you're --

Q Oh, at the other one.

A -- at the other room. But if you're confined to a single room, I think two or three an hour is about the best you can do.

Q Okay. Over the -- the course of your practicing in gastroenterology I -- I would assume you've used bite blocks for the upper endoscopies?

A Yes.

Q Was there ever a time when those pieces of equipment were reusable to your knowledge?

A Yes.

Q And when -- what time period was that?

A Oh, up until about maybe 10 or 15 years ago.

Q Okay. And now it's all disposable?

A To my knowledge, yes. I think the industry standard is to use disposable bite blocks.

Q Okay. And would you ever in your practice in the disposable era reuse a bite block?

A No.

Q During -- at your practice do you utilize CRNAs to sedate during the procedures you perform?

A Yes.

Q And how -- how many CRNAs are employed in your practice?

A At the present time one.

Q In your -- over the time in your practice, how would you describe your interaction with the CRNA during a procedure?

A The CRNA is responsible for the sedation of the patient and the monitoring of vital signs during the examination. And that's the purview of the CRNA. The surgeon or gastroenterologist who has performed the procedure is responsible for the supervision of the nurse anesthetist, but we do rely on their training and expertise to properly monitor the patient and perform the procedure safely.

Q Have you ever administered the anesthesia yourself during a procedure, or is that always done by the CRNA?

A I have back with the use of Valium and Demerol and later Versed and propo -- excuse me, Fentanyl, but I haven't administered propofol.

Q Okay. In -- when you -- in your practice over the years, have you had patients move around or -- how -- what are -- I guess, describe the range of movement you've seen with patients who are sedated with propofol?

A For the most part, they're comfortable and they don't really move.

Q Okay. If there's an issue with whether or not to give another -- or give another dose of propofol to a

patient during the course of a procedure, can you describe what communication you might have with the CRNA?

A As I'm withdrawing the instrument, a lot of times the patients do start to awaken. If the anesthetist is unaware that I'm in the process of withdrawing the instrument I will tell them, you know, I'm just about done and, you know, you really don't want the patient to get excess sedation, so we'll hold off on giving any further -- further sedation.

The withdraw of the instrument, for the most part is not painful or uncomfortable for the patient, and in fact, sometimes they like to watch on the monitor as we're removing the instrument. If they do -- if they are uncomfortable, we will give them additional sedation even if we're just withdrawing the instrument.

Q If there's a difference of opinion as to whether or not the patient requires more sedation, how is that arbitrated between you and the CRNA?

A I think for the most part the gastroenterologist sets the tone.

Q Okay. In your -- in your work you would treat patients who have contracted hepatitis C?

A Yes, ma'am.

Q And can you give the members of the jury just a little bit of a description of hepatitis C and -- in the sense of once you contract you develop symptoms and how soon, that

type of thing?

A Hepatitis C is generally a blood-borne pathogen; that is, it's given by -- it's transmitted by needle stick exposure, blood transfusions, IV drug abuse, occasionally intranasal cocaine use, and more unusually close intimate contact with sexual intercourse.

The initial phase is called acute hepatitis. That's people who have had hepatitis C for less than six months. About 25 percent of those patients will be symptomatic with yellowing of the eyes which we call jaundice; they'll be fatigued, they might lose weight, and then they generally recover.

A majority of those patients will go on to chronic hepatitis C, which is a phenomena where they don't have any symptoms but they continue to have viral replication and inflammation of the liver.

Q And you treat people with hepatitis C with Interferon treatment?

A With Interferon, Ribavirin, Telaprevir, and Boceprevir, yes.

Q And can you describe the nature of that treatment, what the patient has to go through to complete that treatment?

A Well, it depends on the stage and genotype for -- there are six different genotypes of hepatitis C. The most

common we deal with are genotypes 1, 2, and 3. About 70 percent of Americans have genotype 1 and, you know, there's a 1a and 1b, but they're basically treated the same, which is a 48-week course of Interferon and Ribavirin.

Q And is the -- is the treatment difficult, or what are the side-effects of the treatment of Interferon and Ribavirin?

A The side-effects are fatigability, low-grade fevers, feeling bad and punky, loss of air which we call alopecia, anemia, thyroid disorders, sometimes dermatologic problems and rashes.

Q And of the people that go through the Interferon treatment, what is the rate of success of them eradicating the virus or getting better?

A This is an evolution, you know, with the Interferon and Ribavirin therapy alone -- excuse me, just with -- excuse me -- Interferon alone, the success rate for genotype 1 was only about 8 percent. With the addition of Ribavirin and a 48-week protocol, the success rate went up to 45 percent. With the addition of the first-generation protease inhibitors like Boceprevir and Telaprevir, the success rate has gone up to 60 or 65 percent.

Q And when -- when we say "success rate," does that mean the virus is cleared from the person?

A We call it a sustained virologic response. And

this is defined by the absence of any detectable virus six months after completion of antiviral therapy.

Q And are there any studies that you know of of whether, like, once the virus is cleared from someone could they become symptomatic or have problems, like, a decade later or -- or once it's cleared, are you good?

A We don't have a lot of long-term data about that. But our best belief is that those patients have been permanently cleared of the virus and will have no recurrence.

Q The -- the weeks of the treatment itself, is that, in your experience, traumatic for the patients that you have go through it?

A I think it's very difficult, yes.

Q And are some people unable to complete the treatment or --

A That's correct. I mean, the side-effects are so severe that they just cannot complete the full 48-weeks of therapy and they have to leave -- leave the antiviral program.

Q And if they leave the antiviral program, what types of problems might they experience if they're unable to complete the therapy?

A Well, unfortunately the hepatitis C virus is prone to fairly frequent mutations. And what you've done when you have a partial therapy is select for the most resistant subpopulation of viruses. So you end up with a patient who is

actually more difficult to have successful antiviral therapy in the future.

Q And will -- I mean, will that, like, ultimately impair their liver function, or what types of health problems would they experience from stopping it?

A With the ongoing inflammation of the liver, it leads to some scarring which we call fibrosis; and once that fibrosis has reached a certain stage, we call that cirrhosis.

Q Okay. And if you are one of the people that gets through the treatment and the virus, the sustained -- what did you call it a sustained --

A Sustained virologic response.

Q Okay. And once you get to that point, are there any precautions that are recommended medically that people take so they don't transmit the disease to other people?

A Those patients are considered cured and will not transmit the virus.

Q And the ones that are unable to complete the therapy, do they have to take precautions?

A Right. We recommend for people in nonmonogamous relationships to use barrier protection. Don't use, you know, don't share razor blades and toothbrushes, don't donate blood.

MS. WECKERLY: May I approach, Your Honor?

THE COURT: Mm-hmm.

BY MS. WECKERLY:

Q Sir, I'm showing you what's been admitted as State's 108. Do you recognize what that is?

A No.

Q Is the -- let's see if I -- have you seen this report on colonoscopy procedure times at all?

A No.

Q Okay. And that one was published in 2006, but you're not familiar with it?

A No, I'm not.

Q Okay. And did I -- did the State ask you to bring this second demonstrative exhibit to court?

A Yes.

Q What is that?

A This is a bottle of propofol.

Q And what size vial is that?

A 20ccs.

Q Okay. And is that -- not -- maybe not that bottle or that vial anymore. Is that the size vial that you would use in your practice?

A Yes.

Q Or the CRNAs use in your practice?

A Yes.

MS. WECKERLY: Court's indulgence.

THE COURT: Mm-hmm.

MS. WECKERLY: Thank you, sir. I'll pass the

witness.

THE COURT: All right. Cross?

CROSS-EXAMINATION

BY MR. WRIGHT:

Q Dr. Nemec, my name is Richard Wright. I represent Dr. Desai. The -- that propofol vial, the exhibit there, is that single use?

A Yes.

Q Does it say it on there?

A Yes.

Q What's it say?

A It says, Single patient infusion vial. It's really little.

MR. WRIGHT: I'll pass it to the jury.

THE COURT: That's fine.

MR. WRIGHT: Pass it around.

BY MR. WRIGHT:

Q They also come in 50cc size, correct?

A That's correct.

Q Prior to the hepatitis outbreak here in Las Vegas in early January -- in 2007, early 2008, were propofol vials like 50s being multiused? Meaning used for multiple patients to your knowledge?

A There was split dosing. That is a anesthesiologist would draw up vials of propofol prior to

starting procedures for use throughout that day.

Q Okay. So if -- just if I could take a 50cc and draw up 10 separate -- pardon me, five separate 10cc syringes and then use them throughout the day was the practice?

A It was a common practice among --

Q Okay.

A -- anesthesiologists, yes.

Q That -- to your knowledge has that now changed here?

A That's correct, yes.

Q Okay. And that changed after the outbreak that occurred?

A That's correct.

Q Okay. After six weeks of trial I'm still confused on acute hepatitis, chronic hepatitis C, symptomatic and nonsymptomatic, okay? Does -- does the acute hepatitis, chronic hepatitis, that deals solely with time, duration?

A That's correct.

Q Oh -- okay.

A Zero to six months after the infection we call that acute; more than six months, we call it chronic.

Q Okay. So that -- the -- the acute designation, I mean, we're not medical here and sometimes you think of acute as severity.

A That's correct.

Q Okay.

A But that's -- you're right, people do have that belief, but acute has nothing to do with severity, it has to do with when it occurred. Acute is --

Q Okay.

A -- recent and chronic is long term.

Q Okay. So every -- every hepatitis virus transmission, if -- every -- whenever I got it then, like, using six months as an arbitrary cutoff, I'm acute for six months; thereafter chronic, if I still have it?

A That's correct.

Q Okay. And so that -- every person who had -- contracts hepatitis C has acute hepatitis C, but --

A That's correct; however, frequently it's never recognized because they have no symptoms or they don't seek --

Q Okay.

A -- medical attention. They thought they had the flu or something.

Q Okay. And so then we get into the, what we've called symptomatic and nonsymptomatic, right?

A That's correct.

Q Okay. So I -- I could contract hepatitis C and whether I have -- well, just suppose I got it today, and then whether I demonstrate symptoms or not has nothing to do with acute or chronic.

A Generally symptoms occur in the acute phase. As the virus becomes chronic, many of those symptoms resolve and the patient is symptom free, until with the chronicity and the development of scarring of the liver and the person goes on to cirrhosis, then they have the symptoms of cirrhosis; not so much hepatitis C; but cirrhosis.

Now, there are some exceptions. There are, you know, vasculitis problems that you can see with hepatitis C like with the cryoglobulinemia where we have so much antigen, so much virus, hooked up to so many antibodies that it starts to sort of cause a sludge phenomena in the lower extremities, you know, where it's colder and they'll develop, like a dermatitis or a skin -- skin problem --

Q Okay.

A -- as a consequence of the cryoglobulins. And that would be a direct hepatitis C complication. But most of the chronic problems are related to the failure of the liver.

Q The -- in -- every time I think I get it I read a new sentence that floors me on this acute/chronic. I got to read a sentence to you. These -- these patients have tested positive for the virus, but have not developed an acute case of the disease. Does that make sense?

A What do you mean by "these patients"? What patients are you talking about?

Q Just -- well, just patients who have tested

positive for hepatitis C virus.

A Patients that --

Q I -- I --

A -- test positive for hepatitis C have hepatitis C.

Q Right. Okay. But when --

A We know whether it's acute or chronic based on -- well there's a couple of ways. One is that if we had serial serologic tests -- that is, the person was negative in January and became positive in March -- you know that it's acute.

Q Okay.

A But -- or if they had a -- a risk factor. That is, they had had a blood transfusion that we later found out was contaminated with hepatitis C, then we would set up a timeline; but most patients with hepatitis C that we see out in the community we have no idea when they got it without some sort of historical marker they tell us about. Sometimes they'll say, you know, when I was a teen I used drugs, then we know they probably got it in their teens.

Q I got it. So when -- like in -- in this sentence that I've written out here, these patients have tested positive for the virus, and it's talking about hepatitis C, but have not developed an acute case of the disease. I mean, I'm guessing the person is just misusing the

word "acute" and is meaning symptomatic? I mean, this -- this is where I get mixed up when I read these things.

A I still don't understand, who is "these patients"?

Q Patients who tested positive for hepatitis C.

A That's not what it says.

Q I mean, but acute has nothing to do -- well, the next sentence. Fewer than 10 percent of persons infected with the virus develop acute hepatitis C. Do you know what that would mean?

A Nope.

Q Okay. Me neither and that's why I'm confused on some of these things. The -- because it -- the word to me, the way I'm understanding it as acute and the chronic distinction, we could just say the first six months of hepatitis C is acute.

A I don't know what the author of that sentence meant. Perhaps they just confused acute with symptomatic. I don't know.

Q Okay. And so the -- everyone that contracts hepatitis C at the beginning has acute, whether they know it --

A Correct.

Q -- or not?

A That's correct.

Q And then if they don't get rid of it either themselves, naturally, or through treatment, they then will have chronic thereafter?

A Correct.

Q Okay. And then the -- the symptomatic/nonsymptomatic [sic], that -- and symptomatic, as you said, is normal -- it occurs in acute hep C, first six months --

A Yes.

Q -- if it occurs?

A Now, we do have patients with chronic hepatitis C that are fatigued, and it probably is because of the viremia, the ongoing viral replication.

Q Okay.

A But usually the most pronounced symptoms are in the acute hepatitis.

Q Now -- colonoscopies without anesthesia, okay? And we've heard a lot in this courtroom about CRNAs and the vast majority of the people get propofol and go to sleep and then wake up and don't remember. Are -- do some patients get colonoscopies without anesthesia?

A Yes.

Q And how frequent is that?

A Maybe once a month I'll do one without sedation.

Q Okay. And does -- what -- why? Are they

allergic to it, or what -- I mean --

A Some patients want to watch the procedure. Some patients don't like the idea of being sedated. Some patients don't want to take a whole day off from work. There's --

Q Well, is it -- I mean, it's not a painful procedure? Or do they just tolerate pain well?

A The ones who request no sedation tend to do very well without the sedation. We occasionally have patients who we do a colonoscopy with little sedation because they are not hemodynamically stable. This might be in a, you know, an emergent situation in the ICU or the ER and because you're worried about their blood pressure, you don't give them very much. And some of those patients do have quite a bit of discomfort during the procedure.

So I think a lot of it is the frame of mind the person is in if they -- you're right, I think some people just tolerate pain better.

Q Okay. Some of them who don't want -- who you perform colonoscopies on who don't want anesthesia, are some of those physicians?

A Yes.

Q Okay. When you -- when you're performing a colonoscopy and working -- you're working with a CRNA as a team; is that correct?

A Correct, yes.

Q And is it -- when you have completed your entry with the scope and you are withdrawing the scope that is -- that is the least painful part of it; is that fair?

