted, you throw away the syringe and you throw away the needle and you start all over with the second case. That is the only way you can be assured of safe injection practices.

Q Getting back to reality though with certain practitioners, if you did as I described and you ended up with these five syringes that had not been used on patients before, theoretically, if I understand you, you could use those on five patients? I know it's not the guideline and what's recommended, but you could use those, if you were very careful, safely on five successive patients?

A Theoretically, yes.

Q Now, same situation where -- or a different situation rather, where you've got a vial of medication and you don't pre-draw, but you just as you need it draw with a clean syringe, clean needle and so forth, you are able to draw out 10 cc at a time for this patient.

Then you were careful. The next patient rolls in, new syringe, new needle, same medication. You draw the same 10 cc out and use it for the next patient, and so on until it's gone, you could do that theoretically?

A Okay. That's if -- let's go over this again. You only use the 10 cc syringe on the first patient.

Q Yes. Never re-enter the vial. Never re-enter the vial.

A And then that's it. And then you go to the second patient and you put a new syringe and a needle on; is that correct?

Q Correct.

A Theoretically that is correct.

Q Now, if you didn't quite do it that way, where you took that syringe and you took your medication out of it and you gave it to a patient, and let's say you even changed the needle and you put a brand new needle but it's the same syringe that actually came in contact with the patient, go back into that vial of medication, could you then use that vial of medication on a next -- on the next patient?

A Absolutely not.

Q And why not? What would be the problem?

A The reason is, is that because they have shown that even though you may think that you may not be -- you may not have blood on your syringe, the closer first of all you are to a patient's bloodstream, the higher probability that you will end up with blood on the needle and in the syringe, the closer you are to the port where you're giving your medication to the bloodstream.

And if you have a patient like we have here who could have hepatitis C, which is a blood-borne virus, a certain percent of cases, that syringe now will be contaminated. Even if you throw away the needle and you then put a new needle on and you go into that vial the second time, that then will contaminate the contents in the vial.

Q What about if you went into that vial of medication with a syringe, maybe even change out the needle, and I'm talking about one that you used on a patient and you did something with the plunger, where you were either holding the plunger from moving or you were putting negative pressure on it or something of that nature, would that be okay?

A No.

Q Why not?

A Because the same thing can happen. You still have come in contact with potentially a patient who has a

blood-borne virus that will then still, regardless of what you do with the syringe and the plunger, the -- still comes in contact with the syringe.

Q So let's move to a different area. I want to ask you about anesthesia billing and the like. The sheet that you put together, the anesthesia record, what's the purpose of that?

A Well, it's multiple things. You go ahead and you put a patient's height and weight. You put their allergies on. You put that you have identified the patient, that you've looked over their chart and the patient is ready to go. You put down any of the monitors you're going to put on them. Usually it's circled or it's check-marked.

It has a place where we can use all the vital signs, usually meaning the blood pressure, what the heart rate is, what the oxygen level is that we're monitoring, their end-tidal carbon dioxide, so that we know that they're breathing. We can put an arterial line in the artery so that we can have a more exact idea of what the blood pressure is.

We have an area where you can see where the inhalational agents have been given, whether it's a general anesthetic or whether it's a drug like propofol, or it's something else where we paralyzed a patient so that they don't move, so the surgeon doesn't have a problem with a moving target.

It also shows the fact of how much fluid we give them. It's a place where we can go ahead and show where the blood products are, if the patient bleeds because they have a problem with coagulation. So it gives us really all the information in a very short window, and it's obviously a time lapse.

Q A time -- a time lapse?

A A time lapse. So in other words, we have something where we can record literally every five minutes. Now, with electronic systems, you can even do it more than that if you wish.

Q So you keep track of all those parameters that you talked about. Are those called vital signs?

A That is correct.

Q Is that something that you track as the patient's under anesthesia?

A Yes, sir.

Q And what's the purpose of even doing that? Why is that important?

A Because you obviously need to have some documentation of not only what it is that's going on with the patient, but what it is that you did to prevent adverse events from occurring. You need the documentation. That's a standard in medicine. We can also use it to go ahead and accumulate research data. But the primary reason is to go

ahead and have something that spells out what occurs to the patient during a time that potentially is risky.