A That's correct. Yeah, the -- getting the scope up to the cecum, which is the upper part of the colon, is much more uncomfortable than withdrawing the instrument.

Q Okay. And if you are, say three or four minutes towards the completion, the withdrawal, and you see the CRNA either asks you or he is going to redose more sedation, would it be unusual for you to say, I'm almost done, don't even --

A That's not unusual at all. I frequently would say let's hold off, I'm just about done --

Q Okay.

A -- and complete the exam.

Q I want to talk to you about Gwendolyn Martin, a patient of yours. She is one of the victims in this case, and you treated her for her hepatitis C; is that correct?

A Am I allowed to -- you know, is this breaching a patient confidentiality issue?

Q I don't think so because --

THE COURT: I'll see counsel up here, no, I mean, her medical records have --

MR. WRIGHT: -- she -- she was here --

THE COURT: -- already come in. She's named in the --

THE WITNESS: Okay.

THE COURT: -- indictment. I'll see counsel up here though.

(Off-record bench conference.)

BY MR. WRIGHT:

Q The answer is you can testify about your treatment of her and it's fully protected and allowed under -- what?

THE COURT: Well, you -- it's allowed because I'm directing you to answer the questions.

THE WITNESS: Okay.

BY MR. WRIGHT:

Q She appeared here and testified --

THE COURT: -- that she was being treated by you and --

THE WITNESS: Okay. Fine.

BY MR. WRIGHT:

Q And the -- and I'm aware of it because I have a deposition that you gave and --

A Okay. Fine.

Q -- her -- in the civil case and included with it as exhibits were your -- your medical records for Gwendolyn Martin, okay?

A Fine.

Q Okay. You -- I wanted to go through -- and you

recall her as a patient?

A Yes.

Q Okay. And I wanted to go through that because that is a successful treatment of a hepatitis C patient; is that correct?

A Correct.

Q Okay. And do you -- do you recall that it was in November of 2007 when you first got Gwendolyn?

A I can't remember the exact time, but it was either late 2007/early 2008.

Q Okay. And can you -- without -- if -- I don't want to -- I don't intend to drag this out and go through all of your records, and the dates really are not significant, but if you do want to look at your records, I'll give you a copy of the deposition that I'm talking about and your records are there.

A Okay. Thank you.

Q Would you like -- did you float through there? You recognize those as your records?

A Yes.

Q Okay. And when she -- you're -- you are a gastroenterologist who treats people who have hepatitis C?

A Yes.

Q And so Gwendolyn Martin came to you, and at the time had acute hepatitis C?

A Yes.

Q Okay. And what -- just generally walk us through your treatment and what you did for her.

A We confirmed the diagnosis by doing hepatitis C RNA, quantified or found out exactly how much virus that she had, determined her genotype and started her on antiviral therapy.

Q Okay. And you could -- you did the blood testing and things to confirm she had hepatitis C, right?

A Correct.

Q You recall it was acute hepatitis C and she was symptomatic, had been in the hospital?

A That's correct.

Q Okay. And had jaundice, the classic symptoms, and nausea, fatigue; do you recall that?

A Yes.

Q Okay. And so then you confirmed it through testing and then started her on what treatment?

A I believe it was Interferon and Ribavirin. That's correct.

Q Okay. And so -- and she was a genotype 1a?

A Yes.

Q Okay. And so that, if I understand -- and I -- because I read your deposition, sir, and the -- everyone with hepatitis C, if they're going to get the Interferon and what

do you call -- what's that other Ribo?

A Ribavirin.

Q Ribavirin treatment, regardless of your genotype you get the same treatment, it's just the duration is different?

A No, I -- I think it is a little bit different.

Q Okay.

A If someone has minimal inflammation on a biopsy for chronic hepatitis C, genotype 1 you might hold off on therapy. Plus we have evolving therapies and, you know, sometimes we hold off if they're early on waiting for the second-generation protease inhibitors and direct-acting antiviral agents that will -- are going to be approved by the FDA probably second quarter 2014.

Q Okay.

A So they're not exactly the same, but at the time we were treating, yes.

Q Okay. And so the -- she started -- and her as a 48-month -- week treatment?

A Correct.

Q Okay. And within a couple of months of the commencement of the treatment you are seeing her on monthly or six month -- pardon me, six-week intervals --

A Correct.

Q -- is that correct? Because you are monitoring

her progress --

A Correct.

Q -- and testing as we go along. And do you recall that you did a liver biopsy?

A I don't recall that, but --

Q Okay.

A -- do you have a page?

Q Yep. I'll use your deposition transcript. I'll just refer you to a page.

A Okay.

Q 32.

A Okay. Yes.

Q Okay. And the liver biopsy is done for what?

A To determine how much inflammation and fibrosis there is.

Q Okay. And do you see there the results?

A Yes.

Q Okay. And what was that?

A The grade two inflammation and stage one fibrosis.

Q Okay. And what -- characterize that as to severity or something?

A There's four different stages of inflammation -- I guess, five, zero, one, two, three, and four and five; stages of fibrosis, zero, one, two, three, and four.

Q Okay. And so was hers on the low end?

A Yes.

Q Okay. And do you recall that -- first let me back up a minute. She has acute hepatitis C?

A Yes.

Q And of course, before you put her on the treatment, she elected to take the treatment, correct?

A Yes.

Q Tell the jury about the discussion you have with the patient about what it -- just like, I'm a new patient, I'm in, I got acute hepatitis C and I'm scared to death.

A Well, I told Mrs. Martin that I had not seen acute hepatitis C before. This is a fairly rare thing to be able to treat because there are so few new cases of hepatitis C, we're generally not seeing them. Most of what we see, in fact, all prior to Mrs. Martin coming in to see me, was chronic hepatitis C.

Our experience with treating hepatitis C -- when I say," "our experience," the worldwide experience with treating hepatitis C is -- that's acute is fairly limited. But it was felt that theoretically an early intervention with the hepatitis C gave the best possibility of having a favorable long-term response.

Q Okay. But I'm scared to death. What are the side-effects going to be for me?

A You're going to feel fatigued, might have some hair loss, anemia, low-grade fevers.

Q What are my chances? What if I -- I don't know whether I should do it or not?

A Well, I would tell you that for most patients with this particular genotype, your success would be about 45 or 50 percent; but given that we're treating earlier, we should have a better outcome than that.

Q Okay. I'm lean.

A You're lean?

Q Well, hypothetically.

A Your chances of having a successful eradication are better than if you were overweight.

Q Okay. And Mrs. Martin was motivated?

A Yes.

Q And wanted to fight it?

A Yes.

Q Okay. And then what if it doesn't work, Doctor? I mean, I'm going to go through this for 48 weeks and I'm hearing it's 50/50 --

A Well, we do have --

Q -- do I then do it again?

A We do have early indicators of success. People have an early virologic response; that is, they lose their viral load or -- we can't detect any virus. Early on in the

treatment gives a much likelier positive outcome.

Q Okay. But what -- at the end of 48 weeks am I -- what's -- how are we going to know if it worked or not?

A By checking the virus in the blood.

Q Okay. And if -- if there is -- if it's not in my blood anymore at the end of the 48 weeks, will I then know I'm most probably cured?

A We'd have to wait another six months, and if the virus was absent six months after completion of therapy then, we call that sustained virologic response. At least that's what the researchers do. I call it a cure.

Q Okay. And what if at the end of 48 weeks I still have -- it's still detected in my blood? Can I do it again?

A It would be unlikely you would have a successful outcome by re-treating; however, there are some hepatologists that would put the person on, not a curative protocol, but a suppressive protocol just to keep the amount of virus lower by giving the Interferon/Ribavirin on a chronic basis.

Q Okay. If I -- maybe I ought to wait a few months because -- my -- you just tested me and my viral load -- is that the right word?

A Yes.

Q Okay. My viral load has gone down. Is there any chance I'm going to kick this on my own?

A Yes, it is possible you kick it on your own.

Q Okay. And if I -- and if I do, I just don't get any treatment and then all of a sudden I have no sustained, what's that word, sustained --

A Well, we wouldn't call it a sustained --

Q Okay.

A -- virologic response, we would call it self -- self -resolution of the virus. You just fought it off with your own antibodies and immunity.

Q Okay. And that happens to some people?

A Yes.

Q Okay. And so if that happens with me, I simply fought it off and it's gone?

A That's correct.

Q Okay. If I don't -- if I elect not to take treatment, how long do you think I'm going to stay symptomatic, if I'm, you know, having symptoms before I move in the nonsymptomatic chronic?

A Probably about six months.

Q Okay. So I either put up with this for about six months then -- and if I don't fight it off myself I'm going to have chronic hepatitis C probably for the rest of my life?

A That's correct.

Q Okay. And then am I going to die of hepatitis

C?

A There's a 20 percent chance that you go on to cirrhosis and death of the liver if the hepatitis C is chronic and not treated.

Q Okay. So if I just do nothing, get past the symptoms, most probably I'm going to die of old age and not hepatitis C?

A Yes.

Q Okay. And there is a 20 percent chance I'll get cirrhosis of the liver -- I mean, this is from the statistics and studies -- within, is it 20 years of --

A Well, we've seen it as little as five or even two or three years, but generally this takes decades of ongoing inflammation of the liver. But, you know, everybody's got a different immune system and, you know, as you're older your ability to fight off infections might not be as vigorous as a younger person and who, you know, may have a more accelerated progression of disease.

Q Okay. Cognitive deficits. I'm worried I have hepatitis C now. I just caught it and I have symptoms. What cognitive impact is this going to have on me?

A Well, in the acute phase a person would have the same type of cognitive deficits that you'd have, like, with a virus or a cold. Your ability to concentrate is impaired. Attention to detail might fall off. But as you became more

chronic, that would tend to normalize. Later in the disease if you developed cirrhosis and the buildup of the toxins in the blood which we call encephalopathy, then you'd have a fairly profound century -- excuse me, deficit of mentation.

Q Okay. Now, going back to Mrs. Gwendolyn Martin, the -- she successfully went through 48 weeks of treatment?

A Correct.

Q And she tested clear -- whatever you call it?

A Correct.

Q Okay. And then again at six months?

A Yes.

Q Okay. And so she is -- she is cured?

A We call it a sustained virologic response. The likelihood of this virus coming back is very, very, very small.

Q Okay. And the -- it's obviously not pleasant treatment?

A No.

Q And there's side-effects forgetting the -- I'm symptomatic to begin with because I've got hep C; now I'm going to go through this 48 weeks and that's going to cause what generally?

A Mostly fatigue as a consequence of the Interferon and maybe exacerbated by the underlying anemia as a consequence of Ribavirin therapy. Sometimes they just get

muscle aches at the sight of the injection of the Interferon. They just don't feel it very well.

Q Okay. And the -- Gwendolyn, if you recall, and I just know from reading your deposition, had a good support structure; her husband was there every single time?

A Yes.

Q And she cleared it and was a success story?

A For clearing the virus, yes.

Q Okay. Now, we had a -- were you aware of any dementia for Gwendolyn Martin?

A She -- you know, I'm not a neurologist. She told me she had some cognitive problems during the treatment. She continued to have some anxiety issues. I think, you know, when someone gets hepatitis C as a consequence of, you know, IV drug abuse or, you know, bad behavior, that's one thing. But when it's, you know, in a healthcare setting, that's fairly traumatic for that person.

Q Okay. The -- I mean, anything about brain damage caused to her because of the treatment or the hepatitis --

A I don't know of any anatomic or physiologic brain damage.

Q Okay. We had a --

THE COURT: You again.

THE MARSHAL: Everybody, check your cell phones; make

sure they're on silent.

BY MR. WRIGHT:

Q We had a doctor in here this morning. Dr. Richard Perrillo testified. He calls himself a neuropsychologist. Did he ever consult with you regarding Gwendolyn Martin?

A Not that I recall.

Q Okay. He testified that -- understand, he testified he was hired by plaintiff's personal injury lawyers for her case to give an assessment of her.

THE COURT: Mr. Wright, keep your voice up.

BY MR. WRIGHT:

Q He testified he was brought in by -- or plaintiff's personal injury lawyers to assist Gwendolyn Martin and four other people suing for their civil cases, okay? Regarding Gwendolyn Martin, he said he was -- he was certain she had brain damage, I can tell you that. It's not brain fog. She has front occipital -- front occipital dementia and is permanently disabled, although it may not be permanent because the brain has plasticity.

You ever hear anything like that?

A I'm not a neurophysiologist and no, I never -- I'm not familiar with that.

Q Okay. Does that sound like Gwendolyn Martin to you?

A Well, you know, I've only known Gwendolyn Martin since she had her bout of hepatitis C and I didn't know her beforehand, so I can't say, you know, whether there was a change in her skillsets or cognitive abilities. I don't know.

Q Okay. He said that the disease -- and he -- we were talking about hepatitis C. He said the disease and the treatment of the disease cause dementia, and that hepatitis C is neuro viral and affects your brain before the liver. You ever hear of that?

A No.

Q He said the neuro not -- cognitive impairment is independent from the Interferon treatment, and that the Interferon treatment is a double-whammy. It sort of accelerates one's brain dysfunction caused by the hepatitis C. Have you ever seen or heard anything like this in the studies you've read about --

A No.

Q It -- with hepatitis C, even the treatment -- I opt to take the treatment, I've got hepatitis C, I'm going to go through 48 weeks of Interferon, whatever side-effects I have, even if cognitive from the treatment, those are going to cease when I'm done with the treatment; is that fair?

A Well, you know, I would hope so, but, you know, I think you need to understand that there are all sorts of unintended consequences of the therapies we give patients, and

some of these consequences aren't known for years or even decades later. So there may be long-term sequelae of the treatment that, you know, most gastroenterologists are not aware of.

However, in my own practice most patients after completing therapy seem to be alert, oriented, and not having any appreciable cognitive deficit that I can detect.

Q Okay.

A But I don't specifically challenge that. I don't give them neurocognitive testing.

Q Almost done. Just check my list. Thank you very much, sir.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: Thank you.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Doctor. I just wanted to follow up a little bit about what Mr. Wright was touching on regarding the relationship of cognitive damage to the hepatitis C virus. I believe in your grand jury transcript you seemed to associate that deficit with the degree of liver damage; is that correct?

A In patients with cirrhosis, you know, end-state cirrhosis, rate 4 fibrosis, yes.

Q So am I -- as I understand it, there would have

to be significant liver damage, i.e. cirrhosis, in order for there to be permanent cognitive damage? There's a relationship there, isn't there?

A Well, the cognitive deficit asscciated with cirrhosis is not irreversible. I mean, those patients can clear their sensorium with, you know, treatment with, you know, antibiotics like -- like facts and medications like Lactulose. Dietary changes can help them improve their sensorium quite a bit. So it's not permanent; it's not irreversible.

Q So even with that degree of damage to the liver, cirrhosis of the liver, the cognitive abilities can come back --

A Yes.

Q -- in return? Yes?

A Yes.

Q And I believe you described, sort of, this cognitive damage early on as being like related to, like, flu-like symptoms like a child would get if they have a high fever, correct?

A Correct.

Q And after that fever passes, all of that cognitive ability, or the majority, comes back, correct?

A Correct.

Q Can you give me some kind of idea as to how long

it takes to develop cirrhosis of the liver?

A It's variable. It can be as short as three or four years, and sometimes it never does occur; the person succumbs to old age.

Q But I mean on an average, three is the -- three to four years is the low end, isn't it?

A It's usually a couple of decades.

Q Okay. So 10 to 20 years?

A Yes.

Q And even if someone has cirrhosis of the liver when you first detect it, what's the lifespan of someone that has cirrhosis of the liver?

A It depends on how bad the cirrhosis is. You know, we have a classification for that, you know, the child's classification for liver disease and people with advanced liver disease, their prognosis could be very poor with a life expectancy of less than six months.

Q I want to just talk a little bit about the CRNAs -- your familiarity with CRNAs in your practice. In the procedure room you have a CRNA?

A Correct.

Q Yourself?

A Correct.

Q Do you have a nurse also?

A No, we have a tech.

Q GI tech?
A Yes.
Q Okay. In that procedure room, who is in charge of that procedure room?
A The gastroenterologist.
Q So that would be you?
A Yes.
Q If you were performing the procedure. Is that standard and customary?
A Yes.
Q And in fact, the CRNA doesn't need an anesthesiologist to supervise them in Nevada, correct?
A No, they do not.
Q An M.D. can supervise a CRNA --
A That's correct.
Q -- such as yourself? You're the supervisor of that CRNA in that procedure room?
A Yes.
Q You talked about -- maybe you didn't talk about it here, but I was reading in your grand jury transcript about the procedures that you use in logging in information about a patient after the procedure?
A Yes.
Q Do you use electronic devices to do that?
A Yes.

Q Can you tell me how that goes?

A Well, it's a computer program that has various boxes that are clicked, you know, normal examination or polyp or ulcer or inflammation and it -- it generates a report.

Q Okay. And you talked about that normally you would do that right after the procedure, correct?

A Correct.

Q But there would be times when you wouldn't get to it right after the procedure and it would be some minutes later, correct?

A Some minutes, but it wouldn't start a new procedure until it had been completed.

Q Correct. And you also said you would -- there wouldn't be six patients that would come in before you would do it --

A No.

Q -- because you would remember it?

A Right.

Q But there could be a matter of several minutes before you actually logged into that computer, or whatever you call it, and -- and put in the results of what you found, correct?

A That's correct.

Q Now, in that machine does it have a time stamp, a time strip; do you know?

A Probably. I don't know.

Q So the time that you ended the procedure or the time that the CRNA logged in the end of the procedure could actually be a couple of minutes different from what your notes indicate on the machine, correct?

A There is -- we run into this problem a lot of times in the procedure room. We've got a clock and in our office it's an atomic clock that has the exact time. There's also a clock on the scope that takes the pictures and has a time stamp for the pictures that we take that is not synchronized with the atomic clock. And then we have another machine that generates the procedure report with a different clock.

So you can have three different times a couple of minutes apart for the exact same procedure. So a lot of times you won't see synchrony. In our facility we are -- our stop time and stop time for the procedure is all coordinated with the clock on the scope.

Q Okay. But you can't change the clock on the computer that you're typing in your notes, right?

A I'm sure someone could. I can't. I don't know how.

Q I couldn't either. But I'm just saying, I mean, you don't calibrate every time you do a procedure?

A No, we do not.

Q Okay. So there -- there could be -- and typically it's some variation in the time?

A Yes.

Q Fairly common?

A Fairly common.

Q You talked about in your grand jury testimony, I think, someone asked you about the procedures can get very messy at times, correct?

A Yes.

Q It's a messy business?

A Yes.

Q And when you're extracting a scope -- I don't know if you -- I'm using the right words, but when you pull a scope out, things can happen, right?

A Well, specifically what kind of things?

Q I don't want to tell you what we've discussed here. You tell me, you're the doctor.

A Well, you know, I think what we're talking about is splatter of fecal material --

Q Correct.

A -- on removal of the scope. And, you know, we try to keep that to a minimum and, you know, make sure that, you know -- because the staff doesn't want to get splattered, you know, we try to be careful when we remove the scope.

Q But it happens?

A It occasionally will happen, yes.

Q And it can be very messy?

A When there's a bad prep, yes.

Q When you say a "bad prep," that means the patient hasn't prepped properly?

A Sometimes they prep properly but the prep did not have its desired effect. There's residual fecal material within the colon.

Q Okay. And related to that you talked about scope cleaning in your -- in your grand jury testimony --

A Yes.

Q -- right? And, I believe you testified that there was -- in your practice the scope cleaning takes 55 minutes?

A Correct.

Q That's relatively new since the hep outbreak?

A No, I think that's been fairly standard.

Q Okay.

A I mean, there is a timer on the scope washer and, you know, by the time you get the prewashing and brushings done and get it into the cleaner and then do all the due diligence to make sure the scope is clean, that's how long it takes.

Q And I believe you testified that you cleaned two scopes at a time in the enzymatic fluid?

A Well, I don't know about -- I don't know about that.

Q Okay.

A I don't know.

Q Let me see if I can find that.

A I think you're talking about a double scope washer?

Q Yeah, tell me about that.

A Well, there's some scope washers that you can clean two -- two scopes at the same time.

Q Okay. And what does that look like?

A It's like a plastic box and there's a lid that opens up and --

Q And you put enzymatic fluid in there?

A You know, the details of how you clean the scope is not what I do. I don't know.

Q All right. I'll yield on that point. But you would acknowledge that the cleaning of the scopes is important?

A Yes.

Q And why is that?

A Because viruses, parasites, bacteria can be in the channels of the scope and can potentially be transmitted to another patient.

Q So if a scope wasn't properly cleaned, it has

the potential to transmit disease?

A Yes.

Q Well, I think that's all I have, Doctor. Thank you very much.

THE COURT: All right. Redirect?

MS. WECKERLY: No redirect. Thank you.

MR. WRIGHT: I want one more. What's one of those scopes cost?

THE WITNESS: They're -- well, you know, there's more to the scope than just the scope. You've got the processor and the light source and all the telemetry, but the scope itself costs about 30 or 35,000.

MR. WRIGHT: That's it.

THE COURT: Anything else, Ms. Weckerly, based on that last question?

MS. WECKERLY: No.

THE COURT: Do we have any juror questions for this witness?

All right. Doctor, apparently there are no further questions for you. Thank you for your testimony. You are excused at this time.

THE WITNESS: Thank you.

THE COURT: And, State, I believe that's all you have for today?

MR. STAUDAHER: That's correct, Your Honor.

THE COURT: All right. Ladies and gentlemen, we're going to go ahead and take our weekend recess.

During the weekend recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research by way of the Internet or any other medium, and please do not form or express an opinion on the trial.

We will reconvene Monday morning at 9 a.m. Please place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed for the weekend at 4:44 p.m.)

THE COURT: Ms. Weckerly, what do we have to look forward to on Monday?

MS. STANISH: That's what we were talking about.

MS. WECKERLY: Well, I know it will be --

MR. WRIGHT: I didn't know whose it was.

MS. WECKERLY: That's whose it is. Well, I know -- I know we'll have Brian Labus Monday and Tuesday. I'll have to kind of schedule everybody else after that, but --

THE COURT: Okay.

MS. WECKERLY: -- that will give us a --

THE COURT: All righty.

(Court recessed for the weekend at 4:45 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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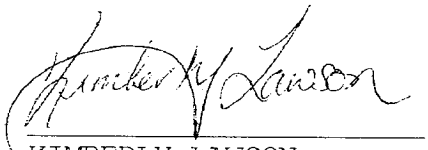

KIMBERLY LAWSON

MR. WRIGHT: I'll hold the door.

THE WITNESS: I think the point is you cannot give me anesthesia from that far, No. 1. And No. 2, you cannot do the preanesthesia evaluation from that distance either. So, you know, it's present with the patient.

BY MS. STANISH:

Q Right.

A It has to be face-to-face. You can't give anesthesia unless you're face-to-face with the patient, or you're at the head of the table or how -- side of the table, whatever you want to call it, but you're still present with the patient.

Q Okay.

A Present.

Q Right. Okay. I get it.

THE COURT: May I see counsel at the bench, please?

MS. STANISH: Wait, I just have one more question.

THE COURT: Okay. Ask the question.

BY MS. STANISH:

Q So as I understand your testimony, you know, if they're -- what you expect, what you're adamant about, is that there is a set of rules and everyone follows them.

A Supposed to, yes.

Q And fair statement that you want a set of rules that everyone can understand?

A Yes, I would like for everyone to understand them.

Q But not everyone does.

A Not everyone does.

Q And not everyone, even though there's a contract provision that requires them to do so, not everyone keeps up with it?

A Not everyone does. You're --

Q And not everyone does it personally, providers. They may have a billing coder, a third-party coder help with these intricacies of the billing scheme?

A Yes, that's why many physicians in any kind of practice or hospitals will have people that have the knowledge, the skills, the credentials to accurately reflect what's -- where the provider comes in, in this case anesthesia, is they have to make sure their documentation is accurate because these people over here that are going to be taking this information and this procedure and this documentation to support what they want to bill because if they don't you're asking these people over here to build something that is not really supported by documentation.

So even if the providers don't know these people over here, the coders, people like me should be educating them. But they normally don't like that. They don't like it at all.

Q I wonder why.

A Because, you know, what they really want to do, most providers, is they just want to practice medicine. They just want to give anesthesia. They just want to practice medicine. But there's more to it than that. We're -- you know, we're back to the quality of care and the health record, you know, how important that is. We're back to being accurate and have sufficient documentation to support what you want these people to bill for you.

It -- it's just being responsible, it's being accurate, it's being appropriate; and if you don't know it, don't understand it, then I think you should seek out that information from those who have it and keep asking until you do understand it because that is what insurers expect and certainly Medicare does, and their language can be difficult at times.

Q At times?

A Frequently.

Q All right.

A It can be difficult, but that doesn't release us from the responsibility of trying to find out and there's many ways to find out so that you will be accurate in what you're doing.

Q Great. Thank you.

A You're welcome.

THE COURT: All right. Is that it for you, Ms. Stanish?

MS. STANISH: Yes.

THE COURT: Mr. Santacroce -- you don't need to approach the bench. Mr. Santacroce, do you have any questions?

MR. SANTACROCE: No.

THE COURT: Any redirect based only on what Ms. Stanish asked?

MS. WECKERLY: No, Your Honor.

THE COURT: Any juror questions for the witness before I excuse her? No juror questions?

All right. Ma'am, thank you for your testimony. You are excused at this time.

THE WITNESS: Thank you.

THE COURT: What's that? Oh. Ladies and gentlemen, we're going to go ahead and take our lunch break. We'll be in recess for the lunch break until 1:50.

During the lunch break you're reminded you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Do not do any independent research by way of the Internet or any other medium. Please don't form or express an opinion on the trial.

Notepads in your chairs. Follow the officer to the door.

(Jury recessed at 12:44 p.m.)

THE COURT: While I remember, before we take our lunch break I just wanted to note on the record that at the conclusion of yesterday, after I had left the bench I had my JEA Sheri run in and tell the lawyers that they didn't need to be here until 9:30 this morning and that's when they got here. So I just wanted the record to be clear on -- on that, that it was a 9:30 start time.

MS. STANISH: Thank you, Your Honor.

THE COURT: All right. Go to lunch.

(Court recessed from 12:46 p.m. to 1:52 p.m.)

THE COURT: Bring them in.

(Pause in the proceedings.)

THE COURT: Bring them in.

THE MARSHAL: Ladies and gentlemen, please rise for the presence of the jury.

(Jury entering at 1:56 p.m.)

THE COURT: All right. Oh. All right. Court is now back in session. And the State may call its next witness.

MR. STAUDAHER: Mark Silberman, Your Honor.

THE COURT: Sir, just right up here, please, next to me. And then just remain standing, facing this lady right there and she'll administer the oath to you.

MARK SILBERMAN, STATE'S WITNESS, SWORN

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

THE WITNESS: My name is Mark Silberman, that is S-I-L-B as in boy, E-R-M-A-N.

THE COURT: All right. Thank you.

Mr. Staudaher?

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Mr. Silberman, are you the designated custodian of records person most knowledgeable from the American Association of Nurse Anesthetists?

A I am.

Q Were you sent out here to -- to act in that capacity to talk about records of your organization?

A Yes.

Q Are you familiar with those records?

A I am.

Q And did you provide those records to us initially in this case?

A I did.

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q I'm showing you what has been marked as Proposed State's 219 to 227. And just flip through those generally, and we'll go through them in a little more detail. Yeah, flip through them, and you can go ahead and just tell me -- tell us if you're familiar with them, if, you know, the records of your organization and if those are the ones you provided to us?

A (Witness complied.) Yeah.

Q And exactly what are these records?

A These are documents that we provided in response to a subpoena. The subpoena requested information related to a series of documents and a letter that was issued by the AANA, the president of the AANA in, I believe it was 2002 in response to a hepatitis outbreak that had taken place, and it also included some membership regarding -- information regarding two members and a press release related to that same outbreak.

Q The records that you just looked at, are they records of your organization?

A Yes, they're records from the AANA.

Q Are they kept in the ordinary course of business?

A They are.

Q Do you rely upon those records in the duties and things that you need to do as -- in conducting your business?

A We do.

Q Do these accurately and truly represent the records that are contained at your location, your business?

A Yes, they do.

MR. STAUDAHER: Your Honor, at this time I'd move for admission of State's Proposed 219 to 227.

THE COURT: Any objection?

MR. SANTACROCE: No objection.

MS. STANISH: No objection.

THE COURT: All right. Those are admitted.

(State's Exhibit 219 through 227 admitted.)

BY MR. STAUDAHER:

Q Now, I'm going to ask you -- as we go through them I'm going to ask you some questions about them, but the exhibits themselves are unhighlighted. I'm going to show you some that -- to facilitate your examination that are highlighted. Those are my highlights. I'm just putting that on the record as we go forward, okay?

And I'll --

MS. STANISH: It's --

BY MR. STAUDAHER:

Q -- refer to the pages by Bates --

MS. STANISH: -- it's --

MR. STAUDAHER: -- I'm sorry?

MS. STANISH: -- do you mind if I borrow that other

one --

MR. STAUDAHER: Sure.