Q Is that important for maybe future practitioners who may want to review how somebody did?

A It can do -- it can -- well, you can see what that practitioner has done so that if there's something bad that happened you can stay away from that. What are those things? Like an allergic reaction, like something that you put on a face to go ahead and protect the eyes, that they have an adverse event, a difficult airway. There's a lot of things that it gives you in terms of that kind of an information.

Q Is that document considered part of the medical record?

A Yes, sir.

Q Is it important that you as the person who -- and I assume. I didn't ask you that, but are you the one that would fill that information out?

A Yes.

Q I mean as the anesthesia person during the procedure?

A That's correct.

Q Is it important that the information that you put in there be accurate?

A Yes.

Q Is there any wiggle room on that at all; meaning

could you fabricate vital signs or anything like that?

A No.

Q Would you ever do that?

A No.

Q Would that ever be acceptable in any situation that you've ever come in contact with?

A It would not be acceptable. It would be below the standard of care.

Q Now, with regard to you mentioned a time, that this records time; is that right?

A Yes.

Q Why do you even -- why are you even concerned about time on a procedure?

A Well, I mean, since you have different data points obviously you go on in terms of the procedure, so you need that in order to go ahead and say when you gave certain medicines, when you reversed them. If a patient's blood pressure went down, you have to know what time that happened, what you did. That's not only for this patient, but anybody else who may take care of that patient.

It could even be for afterwards in terms of the postoperative care, whether they go to the recovery room or whether you go to an intensive care unit. It gives you an idea. It gives you a footplate of that real time what goes on to a -- what goes on with a patient.

Q Does the time have anything to do with your reimbursement?

A Yes.

Q Is that important for you to get paid for what you do is document that time?

A Yes.

Q Now, is that a big secret?

A No.

Q As far as the anesthesia time, can you tell us, define for us how anesthesia time is calculated?

A The anesthesia time starts from the minute you see a patient and you remain in attendance to that patient until you turn them over to another healthcare provider. That can be another physician let's say in an intensive care unit. In the recovery room you're usually handing it over to a postoperative nurse.

When you finish telling her about the patient, you give the information as to the history, the physical exam, what went on, what to look for postoperatively, what we've given let's say in the number of transfused units, what drugs, if it's a continuous drip. After that and we are finished being at the bedside with that patient, our anesthesia time ends.

Q You said personal attendance. Is that -- do you have to actually be physically with the patient?

A You have to be physically with the patient. You cannot go ahead and be doing something else and billing at the same time. That's concurrency. In other words, you can only bill when you are right there with the patient.

Q Now, with regard to that, what about if you're in a procedure room, you've done an anesthetic procedure on a patient. The patient has left the room. Maybe you've even gone out and passed the patient off to the nurse like you described. When you come back into the room --

You leave that patient. You come back into the room and you actually are engaged on the anesthetic procedure of another patient. You're just a few feet away if anybody needs to call you to ask a question. Can you still bill for that patient?

A No.

Q Would you ever be able to bill for that patient in that scenario?

A No.

Q Now let's say you finish your procedure and they call you over to do something with that patient, airway issue or whatever, could you then bill for that time?

A Yes.

Q How would that work?

A Well, it works where let's say an emergency comes up and you are no longer in attendance with another

patient. The nurse calls you because the blood pressure is down, there are problems, having trouble breathing. You can then go ahead and you can take care of that problem, but you have to document in the record that you spent time with the patient in attendance.

And so you put the beginning and you put the end in terms of the time, and you put what happened, why you were needed and what you did. And if you then have to go ahead and turn the care over to another provider, healthcare provider, like another physician, another specialist, you document all that. But you can only -- it's that time that you spend with the patient can you bill.

Q Your liability may be larger than that time window though.

A And that's not infrequent with surgeons and anesthesiologists. What can happen is, is that we might be finished with the first case. Our anesthesia record stops because we no longer are with them, we've turned it over to another healthcare provider. We start the next case, and then all of the sudden, you know, 30 minutes later there's something that's going wrong with the patient that we just finished.