MS. STANISH: -- while you have your --

MR. STAUDAHER: You bet.

MS. STANISH: -- colored one?

BY MR. STAUDAHER:

Q And I will refer to them by Bates Number, which is -- appears in the lower-right-hand corner, and I won't tell the whole thing every time, but it's DA Endoscopy AANA Documents, and then the number is the Bates Number.

Now, the first thing I want to do is to go and look at what is termed Bates No. 1 and ask you some questions about it.

A Okay.

Q I'll display this on the screen. And as we go through this, I just want you to know that if you need to at any time, this screen -- you can take your fingernail and draw on it like that, and then you just tap it down here on this corner and that will go away, okay?

A All right. Thank you.

Q So if you need to highlight something, I would ask you since we're using documents to actually kind of point out the areas that we're talking about if we need to, okay?

A No problem.

Q Now, specifically -- and I'll go in a little bit

more -- before I do that what -- are you familiar with this particular document?

A Yes.

Q And what is this?

A This is a printout of the web page. This was a copy of the letter that was sent out by the then president of the AANA, Dr. Lester, in 2002.

Q And do you know why this letter was sent out?

A This letter was sent out as an advisory to all nurse anesthetists in response to a series of events regarding the -- an outbreak of hepatitis and to make sure that all nurse anesthetists had access to all of the information and policies and guidelines regarding the reuse of needles.

Q Regarding what again?

A The reuse of needles.

Q Now, as far as this particular outbreak is concerned, you said that it went out to the membership as you had it at the time?

A Correct.

Q If you know -- I assume that there are more -- there's nurse anesthetists that practice in the country than are members of your organization; is that fair?

A That is true.

Q Do you know about how many percentagewise nurse anesthetists are part of your organization?

A Historically and consistently the AANA, the membership represents over 90 percent of nurse anesthetists.

Q As far as the -- your organization what kinds of things do you do as an organization for your membership?

A It's an advocacy organization. It's a professional -- a professional organization, so it advocates on behalf of the profession. It provides continuing education. It provides guidance policies. It sets standards for the practice of nurse anesthesia.

Q The membership as it is constituted, I mean, what kinds of things do you do for the members as -- as sort of members of your organization?

A There are multiple annual meetings that are open to the public; the board establishes policies, guidelines; there are -- there's an AANA journal which publishes information for members; there are newsletters, and then there's obviously political advocacy with regards to legislation, both on a national level, but also to assist state by state.

Q Now, you mentioned journal. Is there -- is there other -- another professional organization for nurse anesthetists besides yours?

A The -- well, there are other professional nursing associations. The only nursing association dedicated to nurse anesthetists is the AANA.

Q So you're the exclusive one?

THE COURT: And, sir, some of the jurors are having trouble hearing you.

THE WITNESS: Sorry.

THE COURT: Right in front of you there is that black box; that's the microphone. So if you can just speak up into that so we can make sure everybody hears you.

THE WITNESS: Will do. And my apologies.

BY MR. STAUDAHER:

Q So I want to go back to this. You said that there was an outbreak of hepatitis C and you wanted -- your organization wanted to disseminate information to the membership?

A That was what the purpose of this letter was.

Q Now --

THE COURT: And, Mr. Staudaher, you need to keep your voice up too.

MR. STAUDAHER: I'm sorry. I'll try to talk louder myself.

BY MR. STAUDAHER:

Q As far as that is concerned, this particular notification, was this an unusual event, or is this something that happens every six months or so with your organization?

A The outbreak of hepatitis or the --

Q A notification --

A -- issuance?

Q -- like this.

A This was an extraordinary situation. An extraordinary notice that was sent out.

Q So tell us about that, if you would. I mean, what about the notice, what was accompanying the notice, that kind of thing.

A So the notice itself -- I guess if I can --

Q Well, I'll move it to whatever you want me to.

A There's a reference to what is accompanying -- here we go, in this paragraph here. The notice is a letter from the president of the AANA, and what was sent out was the standards of the AANA related to office practice and I believe it was also a hospital-based practice, and then the guidelines related to infection control, and then the code of ethics that the AANA has in place.

Q So the documents that accompanied this that you provided are those what we -- we have in the exhibits that are now in evidence in this case?

A Correct. The exhibits you showed me, with the exception of the membership information and then the press release, those other documents is what accompanied this letter.

Q Okay. Now, specifically I want to go try and zoom in on this a little bit more. Can you clear that for us,

please? Will you read that section for us, please? It's --

A Beginning with --

Q -- highlighted.

A -- after discussion?

Q Yes.

A After discussion with infection control experts, we have concerns that there may be a widespread misunderstanding by healthcare practitioners of the dangers associated with the reuse of needles and syringes. Needles and syringes are single-use items and should not be reused on the same patient or from patient to patient.

The possible exception is when a syringe and needle are used on the same patient for incremental dosing; however, once the syringe is partially or completely emptied, it should not be refilled for use even on the same patient.

Reuse of needles and syringes is a clear violation of AANA's infection control standards and guidelines, ASA's recommendations for infection control, as well as guidelines adopted by individual healthcare organizations.

Q Now, I want to go slide this up a little bit and have you tell us what the date of this letter is.

A The letter was issued on September 30, 2002. I believe that is the date that the letter went out. There's a -- I don't want to call it another version, but the letter also has a date, I think, of the week prior, which I believe

was when it was finalized for mailing.

Q So this one says September 30th of 2002, correct?

A Correct.

Q Now, I'll show you what is listed as Bates No. 3. And this one has a date that is September 23rd of 2002; is that correct?

A Correct.

Q Is this the second letter that you were talking about?

A It was. Yes, it is.

Q Okay. And if you need to -- me to bring anything back to you so you can -- I know I'm giving you kind of a window to look at on the screen. If you need it in better context, I can return it to you to look at, okay?

The same language, though, appears in this secondary letter?

A Yes.

Q Now, what was the purpose of having two separate letters; if you know?

A My understanding is the only difference in the dating of the letters is when they were prepared to be sent out versus when it was posted on the website.

Q Okay. So --

MR. SANTACROCE: I didn't hear the last part of that.

THE WITNESS: When the letter was prepared to be sent cut versus when it was posted onto the AANA website.

BY MR. STAUDAHER:

Q Now, with regard to the accompanying documents that you talked about, Bates No. 84, is this one of those series of documents that was presided -- provided to the nurse anesthetist?

A Correct.

Q And what is this particular item?

A That is the cover page for the standards for office-based anesthesia practice, the policy of the AANA.

Q What you go by?

A Correct.

Q And this was disseminated along with that letter to all the membership?

A Correct.

MS. STANISH: What was the Bates stamp on that, please?

MR. STAUDAHER: Oh, that was 84, I believe.

BY MR. STAUDAHER:

Q Now, specifically I want to ask you a couple of questions related to, I think it was another one of these documents. Just let me get to it here. There's another document that I wanted to ask you about that is Bates No. 25, which is -- it's titled, Infection Control Guide. Was this

also sent out to the membership along with that letter?

A Correct.

Q With regard to that particular item, I want to move forward to Bates No. 36. Do you see the title of that section?

A Yes.

Q What is it?

A That subsection is, Administration of Drugs and Solutions.

Q Slide down to the highlighted portion. Could you read that for us, please?

MS. STANISH: I'm sorry, could I have the Bates stamp --

MR. STAUDAHER: Oh, I'm sorry --

MS. STANISH: -- again?

MR. STAUDAHER: -- 36.

THE WITNESS: Strict adherence to infection-control procedures and standard precautions as required. Multiple-dose vials should be limited to a single patient use unless strict aseptic technique is used and a new sterile syringe and access device are used each time the vial is penetrated. The danger of cross-contamination from multiple-dose vials used for more than one patient must be weighed against any cost savings.

BY MR. STAUDAHER:

Q So part of your infection control guide?

A Correct.

Q Moving to the next one. There is a diagram -- and this is Bates No. 38. And the highlighted portions are what I'd like you to read, and then if you can tell us what the purpose of this diagram is.

A The --

Q Go ahead and read it first --

A -- it is --

Q -- for us.

A -- Classification of risks for transmitting infection in anesthesia applications. And the next highlighted section reads, Critical Risk. Items that enter a sterile area of the body or the vascular system, condition at the time of use equals sterile.

Q So we have that as being a critical risk, then we have three other areas -- or, I guess, a total of four. This one here?

A Reads, Semicritical Risk.

Q Noncritical and Environmental Surfaces?

A Correct.

Q So of the classification here, which is the highest level of risk?

A It is critical risk.

Q With regard to -- make sure we're on the right

document here -- Bates No. 50. A conclusionary section of that document. Go ahead and read for us these sections if you would.

A When --

Q And the highlighted portion is all you need read.

A The assumption is made that all patients are potentially infectious. Acceptance of this concept requires anesthesia providers to approach the risk of infection, transmission of organisms, and cross-contamination in a careful, consistent, and logical -- I'm assuming it finishes "manner." It is clearly unacceptable to adopt the practice of standard precautions at one time and disregard it or apply its practices in part at other times.

Q You can go -- go ahead and read it since it's just two paragraphs. Read the entirety of that.

A The unique requirements of decontamination, disinfection, and sterilization for anesthesia equipment, ancillary devices, and accessories requires nurse anesthetists to fully understand and minimize the actual risks present for all parties. Anesthesia equipment mandates specialized attention as to how each product is processed to effectively destroy potentially infectious organism without destroying the integrity, performance, and safety of the product.

Decisions regarding the level of decontamination for

routine disease-specific, or case-specific management are no longer the sole responsibility of one individual. The CRNA in conjunction with all healthcare providers share the responsibility and accountability to ensure the safety of employees, staff, and patients.

Q Is that also part of your policy of the AANA?

A That is correct.

Q Now, I want to move to a section which you -- you said was, I believe, some -- some sort of computer -- it was a thing related to the membership itself or two members specifically?

A Yes, there was --

Q Who --

A -- membership information.

Q -- who were those members that you gave information about?

A Mr. Lakeman and Mr. -- I don't want to pronounce it wrong -- I believe, Mathahs or Mathias.

Q Okay. I'm going to show you a first page -- this is Bates No. 57. Tell us what we're looking at here.

A This is --

Q I need to -- let me move it out so we can try and get the entire document there.

A This is a printout from the prior computer system used by the AANA. I believe it was the WANG [phonetic]

system and the -- it contains various information on Mr. Lakeman's membership with the AANA.

Q So he was an active member?

A Correct.

MR. SANTACROCE: At what time period?

MR. STAUDAHER: We'll get to that.

BY MR. STAUDAHER:

Q I mean, he had been an active member at some point; is that correct?

A That is correct.

Q The next page, Bates No. 58. Do you see this?

A I do.

Q Okay. Can you tell us what this document is?

A This is a printout from the newer, the Aptify system that -- I think it was in 1999 the AANA converted over to to track membership information.

Q So you had two different systems over the course of your organization's life?

A I believe there are substantially more than two, but those are the most two recent, yes.

Q Okay. And do these two capture the time period in question that we were interested in?

A Yes.

Q So this one came from which system again?

A This came from the Aptify system.

Q Now, can you tell us what we're looking at here on this particular --

A This -- it's listed under the orders tab, but what it is is the listing of bills sent out and then payments made with regards to membership. And it identifies the time period of each, and then identifies the individual, in this case Mr. Lakeman, whether or not he was an active member? There's a few classifications. There's active, inactive, retired.

Q So in order to be active what do you have to do?

A To be an active member of the AANA, assuming that you're not a student anesthetist at the time, nurse anesthetist at the time, you need to have completed the national certification exam or successfully have been recertified by the now national board of certification and recertification of nurse anesthetists, and you have to have completed an accredited educational program by the -- at a nursing school accredited by the council on accreditation.

The other requirements of being a nurse anesthetist also include having completed a critical care and then also having your RN.

Q Do you as part -- I mean, in part of your organization you mentioned a journal; is that right?

A Right.

Q Is that something that gets sent out to the

members?

A It does.

Q Do you have other mailings and the like during the course of, you know, a year that gets sent to members and so forth?

A There's newsletters, there's emails, there's various, you know, just advocacy issues or things that might be of interest or note for the membership, so yes.

Q So the information that was contained in the document -- the letter that I had showed you earlier, as well as the accompanying pamphlets, the infection control guy, the code of ethics, all of that kind of thing -- did -- did those items actually make it into -- I mean, some form to get to the -- every one of the members? I mean, as far as either emailed, mailed, both, what? How did you get them out?

A The -- in this instance these were all hard-copy mailed to all members, along with the letter from President Lester.

Q So to be an active member, do you have to continue to give your address information and so forth? I mean, do you have to know where these people are?

A I mean, it certainly helps, yes.

Q Okay. I mean, can you --

A The AANA --

Q -- communicate with them --

A -- does track its members' information.

Q Okay.

A Contact information.

Q And do you -- did you track -- and as a part of your coming here, the locations where Mr. Lakeman had worked in the past, or where he had resided, rather?

A Yes.

Q Did there appear to be any time period in which you weren't able to track him? I mean --

A No, there was an --

Q -- if you lost him or something?

A No, there was an address that was identified in 1999, then there was an address change in 2004, and then one more in 2007 when he moved to, I believe, Georgia.

Q Okay. So the prior address in 2007 before he moved to Georgia was where?

A In Las Vegas. I don't recall the exact address.

Q But it was in Las Vegas?

A Yes.

Q Now, looking at the -- at this section here, the lower-right -- left-hand corner, rather, of Bates No. 58. Can you tell us what we're looking at there as far as those entries? And let me zoom in on those a little bit, just so that they're a little bit bigger for --

A So this just represents basically bills issued

and payments made starting in 1998 and continuing through 2007, showing an active membership. And then in 2008 and 2009 showing an inactive membership.

Q Okay. So at least during this period of 2000 -- and it looks like there was a renewal; is that what this date is?

A That would be the date that the -- I believe it's the payment was received.

Q So you get the money for membership?

A For dues.

Q Okay. So we're talking about July 11, that's when that was received and it shows that he is active?

A Correct.

Q Now, the following year the same -- same month it's now showing he's inactive?

A That -- yes.

Q But if we go back in time to 2002, what is it showing?

A It shows an active membership.

Q So you had his address; he was an active member at that time?

A Correct.

Q When this -- all this mailing went out?

A Correct.

Q Can you say with 100 percent certainty that he

actually got this stuff?

A No.

Q But no -- is there any indication that it was ever returned or bounced back, anything like that?

A No.

Q Now, as far as the code of ethics that I asked you about a moment ago -- and this is Bates No. 22. Let me zoom back out. Can you read those highlighted portions? And this is entitled what? What is the -- what is the section?

A Section 1 is, Responsibility to Patients. Subsection 1.2, The CRNA protects the patient from harm and is an advocate for the patient's welfare. Section 1.4, The CRNA avoids conflicts between his or her personal integrity and the patient's rights. In situations where the CRNA's personal convictions prohibit participation in a particular procedure and the CRNA refuses to participate or withdraws from the case, provided that such refusal or withdrawal does not -- does not harm the patient or constitute a breach of duty.

Section 1.5, The CRNA takes appropriate action to protect patients from healthcare providers who are incompetent, impaired, or engaged in illegal or unethical practice. And Section 1.7, The CRNA does not knowingly engage in deception in any form.

Q Now, the very first page of that document, just so we know which one we're looking at, is entitled, Code of

Ethics, correct?

A That is correct.

Q Now, the last one that I want to go through with you is a document that is entitled Scope and Standards for a Nurse Anesthesia Practice; do you see that?

A Yes.

Q And this is Bates No. 78 for counsel. Now, specifically, Bates No. 80. And these are the standards, correct?

A Correct.

Q If we go to standard 6, can you read that for us?

A Standard 6, There shall be complete, accurate, and timely documentation of pertinent information on the patient's medical record. And then it includes an interpretation, Document all anesthetic interventions and patient responses. Accurate documentation facilitates comprehensive patient care.

Q Okay. And then the last page of that, which is Bates No. 81. And I think there is the section here -- let's just go ahead and start over with section -- Standard 8.

A Standard 8. The highlighted portion reads, Adhere to appropriate safety precautions.

Q And then -- and you can read the whole paragraph. That's fine.

A As established within the institution to minimize the risks of fire, explosion, electrical shock, and equipment malfunction. Document the patient's medical record -- excuse me. Document on the patient's medical record that the anesthesia machine and equipment were checked.

Q Now, the last one here Standard 9, it looks like.

A Standard 9 reads, Precautions shall be taken to minimize the risk of infection to the patient, the CRNA, and other healthcare providers.

Q And again, are those the policies and practices that are disseminated to all members that they're supposed to adhere to, those standards?

A Correct.

Q And at least that was what the standard was back in 2002?

A These are all of the standards that were sent out with the letter from the president.

Q Have those standards appreciably changed since 2002 as far as the things that we went over?

A Regarding those core issues, no.

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

THE COURT: All right.

MR. STAUDAHER: Pass the witness.

THE COURT: Cross?

MR. SANTACROCE: Thank you.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Mr. Silberman.

A Good afternoon, sir.

Q Can you tell me what your position with the AANA is?

A Yes, sir. I am their outside general counsel.

Q Oh, so you're a lawyer?

A Yes, sir.

Q And what does it mean, "outside general counsel"?

A It means I'm not a full-time employee of the AANA, but I am their general counsel. So I am --

Q Are you in a different location than they are located?

A I mean, I work for a law firm, yes.

Q Okay. So you're not physically in the building where the AANA is?

A No.

Q And what -- were you employed as general counsel for the AANA in 2002?

A No.

Q Did you work in any capacity with the AANA in 2002?

A No, sir.

Q This -- do you belong to any professional organizations like the ABA?

A I believe I belong to the Illinois State Bar Association.

Q Do you get a magazine every month from them?

A I do.

Q Do you read everything in it?

A Not everything, no, sir.

Q I want to talk to you a little bit about these exhibits that you were just shown. Starting off with this letter of 2000 -- September 30, 2002. Your organization, as I understand it, is noncompulsory. In other words, a CRNA doesn't have to belong to your organization to be a CRNA?

A That is correct.

Q And your organization is an advisory group, correct -- or an advocacy group?

A That's certainly a component of it, yes. It represents the professional organization.

Q Well, I guess what I'm getting at is, you guys don't establish rules and regulations --

A Correct.

Q -- correct?

A Correct.

Q Okay. This letter went out as a result of a

hepatitis C outbreak where?

A I believe it was in Oklahoma.

Q Okay. And in 2002, correct?

A Yes.

Q And it was set out -- I believe the predicate in there was that there was a widespread misunderstanding; is that correct?

A That is what the document says, yes, sir.

Q And what was that widespread misunderstanding?

A There -- so, I can speak to what the records that I have provided and reviewed show --

Q Sure.

A -- which is in the press release it shows there was differing opinions with regards to the reuse of needles and whether -- amongst all anesthesia providers, and other physicians.

Q Okay. Do you know more specifically what that misunderstanding was? Was it -- I guess, was it contrary to what you set forth in this letter?

A Well, but what was set forth in the letter was the policy of the AANA, which has always been consistent that needles shouldn't be reused.

Q So it was a misunderstanding that CRNAs were reusing needles and syringes?

A I guess I'm not understanding the --

Q Okay. You were trying to set the record straight here, I guess, saying that the AANA policy is what you set forth in the letter?

A Correct.

Q Because CRNAs were doing different types of procedures and had different kinds of policies, correct?

A I don't believe it was just CRNAs. I think there was concerns regarding all anesthesia providers and they wanted -- the AANA wanted there to be clarity.

Q So an anesthesiologist as well as CRNAs were reusing needles and syringes?

A I can't speak to that factually, but I believe that was part of the concern of the outbreak.

Q And reusing propofol on more than one patient?

A I would be speculating.

Q Okay. Well, I mean, there's a basis for this, is there not? The infection in Oklahoma was from some sort of reuse of needles and syringes, wasn't it?

A Again, that's my understanding, but I don't know the full circumstances of that or what drugs were being utilized.

Q Okay. In any event the ANA -- AANA decided to publish this letter and send it out to their members, correct?

A Yes, sir.

Q Of which Mr. Lakeman was a member at the time,

correct?

A That is correct.

Q And I believe we looked at one of these exhibits which showed him to be an active member; is that correct?

A Correct.

Q And this letter would have been sent to where? Where would this letter have been sent?

A I would have to look to see what address was reflected in --

Q Is it not showing --

A 2000 and --

Q -- on your screen there?

A Well, the address that it shows shows 8117 Highlands Drive.

Q And what's the city and state?

A Midland, Georgia. I don't know the -- as I had mentioned, there was two changes in address, and I believe in 2007 it showed a change to Georgia, but prior to 2007 the two addresses that were listed on the system were in Nevada.

Q So in 2002 you sent this advisory letter to Mr. Lakeman in Georgia?

A No, sir. What I'm telling you is the document you just presented --

Q Mm-hmm.

A -- shows the address from 2007. That was what

came up because it was most recent in the system when the document was printed out.

Q Where did --

A But --

Q -- where did you send the letter to Mr. Lakeman?

A Based on the records, I have every reason to believe it would have been sent to the address that was on file in 2002, which was in Nevada.

Q Okay. 2002 in Nevada? So if I represented to you that he didn't start his employment in Nevada until later than that, would you have any reason to dispute that?

A Again, I'd be speculating.

Q But at least your testimony is that you sent this letter to a Nevada address in 2002?

A My testimony is that there is an address that's in the system that was his address in 2002, and it would have been sent to that address, yes, sir.

Q Okay.

A I believe it to be in Nevada, but I don't have that information in front of me.

Q So you can't testify where it was sent?

A Not from memory and certainly not from that screen because that screen shows the address in 2007, which was in Georgia.

Q Now, you were shown some exhibits -- and I want

to get a clarification as to what this means. Standards for office-based anesthesia practices, what does that mean? What's an office-based anesthesia practice?

A As compared to a hospital-based.

Q Okay. So you have hospital-based and office-based?

A Yes, sir.

Q Is that correct?

A Yes.

Q Oh, okay. And what -- what is the distinction? Are there different rules for hospitals and different rules for offices -- office-based practice?

A Again, not wanting to get into clinical differences, as I'm not a nurse anesthetist, but there are distinct things that are reflected in the practices to reflect the environment in which the anesthesia is being administered.

Q Can you give me some specifics?

A Again, I think it's going to depend on the equipment available and it's going to depend on who is involved in the administration of anesthesia. But again, I would also submit that the practice -- or the -- excuse me, the policy would speak for itself.

Q What does this mean -- this sentence mean here, Most office-based practice settings are not regulated. What does that mean?

A To me as an attorney?

Q No, as a spokesman for the AANA -- a spokesperson. A person that's here to testify about it.

MR. STAUDAHER: Actually, Your Honor, I believe he's the custodian of records. Not a spokesperson --

MR. SANTACROCE: Well, the --

THE COURT: Well, as the -- not as an attorney, but as a -- as the custodian of records -- and well, you said PMK also for the association.

THE WITNESS: I guess I just want to be clear that I do not purport and don't want to be offering clinical, medical, you know, professional --

THE COURT: All right. So you --

THE WITNESS: -- guidance.

THE COURT: -- feel that you can't --

THE WITNESS: I wouldn't feel --

THE COURT: -- answer that question?

THE WITNESS: -- comfortable answering that question.

THE COURT: All right. That's fine.

BY MR. SANTACROCE:

Q Were you not designated the person most knowledgeable for the AANA?

A Again --

MR. STAUDAHER: Your Honor, I'm going to object. That doesn't have to do with office medical-based practice.

It's the organization itself that --

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

BY MR. SANTACROCE:

Q Sir, would you read that sentence for me beginning with most?

A Certainly, sir. Most office-based practice settings are not regulated; therefore, the CRNA should consider the benefit of uniform professional standards regarding practitioner qualifications, training, equipment, facilities, and policies that ensure the safety of the patient during operative and anesthesia procedures in the office setting.

Q And is it your testimony today that you don't know what that, Most office-based practices are not regulated, means?

A I don't -- I can offer you my opinion as an attorney and as a healthcare regulator, but not as --

Q Not --

THE COURT: No, we have enough --

THE WITNESS: -- a nurse anesthetist.

THE COURT: -- attorneys already.

BY MR. SANTACROCE:

Q We have -- yeah.

A I didn't -- sorry.

Q Don't need more attorney opinions. The answer is no, you don't know?

A Correct.

Q Now, after this September 30th letter went out to the membership, was there a survey conducted in November of 2002 trying to ascertain whether there was compliance with this directive?

A Again, I -- there was a survey conducted in -- later in 2002 that I believe accompanied the press release that I provided.

Q And that would be Exhibit 224; is that correct?

A Correct.

Q Showing you Exhibit 224. Is that it?

A That is the press release, and then I believe the documents behind it relate to the survey.

Q All right. Well, let's talk about this survey that was conducted after your letter of September 30, 2002. Can you tell me what the purpose of the survey was?

A And again, I believe the document speaks for itself, but the survey was to reach out to different healthcare providers to ascertain whether or not there were issues with regards to the reuse of needles or syringes.

Q And do you know what that study found?

A I would have to look at the survey to be able to -- I could generally speak to it, but --

Q Well, let's take a look at it and see what it says. Starting with this paragraph and this sentence, would you read this?

A Can I just ask you to pull it out a little so I can see the whole --

Q Let me --

A Perfect. Thank you, sir. The survey also suggests that the reuse of a needle and/or syringe on the same patient is somewhat of a gray area for healthcare providers. 31 percent of the survey respondents who use -- who only use needles and syringes indicated that they reuse on the same patient. The percentage jumps to 35 percent when taking into account providers using needleless systems in which the -- in which case the syringe would be reused on the same patient.

Discussions among healthcare professionals about the appropriateness of reuse with needleless systems is ongoing.

Q So even after your 2002 letter, the survey found that it was still a gray area among providers, correct?

A I believe the survey was taking place at the same time the letter was sent out, and the results were published in November.

Q Okay. And what can you point to to help me appreciate that point?

A That was my understanding as I looked into the circumstance to identify the documents and the background

thereof.

Q And what specifically did you look into to identify that?

A I spoke to the senior staff, I spoke to the CEO and executive director of the AANA and to the head of our program staff, who assisted me in originally identifying the documents responsive to the subpoena we received.

Q So other than that hearsay testimony, did you look at anything? Did you look at anything that actually said that?

A Well, I looked at the documents that you're holding and that I believe -- they accompanied the survey -- or excuse me, the press release which was issued in November, and presumably the survey itself had to precede the issuance of the results. So, I guess I'm making an assumption.

Q Okay. Well, we don't want you to make any assumptions unless you can support it, okay?

Pointing out this paragraph here. Could you start from the quoted paragraph?

A Beginning with, In the?

Q Yeah.

A In the anesthesia field alone, Lester said 3 percent of physician anesthesiologists and 1 percent of CRNAs amounts to roughly 750 anesthesiologists and 250 nurse anesthetists, or a total of 1,000 providers. That is 1,000

too many.

Q Okay. And do you know what those 750 anesthesiologists were doing?

A I believe that was the percentage applied to the number of practitioners to yield how many people were utilizing or reusing needles.

Q And this was after the 2002 letter, correct?

MR. STAUDAHER: Objection, Your Honor.

BY MR. SANTACROCE:

Q At least the publication --

MR. STAUDAHER: That's not his testimony.

BY MR. SANTACROCE:

Q -- of it?

A It's reflected in the November press release.

Q 750 -- and how many people were surveyed?

A Again, I would have to look back to the document itself. I want to say I believe it was at 1,000, but I don't want to be incorrect. I believe it was contained in the cover letter.

Q Well, do you want to take a look --

A If I could.

Q -- at the cover letter? Sure.

A It does not say in the cover letter, but I believe it might have been part of -- here's the methodology: There were 500 telephone phone interviews.

Q Okay. Let's look at some of that methodology. Well, let's go to the key findings, first of all, and then we'll look at the methodology. Key findings, okay? The first bullet point, what was some of the key findings there?

A Needle or syringe use is more prevalent practice among --

Q Reuse, isn't it?

A -- excuse me. My apologies. Needle or syringe reuse is a more prevalent practice among healthcare providers overall than may have been expected. Self-reported data -- excuse me, did you want me to keep reading? Self-reported data illustrates that needle/syringe reuse is most prevalent among anesthesiologists, 40 --

Q How many percent?

A -- 42 percent.

Q So nearly half of all anesthesiologists -- that is, M.D.s -- are reusing needles and syringes, correct?

A Yeah, I believe that was the result of the study -- or of the telephone, I -- or of the survey.

Q Okay. Go on.

A Somewhat less prevalent among nurse anesthetists.

Q And we would know them as CRNAs?

A Yes, sir.

(Off-record colloquy.)

BY MR. SANTACROCE:

Q What was the percentage of CRNAs that were reusing needles and syringes?

A Again related to this survey, 18 percent.

Q So you have nearly half of the M.D. anesthesiologists reusing, but only 18 percent of CRNAs; is that what the survey said?

MR. STAUDAHER: And, Your Honor, of the sample that he said, I would object to it if he says, "all" anesthesiologists. He said --

BY MR. SANTACROCE:

Q And when I say "all," I'm talking about the sample survey.

A That --

Q My comments are related to the survey, okay? Just so we understand.