You then have to tell the nurse to do A, B or C. You have to tell her to try to find if you need another physician, it might be a respiratory therapist. But you have to go ahead

and take care of them, but you are not allowed to bill. That is not -- if you take a look at CMS, which is the Center for Medicare and Medicaid Services, they do not allow you to bill for doing that.

Q Now, along those lines, just so we're clear, you're in a room, and let's say the procedure hasn't started on a new patient and you don't go out and do any personal attendance, but somebody just comes in and asks you a question. You've already released the first patient to the care provider, gone in and you're preparing to do another patient, even though you're being asked a question about that patient, you're no longer in personal attendance?

A And you cannot bill. It would be the same thing like if you go ahead and you call your private physician and you just want some information about medication, you know, he's not going to go ahead and bill you for that. But for anesthesia it's different. It's the sense that we have to be there taking care of a patient face to face without not taking care of another patient for us to be able to bill.

There is no exception that we can be taking care of two patients simultaneously and bill them both for extra time; in other words, that's what concurrency is. So if we -- let me just be very specific. Let's say we finished a case and we turn it over to the nurse in the recovery room at 12:00 o'clock. We bill for whenever we started to that 12:00

o'clock. We cannot then --

We're seeing our next patient. We can't -- we can't bill. We obviously can't see that patient until it -- at least a minute later, which we can then start billing for the next patient. We cannot bill patient number one anything more. We are now dealing with patient number two.

Q Could you ever overlap?

A Never. Not according to the billing -- the billing guide by the CMS.

Q Now, and do -- I mean, does -- are there other guides that deal with how anesthesia time is calculated, or is this pretty much across the board?

A Well, I think most of the other providers, because of the fact that it's the federal government and they're the biggest payer, they usually set the guidelines for what is acceptable and what isn't acceptable. And the providers, the other private health insurance providers follow the rules and regulations --

MR. SANTACROCE: Your Honor, I'd object to him testifying as to what other providers do unless there's a foundation as to how he has this knowledge.

THE COURT: All right.

MR. STAUDAHER: Fair enough. Let's not talk about other providers. Let's just talk about your experience and your familiarity with the actual regulations.

BY MR. STAUDAHER:

Q As far as the -- I mean, have you ever in your experience, ever seen a situation where it was acceptable to overlap billing?

A No. And we are very careful about that with our anesthesia department and group.

Q So you could --

A We never --

Q I'm sorry.

A We never have this occur.

Q So you could never have five patients in the recovery room, even though you're still liable for those patients, that you would be continually able to bill for when you're in attendance of say a different patient?

A That is correct.

Q Now, with regard to billing time, how is billing time essentially determined?

A In anesthesia it's different than any other specialty. For the procedure you get a base unit. And let's say the procedures that we're talking about today, colonoscopies, the esophagogastroscopies, we're talking about five units for the procedure. Anesthesia gets an additional -- for every 15 minutes they get one additional unit.

And the reason is, is that because you have slow

endoscopists. You have slow surgeons and you have fast endoscopists and fast surgeons, so your time is still with the patient. And the belief is that you should not be penalized if you work with a slow surgeon or a slow endoscopist. So for every 15 minutes you get an additional unit.

Once you get past a 15-minute mark, it depends on what the insurer is as to what it is that you can then bill for that last allotment of time over 15 minutes. So in other words, 15 minutes, it's the 16th minute, what happens. If it's 30 minutes, what happens when you go 31 minutes. And it's different between Medicare. It's different between Medicaid. It's different with different insurers, private insurers, and it differs from state to state.

Q Now, the part that's different is what? I mean, is the 15 minute increment pretty much the same, those are the windows?

A The 15 minute is the same. The five -- in other words, for one unit. The five units for the procedure is the same. What is different is that each one of them does something a little different in terms of how they reimburse you.

Let me just go back a little. Each unit translates into a dollar amount that is paid by the insurer, and that's how you then get --

MR. WRIGHT: A foundation as to this, or knowledge

of it.

THE COURT: All right. How is it that you're familiar with the --

MR. WRIGHT: I can take him on voir dire a moment.

VOIR DIRE EXAMINATION

BY MR. WRIGHT:

Q Do you do the billing for your practice?

A When we first started, we --

Q Do you do the billing for your practice --

A Just a minute.

Q -- presently?

A Presently, no.