A And, yes, then we're on the same page. That is what the survey showed.

Q Okay. And then it goes on to talk about oral surgeons, 15 percent, and then less common among nurses, correct?

A Yes, sir.

Q Now, go on to the third bullet point and remembering that this was a key finding in the survey. The third bullet point?

A Many respondents believe that reusing needles/syringes is an acceptable practice under certain circumstances, and they wanted a chance to explain the nature of those circumstances. The most common instances involve same-patient dosing, intravenous or IV tubing and emergency situations.

Q Okay. Was there a problem with IV tubing? Was there a outbreak of hep C that you're aware of due to IV tubing?

A I couldn't speak to that, sir, no.

Q Okay. And then the last bullet point again, key findings of the survey. You can read the last bullet point.

A Although same patient needle/syringe reuse is estimated to be fairly high, ranging from 9 percent to 56 percent by provider type, the estimation of reusing the same needle/syringe on multiple patients ranges from 0 percent to 3 percent by provider type.

Q Okay. So it was a common practice to reuse needle and syringes on the same patient, correct? According to the key points?

A I don't know if I would describe it as a common practice, but --

Q Of course not --

A -- I mean, the numbers --

Q -- you're a lawyer --

A -- are what they are.

Q -- you wouldn't do that. But go ahead.

A Well, I mean, I believe the survey showed 18 percent reporting amongst CRNAs that were interviewed and 42 percent amongst M.D. anesthesiologists that were interviewed.

Q Okay. Is that not a fairly significant number to you?

A Again, I think it was sufficiently significant that that's why the press release and the letter was sent out.

Q Now, let's take a look at some of the methodology. Well, I guess this next portion are just charts to substantiate the figures that we just read, or is there something different in there?

A To my knowledge, they simply are slides that break down the results.

Q Okay. And regarding this slide, if you would just read this part -- this first sentence here?

A Overall, respondents were asked if they themselves ever reused needles or syringes to administer medications.

Q Next sentence.

A One might find it surprising that 42 percent of anesthesiologists admit to the practice of reusing needles or syringes.

Q Do you find it surprising?

A You're asking my personal opinion?

Q No.

MR. STAUDAHER: Objection, Your Honor.

THE COURT: Yeah, that's sustained.

BY MR. SANTACROCE:

Q Again, some more data from the survey. Could you read that paragraph?

A The question of whether there are any circumstances when it is acceptable to reuse needles or syringes is a rather polarizing one.

Q What does "polarizing" mean?

A There's a split.

Q Okay.

A Only 15 percent of nurses stated that there are circumstances when it is acceptable, but significantly more physicians, CRNAs, oral surgeons, and anesthesiologists believe there are circumstances of acceptability with the highest being anesthesiologists. 65 percent of anesthesiologists responded that there are instances when it is acceptable to reuse needles or syringes.

Q Some more data. Could you read this paragraph?

A Significantly more than any other healthcare providers, anesthesiologists believe the reuse of needles or syringes is an acceptable practice. 51 percent of the anesthesiologists who responded to the survey believe reuse is

an acceptable practice. Oral surgeons, CRNAs, and other physicians are all in the range of approximately one-fourth who believe reuse is acceptable. Among nurses only 11 percent think reuse is acceptable.

Q Apparently nurses got your memo but anesthesiologists didn't.

THE COURT: I don't think you need to respond to that.

BY MR. SANTACROCE:

Q And then, finally, the last bit of data that we have on these charts, could you read that paragraph? Let me --

A The chart above displays responses to the question of whether the healthcare provider surveyed would allow another healthcare provider to reuse a needle or syringe on themselves or a family member. The responses correlate closely to responses previously discussed about one -- excuse me -- about whether one apparent -- one -- excuse me. About whether one believes that reuse of needles or syringes is an acceptable practice.

Apparently, if a healthcare provider truly believes that reusing needles or syringes is acceptable, he/she would not be concerned about treating -- about being treated this way or having a family member treated this way.

Q I got all these exhibits out of order, so I'm

scrambling to find them. Sorry.

A Not a problem.

Q Sorry for the delay. You'll still be able to make your plane.

We're going to look at the Infection Control Guide, Exhibit 223 for a minute, okay? Talked a little bit about some of those things in there. I don't know if you're going to be able to answer this for me. It says that the potential for infection and transmission of microorganisms exist during the administration of drug therapy. Instructions for preparation, storage, administration of all pharmaceutical agents provided by each manufacturer should be read and followed. Drug administration by injection offers many opportunities for contamination.

Then it goes on to say, These include previously used needles/syringe, drug administration sets, intravenous tubings, and fluid containers.

My question is what is a drug administration set?

A I --

Q I know, you're a lawyer. Okay. I'll take that as you don't know.

A I would not feel comfortable answering that.

Q Okay. And the same with intravenous tubing?

A I would feel comfortable that intravenous tubing is just that, intravenous tubing.

Q Okay. Are you familiar with heplocks?

A I am not, sir.

Q Again, we're referring to the infection control guide; do you see that?

A Yes, sir.

Q I'm referring to Bates Stamp 000036, bullet -- or paragraph No. 2. Is that on your screen?

A It is not, sir. Yes, sir.

Q Is it now?

A Yes, sir.

Q Can you read that for me?

A I believe I read this before but, Multiple-dose vials should be limited to a single-patient use unless strict aseptic techniques is used and a new sterile syringe and access device are used each time the vial is penetrated. The danger of cross-contamination from multiple-dose vials used for more than one patient must be weighed against any cost savings.

Q Maybe I'm misunderstanding, but didn't your 2002 directive say, can't use multi-dose vials?

A Not that you can't use multi-dose vials for the same patient, utilizing and reusing the same syringe and needle.

Q Okay. It says, Should be limited to single-patient use unless strict aseptic technique is used,

correct?

A Correct.

Q So you can use multi-dose vials?

A Utilizing a new needle each time and a new syringe.

Q So as long as you have aseptic practices?

A That's what the -- that's what the, excuse me, Standard 2 says.

Q And that's not contrary to the 2002 letter?

A I don't believe it is, no.

Q Okay. So is it the AANA guidelines that multi-use vials or multi-dose vials are okay to be used as long as aseptic practices are employed?

MR. STAUDAHER: Objection.

THE WITNESS: Well, I mean, the --

MR. STAUDAHER: Mischaracterizes his testimony, Your Honor.

THE COURT: Well, I think --

THE WITNESS: The procedure --

THE COURT: -- he --

THE WITNESS: -- speaks for itself. It -- what it says, It should be limited to single pace [sic] use unless a strict aseptic technique is used and a new sterile syringe and access device are used each time the vial is penetrated. So it's not just the aseptic technique, but it's also using a new

syringe and using a new needle.

BY MR. SANTACROCE:

Q Okay. But the vial can be reentered?

A Again, in accordance with that policy, yes.

Q Okay. In your practice do you find that the -- the practice of reusing needles and syringes still goes on today? Do you receive reports on that?

A I just want to clarify, you're asking for information I have through the AANA or in my practice?

Q AANA.

A Okay.

Q Not your practice. I'm sorry.

THE COURT: It's unusual we get to pick on a lawyer.

THE WITNESS: And I will stipulate to its being appropriate, so...

BY MR. SANTACROCE:

Q But you are slippery, guy, I give you that.

A The -- I am not aware of any regular complaints that have been brought to the AANA recently regarding the reuse of needles.

Q Okay. Do you get reports from the CDC on a periodic basis?

A I believe the AANA does, yes.

Q Okay. Would you be surprised to know the CDC, even after this Las Vegas outbreak, conducted studies where

they found that the -- that the reuse of needles and syringes was still going on in at least three different states?

MR. STAUDAHER: Objection, Your Honor. Outside the scope of this witness's --

THE COURT: Yeah, it's sustained.

BY MR. SANTACROCE:

Q Would the AANA as a person most knowledgeable be surprised to know that?

THE COURT: Well --

MR. STAUDAHER: Objection, Your Honor. Same objection.

THE COURT: -- the same thing.

BY MR. SANTACROCE:

Q Do you receive any information or updates from the CDC as to whether the policies that you have initiated are being followed? When I say "you" --

A I don't believe -- I don't believe the -- I don't believe the -- I don't believe the CDC tracks compliance with the AANA policy, but the AANA policy is consistent with CDC guidelines; if that answers your question.

Q Okay. And you're sure about that?

A I believe that to be the case. I believe it's incorporated, but --

Q Well --

A -- I don't have the current policy in front of

me.

Q -- you know the passage we just used about the needles and syringes in vials -- you -- well, first of all, do you know what the CDC current policy is?

A I do not offhand.

Q Okay. Well, forget it, then.

I think that's all I have. Thank you, sir.

A Thank you, sir.

THE COURT: All right. Ms. Stanish?

CROSS-EXAMINATION

BY MS. STANISH:

Q Good afternoon.

A Good afternoon.

Q I won't be long. Without rehashing what Mr. Santacroce just reviewed with you am I correct in understanding that in 2002, according to the AANA they identified a misunder -- a widespread misunderstanding amongst healthcare practitioners regarding the misuse of needles and syringes, correct?

A That was the concern, yes.

Q And then it appears that with -- through these surveys that were discussed a moment ago it's a either a difference of opinion or a continued misunderstanding, correct?

A I don't know that the survey wasn't part of

the --

Q Okay.

A -- what led to the concern, but --

Q Let me -- Mr. Santacroce had asked you if you were aware of the most recent CDC guidelines -- I'll call them refinements of guidelines -- that deal with the single use of a syringe, the single use of a vial and no multidosing, one time only, one patient, throw everything away. Are you familiar with that?

A I'm familiar with the general policy, but not the specifics.

Q Are you involved in -- in drafting any of the position or policy statements of the AANA?

A I am, but to be clear, looking at it from a legal and regulatory perspective, not from a healthcare administration or delivery perspective.

Q I'm going to show you this document from the AANA. Is it double A, N-A; is that what you say?

A American Association -- AANA.

Q You don't say, like, AANA?

A Nope.

Q All right. If you would just read this to yourself so that we can discuss that.

A Do you want me to read the entire document or just the highlighted portions?

Q Just whatever you feel comfortable so that you get a handle on what this is about.

A (Witness complied.)

Q Are you familiar with this 2009 policy of the AANA?

A Not to be a lawyer, but I'd -- it was a position statement, not a policy. So it was just a statement reflecting what the current position state was -- position was regarding the safe practices of needles and syringes.

Q What?

A That's a -- there -- simply put, it's just there are things that are labeled policies as, you know, it said the infection control policy. This is identified a position -- as a position statement. So...

Q How you guys take a stand on something? Is that what "position" means?

A Making it clear what the position of the AANA is.

Q This document was prepared in -- what's the date on that?

A The first page of the document shows it in 2009.

Q And am I -- the -- describe for the jury what this position of AANA is.

A It reflects the position of the AANA on the safe practices for needles and syringes, and it reflects the fact

that the -- I mean, if I can --

Q Let me do this.

MS. STANISH: Your Honor, may I just mark this and throw it into evidence so that we can display it and chat about it?

THE COURT: Any objection?

MR. STAUDAHER: No, Your Honor.

THE COURT: All right. Go ahead.

MS. STANISH: Okay. I'll -- it has my highlights on it, but I'll replace it.

THE COURT: Okay. Well, we'll send a clean copy back to the jury, but for --

MS. STANISH: Okie-doke.

THE COURT: -- purposes of right now --

MS. STANISH: Thank you.

THE COURT: -- go ahead and mark that. You can use your highlighted version.

MS. STANISH: Pardon me?

THE CLERK: [Inaudible.]

MS. STANISH: Yes.

THE COURT: It will be next in order.

MS. STANISH: Yes.

THE COURT: Which would be what?

THE CLERK: P1.

THE COURT: P1.

(Defendant's Exhibit P1 admitted.)

BY MS. STANISH:

Q Can you read that?

A I can.

Q Okay. Fair statement that this 2009 document was prepared because of continued -- the -- well, because of this case; can you tell?

A I would not make that representation. It does make reference to the fact that it was to the events that had occurred over the last 10 years, so from 1999 to 2009.

Q So not only this case but 32 other cases in the last 10 years, correct?

A The document does reference 33 outbreaks, yes.

Q And what the 2000 -- what this document does is this position statement further emphasizes or clarifies this, Never administer medication from the same syringe to multiple patients even if the needle is changed. Now, we've already -- did this show to you, to the AANA, that there is continued misunderstanding about reusing a syringe once you put a new needle on it?

MR. STAUDAHER: Objection. Speculation unless he knows.

BY MS. STANISH:

Q Unless you know.

THE COURT: Right. I have a feeling he's not going

to engage in rampant speculation.

THE WITNESS: Yeah, I mean, I'm not inclined to.

THE COURT: I knew that. I knew that about you.

THE WITNESS: Thank you.

BY MS. STANISH:

Q And that's why they sent the lawyer instead of a CRNA or maybe this Mr. Lester who sent this letter in 2002, correct?

THE COURT: So if you can answer the question whether or not this was in response to widespread -- I don't remember Ms. Stanish's word.

MS. STANISH: Well, it sounded like he said he didn't have knowledge, so I moved on to the next question.

THE WITNESS: Well --

THE COURT: Right.

THE WITNESS: -- I mean, my response to the widespread issue was that it referenced 33 outbreaks over the course of the 10 years preceding.

BY MS. STANISH:

Q All right. All right. When Mr. Lester sent his letter out in 2002 reminding those CNRs [sic] who got the letter that this is how we're refining the reuse of needles and syringes. The standard of care didn't change on September 30, 2002, did it?

MR. STAUDAHER: Objection. Outside the scope of his

knowledge about standard care changes.

MS. STANISH: Let me rephrase it.

THE COURT: Yeah, rephrase it.

BY MS. STANISH:

Q You wouldn't have had -- AANA wouldn't keep having to send out these kind of position papers in -- if the standard of care had changed in September 2002.

A To be clear, I think you're misrepresenting. This -- this -- the document reflected what the policies were of the AANA, and therefore they put out the fact that the position of the AANA was, not to reuse needles. I mean, that's what the documents --

Q And he -- you can -- the AANA has to -- has continued to try to emphasize and refine its policies because in the past we have seen that there's at least a disagreement or a misunderstanding about what is appropriate and what is not.

MR. STAUDAHER: Is there an --

THE COURT: Is that a --

MR. STAUDAHER: -- an outright question?

THE COURT: -- question?

THE WITNESS: Yeah, I --

BY MS. STANISH:

Q Correct?

A -- I think the issue is that there seems to be

behavior that isn't consistent with what the AANA position was and therefore they continue to reiterate and clarify their position.

Q They reiterate it and they refine it, correct?

A Based on new information, correct.

Q And this was new information, the new information being that people are still misunderstanding the reuse of syringes with new needles on it.

MR. STAUDAHER: Objection. Speculation.

THE WITNESS: I can't speak to what other people are or are not misunderstanding.

BY MS. STANISH:

Q If I told you that we had testimony in this courtroom for I don't know how long now that there -- CRNAs to this day are still using multi -- or single-use vials, 50 milliliter-use vials to prefill syringes and use them on multiple patients. Would that be a violation of the AANA policy?

A Would the multiple use of a single-use item -- that would be inconsistent with the AANA policy.

Q And do -- the AANA, has it done any further surveys since that one in 2002 that you're aware of?

A Not to my knowledge.

Q Okay. You weren't at the AANA in 2002?

A I was not.

Q You really wouldn't have an indication one way or the other whether Mr. Lakeman's letter was returned to the mail room at the AANA in 2002?

A No, my only comment was based on the fact that anytime there's an identified issue with regards to an address, it's then updated in the system, and there was nothing in the system that indicated an update in the address during that time.

Q So you're the custodian of records, not the mail boy in 2002?

A I'm not claiming to be either in 2002.

MS. STANISH: All right. I have nothing further.

THE COURT: Any redirect?

MR. STAUDAHER: Just -- just two. Oh, could I have that? Thanks.

REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q This position statement -- now, the other document we had, Bates No. 1, this was a letter sent out to the entire membership, correct?

A Correct.

Q And it was because of -- I think you said because of that outbreak, this specific letter with all the policies was sent to everyone?

A Correct.

Q Mr. Lester here, I mean, is he still with the organization?

A I'm embarrassed to say I don't know. He's a former president. I have not formally met him. I --

Q So he's not sitting there --

A -- I did not look at his membership information.

Q -- so he's not sitting there when you go to visit the AANA?

A No, he's certainly not a current board member or has not been in the last few years.

Q This -- this one here, the one that Ms. Stanish showed you and it's entitled Position Statement, does it indicate here that this is like some sort of an emergency letter or anything sent out?

A No.

Q Or it's just the position -- position of the AANA?

A Correct, it's a position statement.

Q Now, you were asked some questions again on cross regarding Mr. Lakeman getting sort of the notification of those documents that we have been talking about up to this point, correct?

A Yes, sir.

Q I don't know if you have -- do you have anything with you or anything you can reference or did reference to

find out whether or not he was -- I mean, there was any problem at all with his address when these things were sent out?

A I looked at a screen shot that had changes of address, and that was what I was testifying regards -- that with regards to Mr. Lakeman there was in 2004 a change of address, and then again in 2007 the address -- the move to Georgia.

Q So in 2004 there was a change of address, and then 2007 there was a change of address?

A Correct. That was what the -- again, when I say a screen shot, when you go on the computer you can print out what you're seeing on there, so I printed that out.

Q But you didn't have anything about a change of address around 2002 that was an issue?

A No. The only changes of address -- there was two on the same day, which appeared to be -- speculating, on a correction of a typo because it started with two numbers and then corrected the address in 2004, and then a change in 2007 to Georgia.

Q But again, nothing --

A Nothing.

Q -- in 2002?

A No changes in that time, no.

MR. STAUDAHER: Nothing further, Your Honor.

THE COURT: Mr. Santacroce?

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q Perhaps I misunderstood you when I asked you the question about the address changes. I thought you said 2002; was I mistaken?

A There was a change in 2004 and then a change in 2007.

Q And again, what were you referring to?

A There's -- when you go onto the Aptify system, there's actually a -- a tab that I think is called addresses, or address history, and I clicked on that.

Q So address changes in 2004 and 2007?

A I believe that's correct.

Q And a letter was sent out in 2002?

A Correct.

Q And do you know what address it was sent to?

A I can go back to the printout I got to -- again, the address that it would have been sent to in 2002 would have been the address that preceded the change in 2004.

Q Okay. And I'm asking you what address that was. Do you have any knowledge of that?

THE COURT: Do you have that address of whatever address was on file in 2002?

THE WITNESS: I think I have a copy of the screen

shot, I can --

BY MR. SANTACROCE:

Q Sure.

A -- if everyone's okay?

MR. STAUDAHER: Yeah.

THE WITNESS: Okay. How do you want me to -- or do you want me to just testify from it?

THE COURT: No. No. Mr. Santacroce will walk up and take a look at whatever it is you have.

BY MR. SANTACROCE:

Q Let me show it to my colleagues too.

A And if you -- if -- okay, I'll show you what --

Q Yeah.

A -- is -- you have here the address. This is the date, so this October 1999 would have been when the system was converted over, and then it shows -- this was what I was pointing out. In 2004 there's a reference to 63 Goody, but then it's corrected to 6381 on the same day. So that's what led me to believe it was a typo. And then there was a change in 2007. That was the Georgia change.

MR. WRIGHT: What did they say?

MR. SANTACROCE: Let me show my colleagues.

MS. STANISH: Yeah. What happened up there?

MR. SANTACROCE: He was explaining what this was here. We'll let him explain to the jury.

THE COURT: Well, if you're --

MR. SANTACROCE: We're not hiding --

THE COURT: -- going to use it --

MR. SANTACROCE: -- anything.

THE COURT: -- yes, Mr. Santacroce.

MR. SANTACROCE: What's that?

THE COURT: I said if you're going to use it, yes, he will --

MR. SANTACROCE: Well, no, I just want to --

THE COURT: -- he will --

MR. SANTACROCE: -- clear it up.

THE COURT: -- that's fine. I mean --

MR. SANTACROCE: And I don't want the jury to think that we're hiding the ball or anything here.

BY MR. SANTACROCE:

Q So let's just -- why don't you explain to the jury what this is, if the -- if the State doesn't mind?

MR. STAUDAHER: No, he can admit it as far as I'm concerned.

THE WITNESS: The only thing I could ask you to do is if you could scoot it over a little so I can, I guess, use this touch feature.

So starting off in -- in this column here there's a date in October of 1999, and I believe that was when the conversion over from the prior system took place, and the

address that it shows there is No. 3 Mallard Court. There was a change here at -- and -- oh, goodness, in -- on May 3rd of 2004 that switched to 6361 Goody Court.

When I referenced that I thought there was a type. It was because 63 Goody Court was entered in, and then that same day it was changed to 6361.

BY MR. SANTACROCE:

Q What was the "Oh, goodness" that you just said?

A Just the arrow popped up. Sorry.

Q Oh, I didn't know if there was something --

A No. No.

Q -- there was a revelation here I should know about.

A And then, finally, if you'll look in 2007, that was when the address that you and I spoke about earlier, Highlands Drive, which I believe to be in Georgia. And so with regards to your prior questioning, nothing would have been sent to that Highlands Drive address in 2007 -- or excuse me, 2002, because that address didn't go on file until 2007.

Q Okay. So --

MR. SANTACROCE: -- go ahead, Your Honor.

THE COURT: Oh, I was just going to say, so the 2002 address would have been the Mallard Court address?

THE WITNESS: Correct.

THE COURT: Okay.

BY MR. SANTACROCE:

Q Okay. Now -- so I'm asking you where -- do you know where the letter was sent? Do you have personal knowledge --

A No, I do not have personal knowledge --

Q -- okay.

A -- of to where it was sent.

THE COURT: Do you want that marked as an exhibit?

MR. STAUDAHER: Yeah, I'll stipulate to its admission. That's fine.

MR. SANTACROCE: Great.

MR. STAUDAHER: If we can have it.

MR. SANTACROCE: Should I just mark it?

THE COURT: Well, we've already shown it to them so --

THE CLERK: B3.

THE COURT: -- it will be B3 -- no, that's wrong.

BY MR. SANTACROCE:

Q Do you want it back?

A I am fine without it.

Q We can make you a copy.

THE COURT: I'm sure -- you can just access that again --

THE WITNESS: Correct.

THE COURT: -- if you wanted to off the computer.

MR. SANTACROCE: I have nothing further.

THE COURT: Oh, I know. There was some confusion. I need to make sure that the clerks are marking the exhibits consistently. It's supposed to be letter designation and then the No. 1 for Dr. Desai and letter designation and the No. 2 for Lakeman exhibits.

MR. STAUDAHER: Your Honor, we could just make it a State's Exhibit, if that would be easier.

THE COURT: See, it should be C2.

(Defendant's Exhibit C2 admitted.)

THE COURT: Any other questions from the State?

MR. STAUDAHER: No, Your Honor.

THE COURT: Any juror -- any juror questions for this witness?

All right. Sir, there being no further questions, thank you for your testimony and you are excused.

THE WITNESS: Thank you, Your Honor.

THE COURT: All right. And, ladies and gentlemen, we're going to go ahead and take our afternoon recess until about 3:30.

During the afternoon recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case and any person or subject matter relating to the case. Don't

do any independent research, and please don't form or express an opinion on the trial.

Notepads in your chairs. Follow the Marshal.

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

THE COURT: Nemec for the rest of the day?

MS. WECKERLY: Yes. Well, he's the only one else -- he's all we have.

THE COURT: Now, he may have to come back. I mean, I don't know that we'll finish with him, but we're ending at 5, so -- you know, if it's 5:05 or 5:10 --

MS. WECKERLY: Right.

THE COURT: -- or something it's fine, but --

MS. WECKERLY: Well, I'll let the Defense tell him that.

(Court recessed at 3:18 p.m., until 3:35 p.m.)

(In the presence of the jury.)

MR. STAUDAHER: Would you like me to get the witness, Your Honor?

THE COURT: Oh, please.

THE MARSHAL: Thank you. Everybody may be seated.

THE COURT: All right. Court is now back in session. And Mr. Staudaher, I believe, is getting the next witness.

THE MARSHAL: I'm going to yell at him for doing my job.

THE COURT: And then just please remain standing,

facing that lady right there.

FRANK NEMEC, STATE'S WITNESS, SWORN

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

THE WITNESS: Frank Nemec, N-E-M-E-C.

THE CLERK: Thank you.

THE COURT: All right. Thank you.

Ms. Weckerly?

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Sir, how are you employed?

A I'm a gastroenterologist.

Q And can you explain to the members of the jury your educational background that allows you to work as a gastroenterologist?

A I did my undergraduate work at the University of California Berkeley, studied bacteriology and immunology. Then I went to the UCLA School of Medicine. And after that an internship at USC and a residency and fellowship at University of California Davis.

Q And when did you start practicing in Las Vegas?

A 1984.

Q And in 1984 did you have your own practice, or were you with other partners?

A I was initially in solo practice.

Q And are you in solo practice now?

A No, I'm in a group with three other doctors.

Q Okay. And so you've been practicing as a gastroenterologist since 1984 until now?

A That is correct.

Q Can you describe for the members of the jury the process you go through when you perform an upper endoscopy on a patient?

A Well, first we have the patient give informed consent where we tell them the risks, the benefits, and the alternatives to upper endoscopy. They're then brought to the -- usually an ambulatory surgical center, which is an outpatient facility. They're kept NPO, meaning nothing by mouth, and then they're put on a gurney. An intravenous line is then placed by a nurse. The patient is then wheeled into the examining room. They're hooked up to monitors so we can look at their oxygen saturation and their respirations and their heart rate.

The patient is placed on their left side. The patient is given a light anesthetic, usually propofol. The upper endoscope is then introduced past the throat and down to the esophagus, into the stomach and up -- down into the duodenum. The scope is then removed and at that time we do the inspection, looking at the bulb and second portion of the duodenum, the antrum in the stomach; a retroflexion maneuver

is performed so it can look at the cardia fundus of the stomach and then look at the esophagus and vocal cords.

Q And typically what are -- what are you looking for in terms of, like, disease for an upper endoscopy?

A Ulcerations, esophagitis, inflammation, polyps.

Q All those. And biopsies are taken in some instances?

A If abnormalities are seen, yes.

Q And that -- the procedure from -- from introduction of the -- the instrument until it's removed, how long does a typical endoscopy -- upper endoscopy --

A About four or five minutes.

Q You also perform colonoscopies, I assume, in your practice?

A That's correct.

Q And can you briefly describe what the process is for that procedure?

A Well, the initial part is similar. The patient is given informed consent; intravenous line is put in. They previously had a bowel preparation the night before where they're given, you know, GoLytely or MiraLax to help clean out their gastrointestinal tract. They're brought into the examining room, again on the left side. A digital rectal examination is performed. An anesthetic is usually given before the rectal examination unless we're concerned about the

inadequacy of a preparation, in which case we would do the rectal examination before the sedation.

After the sedation is complete, we introduce the scope. It's advanced under fiber optic guidance up into the cecum, which is the upper part of the colon. We identify specific landmarks including the appendix -- excuse me, the appendiceal orifice, and the ileocecal valve.

And then with the removal of the instrument, look at the cecum, ascending colon, transverse colon, descending colon, sigmoid colon, and rectum. At the end of the procedure a retroflexion maneuver is performed so we can look at the back side of the rectum that ordinarily is not visible upon introduction of the instrument.

Q Now, is there any -- are there any professional standards or recommendations about how long either of these procedures are supposed to take?

A The only benchmark is the colon withdraw time. A paper was published by Doug Rex from University of Indiana, I think it was in 2002, where he specified that a colon withdraw time, an average of between 6 and 10 minutes optimizes the ability to detect adenomatous polyps of the colon.

Q And is that generally accepted or is that, like, a debatable topic in the field?

A I think there is some debate about -- about it.

I think probably a more important metric to determining whether or not you've got a quality colonoscopy program is the adenomatous polyp detection rate, looking for adenomatous polyps of at least 15 percent of men and 25 percent of women.

Q Would you say, though, there's any correlation between the amount of time taken during a procedure and the discovery of disease or -- or other issues?

A Well, that's what Dr. Rex found is that there was a correlation between the scope withdraw time and the ability to identify these polyps.

Q In your -- you have a gastroenterology practice, correct?

A Yes, ma'am.

Q How many colonoscopies could you perform in an hours' time?

A Probably two to three.

Q And are -- is there -- I assume there's a turnover time for the procedure rooms?

A Let me just clarify that. If I was confined to one examining room, it would be two to three. I think it's possible to do three or four an hour if you had two different examining rooms at -- at your disposal.

Q Okay. And that would include, like, the -- the turnover time for the room?

A Well, one room could be turned over while

minutes -- should you bill 15, you know, for -- the one unit for 15 or does it go to 2, but it's closer to 15. So I think of it that way.

Q You don't think like most people. This is complicated. Let me -- if I understand what you're saying, we're saying if we -- we start off with, let's just assume a colonoscopy is 5, and I think we have -- well, I don't know what we have yet. From 0 to 5 -- 15 you would add how many units?

A One.

Q And from 16 to -- oh, I didn't do that right. From 16 to 30, what would you add?