Q Okay. When's the last time you did billing for an ASC practice where anesthesia was being done?

A Me personally?

Q Yes.

A I haven't because we have a billing service.

Q Okay. And you have a billing department where you are?

A We have a billing service as part of the corporate entity that is with our department; in other words, we have a billing service.

Q Okay. What is "our department"?

A The department of anesthesiology at Cedars-Sinai Medical Center.

Q Okay. So is that a hospital? I'm a layman.

A Okay. Cedars-Sinai Medical Center is a hospital, yes.

Q Okay. So you do -- you do an anesthesia practice in a hospital, right?

A Not just in a hospital. We do anesthesia --

Q Not we. You.

A Oh, me.

Q You.

A I do it just in the hospital, that is correct.

Q So when's the last time you ever even did a ambulatory surgical center gastroenterology, you performed the anesthesia in it?

A Several years ago.

Q How many?

A Well, my practice is a little --

Q How many?

A Okay. I can't tell you when the last one was, but it would be more than ten years ago.

Q More than ten years ago is the last time you've ever done a procedure for a gas -- a colonoscopy or upper endo --

A No.

Q -- in a outpatient clinic?

A Out in --

Q In an outpatient clinic, correct?

A No. Wait, wait.

Q Correct?

A Wait.

Q Yes or no?

A That's -- it can -- you're asking me yes or no. In the outpatient -- okay. Outpatient, the answer is yes.

Q Okay. You did one?

A No. I've done more than one.

Q More than ten years ago, correct?

A Even more recent than that. Okay. Because you are asking --

Q Did you bill it?

A Excuse me.

MR. STAUDAHER: Your Honor, I'm going to ask that he be allowed to answer his question.

THE WITNESS: Just --

THE COURT: Sir. Sir, sir. Both of you.

THE WITNESS: Yes.

THE COURT: Please, if Mr. Wright asks you a yes or no question, then answer it yes or no. Mr. Staudaher will have an opportunity, as I'm sure you know --

THE WITNESS: I do.

THE COURT: -- to come back over and ask you to clarify your answers. If it is a question and you cannot

answer it as a yes or no question, then say I cannot answer that as a yes or no question. Then Mr. Wright will determine whether or not he wants to ask you a different question or rephrase his question.

Okay. If you don't understand Mr. Wright's question, then say, you know, I don't understand the question, or if you don't know, then just simply say I don't know as opposed to offering an explanation. If you don't feel that honestly you can say yes or no, then the appropriate response in my view is I cannot answer that as stated. And then Mr. Wright, as I said, has the option, does he want to ask you a different question, does he want to try to rephrase his question or whatever.

So Mr. Wright, state your question.

Can you try to do that, Doctor?

THE WITNESS: I can. But, Your Honor, let me just explain one little --

THE COURT: No, no.

THE WITNESS: No?

THE COURT: No. The way it works is you can only provide answers to questions. Now, if Mr. Staudaher thinks that your answer was incomplete in some way, it's Mr. Staudaher's duty to come back over the testimony and ask you for clarification or explanation, okay?

THE WITNESS: Okay.

THE COURT: So Mr. Wright, go ahead.

MR. WRIGHT: The last time you performed your services providing anesthesia --

THE COURT: Mr. Wright.

MR. WRIGHT: Yes.

THE COURT: You need to keep your voice up.

MR. WRIGHT: Okay. The last time --

THE COURT: The only person that can always be heard in this room is apparently me --

MR. WRIGHT: The last time --

THE COURT: -- and Mr. Santacroce. Something we have in common.

BY MR. WRIGHT:

Q The last time you performed an outpatient surgery center colonoscopy or endoscopy, by you performing it I mean you gave the anesthesia services, okay, whenever it was, whether it was more than ten years ago or recently, did you do the billing on it?

A No, sir.

Q Okay. And in -- are you a billing expert?

A No, sir.

Q In order to have this information that you're telling the jury here when you have nothing to do with your own billing for your services, what did you do, research it and read up on it?

A No, sir.

Q Okay. You knew all that you're testifying to, CMS, the documents, all of that you had already known, correct? And you did no research, correct, sir?

A Yes, sir. I -- okay. You asked two things. Rephrase the question again.

Q Okay. Did you do any research?

A Yes.

Q Because you're not an expert you needed to read up on it --

A No.

Q -- correct?

A I am not an expert, but --

Q Okay.

A -- I'm not a billing agent.

MR. WRIGHT: No further questions. Can we approach the bench?

THE COURT: Well, actually, I was about ready to take our break.

MR. WRIGHT: Okay.

THE COURT: Well, do approach the bench regarding scheduling issues.

(Off-record bench conference.)

THE COURT: I'm going to go a few more minutes before we take our lunch break. Unfortunately, we won't finish with

this witness at any reasonable time for the lunch break. So Mr. Staudaher's got a few more questions and then we'll be taking a lunch break around 12:30 or so.

DIRECT EXAMINATION (Continued)

BY MR. STAUDAHER:

Q When defense counsel was asking you some questions, you wanted to expound on some of those things. Can you tell us some of the things you're talking -- what you wanted to say in relation to those questions?

A Well, he was asking me two separate things in terms of when I did anesthesia or an endoscopic procedure, and he was talking about the billing. But what was confusing me is that, and maybe I misunderstood it, he said three different things. One was an ambulatory surgical center, one is an outpatient facility, and one is an inpatient facility. And you can do endoscopy in any of the three areas.

Q Okay. So go on.

A And I have done those more as an inpatient and in an outpatient facility, because at our facility we do all three. I do not do them in the standalone ambulatory surgical center that is at a distance from our campus. So that's what the confusion was.

THE COURT: Can you tell us, in case it's not clear, the difference between an ambulatory surgical center and an outpatient facility? I think we all know what an inpatient

facility --

THE WITNESS: Right.

THE COURT: -- that's in the hospital.

THE WITNESS: Usually an outpatient facility is attached to a parent hospital or a medical center, whereas a standalone unit is a standalone unit. They don't do anything else except whatever that procedure is, and that is usually somebody that -- it tends to be more people in private practice.

It's usually surgical centers where the surgeon or the endoscopist or whoever is doing that frequently owns the facility per se, and has his or her people there doing procedures and doing anesthesia if they need, and it's just a different setting.

THE COURT: Okay. So an outpatient would be somebody who's not admitted to the hospital, but the facility is right next to the hospital?

THE WITNESS: That is correct, Your Honor.

BY MR. STAUDAHER:

Q So you've done work in -- you've done endoscopy work in all three facilities, but most recently in the inpatient and outpatient facilities, right?

A That is correct.

Q And although you don't do the actual physical submission of the bill itself to anesthesia, do you provide

the information by which that bill is generated?

A We not only provide the information, is that -- because of this corporate compliance issue that we've talked about, at least once a year our billing service comes and gives us a talk of about what we can do and what we can't do so that we remain in compliance to what it is that they do, which is the billing.

And that frequently is the times that we're talking about, and that's one of the reasons why I'm very well aware of that. And the reason I looked it up was just to substantiate that this is exactly what CMS says. But it's what we do from our billing agents to make sure that we, that the group stays within the letter of the law.

Q So you used that as just to make sure what you were being told was accurate?

A Yes.

Q Okay. So you go through this compliance thing every year?

A Every year it's required.

Q And is that part of -- so you submit the right things to the billing people so that then they can send it off to the insurance company?

A That's correct.

Q So as part of that, you said that this class that you go to where they talk to you about this and provide

this information to you, do issues like we've discussed come up?

A Yes, sir.

Q Okay. And as far as your knowledge, do the different carriers have different -- within the 15 minute increment, do they have different issues of what portion of that they will pay for the whole increment, for example?

A Yes, sir.

Q Is that what we were talking about?

A Yes, sir.

Q And what I'm specifically asking is, is there a difference between going over one minute into the next increment for some insurers versus going over eight or ten minutes into the next increment for some insurers?

A Yes, sir.

Q And as part of the classes or the information that you get from your billing people so that you can comply, do you have those kinds of discussions?

A Yes, sir.

Q Did you then use that information to look into your research to confirm that what they were telling you was actually accurate?

A Yes, sir.

MR. STAUDAHER: At least on that issue, Your Honor.

THE COURT: Let me ask you this. Do you -- when you