A If the procedure was 18 minutes --

Q Right.

A -- it would be 1.

Q I thought 0 to 15 was 1?

A It's 15-minute increments, but if -- if the procedure is 18 minutes, that extra 3 minutes is not enough to get you to the second unit.

Q Well, if I'm -- so you're saying if I'm between 16 and 30 minutes --

A No, I didn't say that.

Q Okay. Go ahead, explain to me again. I didn't get it.

A That's why I was saying I don't think that way.

Q Okay. Well, let me do it this way: Let me just give you a time and maybe you can walk us through it. Let's say I have a procedure that lasts 12 minutes, and I don't have a -- a modifier, okay? Let's keep it simple. There's no, like, somebody with a cardiac problem that I'm going to have to add some kind of patient modifier, okay? So just the colonoscopy and it lasts 12 minutes, what's my bottom line?

A One.

Q All right. It's only one unit?

A Because it -- it falls the closest to 15 minutes, you know, for one.

Q Would you add -- would you add that to five units -- the base?

A Yes.

Q Okay. That's where I was disconnecting with you. So --

A Oh, okay.

Q -- what I -- what you're saying is we have a bit of a formula. You do a colonoscopy, you get five units automatically; is that correct?

A I'm not familiar with what the base unit is for colonoscopy. I did not research that.

Q Okay. Well, just for purposes of this discussion, let's assume it's five.

A Okay.

Q And assuming it's five. What I understand you to say is you take the base unit and you add the time units. And so if I have a procedure that's between 0 and 15, I get another point for a total of 6 units, correct?

A Yes.

Q And then, if I have a procedure that is between 16 and 30 minutes how many more points do I get?

A It depends on the total minutes.

Q Okay.

A Not a differentiation on the 16 to 30 or the 31 to 45.

Q Okay. Well, let's say, then -- let's say I have a procedure that's 18 minutes; how many points should I get?

A One.

Q One point?

A CMS says for anesthesia services furnished after January 1, 1994 -- this is CMS transmittal 1324.

Q Mm-hmm.

A For anesthesia services furnished on or after January 1, 1994, carriers compute time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place.

Q What does that mean?

A Well, that means if it were 18 units, you know, you divide that by 15, that gives you 1 unit, and you could

only go to one decimal place so it's still just 1 unit because it would be 1.0 whatever.

THE COURT: So if it's 1.5 or higher you round up, and if it's -- is it that rule we learned, you know, in school, 1.4 or lower you round down; is that how you do it?

THE WITNESS: You round the time unit to one decimal place. So if it was 1.49 then yes, you would round it to 1.5.

THE COURT: 1.5, and then you'd go to 2 units, correct? Or do you keep it at 1 point --

THE WITNESS: You keep the decimal -- one decimal place.

THE COURT: -- you keep the decimal. So it's not that you round up to the largest whole number --

THE WITNESS: Right.

THE COURT: -- you round to the --

THE WITNESS: To the decimal place.

THE COURT: -- the decimal point --

THE WITNESS: Mm-hmm.

THE COURT: -- so 1.47 would be 1.5, 1.42 would be 1.4?

THE WITNESS: Right.

THE COURT: Is that what you're saying?

THE WITNESS: Correct.

THE COURT: Okay.

THE WITNESS: Correct.

MS. STANISH: Got it?

THE COURT: Do you have it, Ms. Stanish?

MS. STANISH: It doesn't matter; people -- they get it.

BY MS. STANISH:

Q So go -- if I have a procedure, then -- I'm just going to put 16 to 30, going back to my example. I have an 18-minute procedure, okay? And I -- it's five units, remains the same assuming that's the base, and then what's my time unit? Are you telling me -- what do I put there for a --

A One.

Q One? So then there's no difference between a -- what did I say, a 12-minute procedure and an 18-minute procedure?

A Not according to the CMS guideline.

Q All right.

A Which is a code where I'm bound to follow.

Q Understood. What if I have now a procedure that is -- I'm just -- pick a number in between there. How about 32 minutes? Five base units plus -- how many points do I get if it's -- time units do I get if it is a 32-minute procedure?

A It would be -- in my head 2.1 off the top of my head. I'd have to write it down. 32 minutes?

Q How about 31 so we don't have to do a -- how about 31 minutes just so you don't have to mess with decimal

points?

A Okay. It would be two.

Q Okay. Good. Two. Now, the -- so in this case it's going to be seven units?

A But I still have a problem with it. 30 -- the 16 to the 30 --

Q Okay.

A -- and the 31 --

Q The -- oh, because of the --

A -- to 45.

Q -- decimal. I'm sorry. So I'll change that for you based on our hypotheticals.

A Okay.

Q And so what I -- just to kind of summarize what you've told us, if it's a 12-minute procedure you're going to get a total of 6 units, correct?

A Correct.

Q If it's an 18-minute procedure you're going to get a -- it won't change, you're going to get 6 units?

A According to the CMS guideline, that's the way I would calculate it.

Q And do you know if it would change if you did a 29-minute procedure?

A I would -- let's see. A calculation in my head --

Q I've got a calculator if you need it.

A -- I'm coming up with 1.0-something.

Q So it would -- okay. All right. When you get these total units, let's just say -- let's use this 18-minute procedure here. It -- or I guess you could even use the 12-minute procedure since it's the same unit, what is the next step in calculating the value of the anesthesia service in this hypothetical?

A You have to look at modifying units. The modifying units -- anesthesia, when they do a pre-evaluation on a patient based on the patient's age and medical history, they give the patient an anesthesia classification, and the classification is, like, 1 to 5, 1 being the healthy patient, et cetera. If they're basically healthy and they're 79 years old, then you would probably -- the ASA classification would be a -- you would get 1 point for the age factor because the medical history is still good. And then as the -- it's called ASA, the classification system.

So as the classification goes up, the more points that would be added to the modifying units.

Q Okay. So it would be something you would add. If I had a -- is the -- it -- let's just, for the sake of argument say there's no -- well, no, I guess we should say -- are there usually modifiers, do you know, in the world of anesthesia billing; if you know?

A Modifiers or modifying units?

Q Modifying units that you would --

A Okay.

Q -- actually add to this formula.

A Yes, for the ASA -- the anesthesia classification.

Q Okay. And the -- so we would have to have additional information on whether the patient requires -- has some condition that supports closer monitoring or something like that?

A Yes, the medical records should contain sufficient documentation to support the ASA classification that anesthesia is giving.

THE COURT: And is that something the anesthesiologist or the anesthetist would then calculate, like, you know, I have a 92 year old with a heart condition or whatever they're going to consider, they then calculate the modifying units?

THE WITNESS: I don't -- I doubt very seriously if a physician or a CRNA --

THE COURT: Would do that.

THE WITNESS: -- would be involved in the billing. It -- they could --

THE COURT: Okay.

THE WITNESS: -- be. Whoever does the billing --

THE COURT: Oh, okay, would figure that out.

THE WITNESS: -- they would know based on the ASA classification --

THE COURT: I see. Okay. All right.

THE WITNESS: -- what number units to put with it.

THE COURT: Okay. But you know what --

BY MS. STANISH:

Q But to kind of --

THE COURT: -- I'm sorry.

MS. STANISH: -- oh, I'm sorry. Go ahead.

THE COURT: No, I was going to say let's take a quick --

MS. STANISH: Okay.

THE COURT: -- break.

MS. STANISH: Okie-doke.

THE COURT: So we'll take about 10 minutes.

And, ladies and gentlemen, you're reminded that during this quick recess you're not to discuss the case or anything relating to the case with each other or with anyone else. Do not read, watch, listen to any reports of or commentaries on the case, person, or subject matter relating to the case. And please don't form or express an opinion on the trial.

Notepads in your chairs. Follow the officer through the door.

(Jury recessed at 11:16 a.m.)

THE COURT: Ma'am, what time is your flight today?

THE WITNESS: Oh, it's tomorrow morning.

THE COURT: Oh, okay. So we don't have to worry about you.

THE WITNESS: Don't tell them that.

(Off-record colloquy.)

(Court recessed at 11:16 a.m. to 11:35 a.m.)

THE COURT: Kenny, bring them in.

MS. WECKERLY: Judge, we have -- besides Ms. Syler we have another witness here this morning, and he's also out of state; and Dr. Nemec can't be here until 2:30. So we're hoping to put on the third witness this morning, and then just depending on where we are.

THE COURT: What time is he leaving?

MS. WECKERLY: He can fly tonight. I just --

THE COURT: Okay.

MS. WECKERLY: -- I just thought, like, if there's possibly time we'd like to do him this morning. I get that we can't --

THE COURT: Yeah, I mean, I just don't like to -- it's hard enough sitting here that when they're really starving, so that's why I like to --

MS. WECKERLY: Okay.

THE COURT: -- break by 1:00 --

MS. WECKERLY: Yeah.

THE COURT: -- 1:15. You know what I mean, I don't want to break for lunch at 2.

MS. STANISH: No, I don't either.

THE COURT: And I know Nemec's coming, what? You said at 2:30?

MS. WECKERLY: Yeah.

THE COURT: Okay.

MS. WECKERLY: Well, I -- I guess what I'm saying is it either needs to be a long lunch --

THE COURT: Oh, okay.

MS. WECKERLY: -- or something. Maybe we can do the direct to him or something?

THE COURT: Okay.

(Pause in the proceedings.)

THE MARSHAL: Ladies and gentlemen, please rise for the presence of the jury.

(Jury entering at 11:37 a.m.)

THE MARSHAL: Thanks, everybody. You may be seated.

THE COURT: All right. Court is now back in session. Ms. Stanish, you may resume your cross-examination.

BY MS. STANISH:

Q All right. Back to the math. So we've -- we've talked about the base unit, the time units, the -- what was it, modifying units. What's the next step in the equation?

Is there more?

A Sometimes there may be modifiers on codes -- the CPT codes. For instance, if it's a CRNA, they would have a certain modifier on the -- the anesthesia code. If it's an anesthesiologist, an M.D., there would be a certain modifier for that.

Q You know, since we're talking about CRNAs in this case, you -- do you know whether the CMS has a particular modifier for a CRNA without supervision?

A Yes, they do.

Q What is that modifier -- do you know how many points it is? Or maybe I misspoke --

A Q -- I think it is Q -- QX for with supervision -- QZ.

Q Okay.

A QZ.

Q And is that QZ worth any points or -- according to CMS?

A Not to my --

Q What --

A -- knowledge. It just --

Q -- so it does nothing?

A -- differentiates who gave the anesthesia.

Q All right. So it doesn't affect our -- our math here on what is the value of anesthesia service?

A Not to my knowledge --

Q All right.

A -- it doesn't.

Q Now -- now that -- is there anything else that needs to be added besides base unit, time unit, modifying units?

A Not -- not to my knowledge. It --

Q Then what's the next step in determining the value of the anesthesia services?

A The -- this information has to go on the claim form and the -- the 1500 that you were talking about.

Q All right.

A And the -- this claim form has all the identification information about the patient, it has diagnosis coding, which is a separate kind of coding. That's called ICD-9. International classification of diseases.

Q They know that.

A It's the ninth edition.

Q They know that.

A They know that?

Q You don't have to explain it, they know that.

A So ICD-9 codes have to go on. Then there's a section for the CPT codes, which is actually the billing; and there are different columns to indicate the code, how many units, what is being billed. You know, for instance, if

something was $50, you'd -- they would have a column for the $50.

The bottom section of the form -- Block 31, the lower-left-hand corner of the claim form is the actual provider of service who actually performed. And, you know, then there's a block for their address, and, you know, where to mail the money to if it's via U.S. Mail; but like I said, most of it is electronic now, but it's still all that information, it's just electronic.

Q Mm-hmm.

A And there's one particular block and frequently what the block will say -- it's for the patient's signature -- and frequently what the block will say is signature on file. And what that means is all those forms you sign when you go to the doctor's office or the hospital or the ambulatory surgery center, all those forms, you know, you're agreeing that if this insurer, whoever it might be, needs to see my medical records, I'm giving permission to release those records. So that's part of what you're signing. And that's why it will say signature on file. It's been many, many years where there was actual patient signatures even on the paper claims.

Q So going back to the value of anesthesia service, now that we -- once we have the bottom line on the number of units, so for instance, six units for a 12-minute procedure, do we have to multiply it by something to --

A Yes, you --

Q -- get a dollar figure?

A -- usually insurers have per unit -- so many dollars per unit, so then they would have to multiply it.

Q And it -- is that what's referred to as the conversion factor in the world of CMS?

A Yes.

Q And is there an additional multiplication regarding the modifying percent -- modifier percentage, or is that -- am I wrong on that?

A That I don't know or don't recall, either one. I don't -- I don't recall that.

Q Is it in -- in your notes up there or that document you have, does it refer to that?

A There -- there's -- on this CMS document there's information, you know, if someone was supervising -- an anesthesiologist was supervising more than one case, there's those kind of figures, if you will, but I don't think this particular one that I recall has any --

Q No more math?

A -- no more math that I can recall.

Q Good. So then what we basically do is come up with our total units, and then we -- come up with our total units and multiply it by whatever dollar figure -- is it -- what do I call this, a rate or -- conversion rate, is that

what you -- we agreed on or what is it?

A Unit price is what I --

Q Okay.

A -- always --

Q Price.

A -- referred to it as.

Q And that -- so basically if I -- if I wanted -- well, I don't know if I have to go that far. So total units multiplied by whatever the unit price is is going to give me the value of anesthesia service?

A To my recollection, yes.

Q And that's going to be the check that's sent to the provider?

A Yes, it's usually -- if it's Medicare -- well, a lot of large insurers do it as well -- it's a once-a-month check. And this is a very large check, say $10,000. And then attached to the check is an explanation of payment. And on the explanation of payment it will have each individual patient listed where you file the claim, here's what you file for this date of service when the procedure was done, and here's what you billed, and here's what we're going to pay you, and here's what -- if there's secondary insurance, you know, you can bill it, and here's what you've got to write off it's noncovered.

Q Okay. So they kind of bundle all --

A They bundle it.

Q -- the claims together and one big payment with the details on what it includes?

A Yes.

Q And then if there's any claim that's denied for some reason, there would be a -- some -- I bet another code for that?

A Absolutely another code.

Q We're not going to go over those. Are there hundreds of codes for denial?

A I've never counted them; there's quite a few.

Q All right.

A And there's usually a -- the most frequent codes for denial, most providers -- the bill -- whoever does the billing, they're familiar with those. They don't have to look them up anymore to see what they mean. They already know what they mean.

Q Okay. A couple more areas I want to cover with you. On the Form 1500, the CRNA is deemed to be the provider, correct?

A Yes.

Q In the case of a QZ, is that the --

A Yes.

Q -- modifier, a QZ being a CRNA who is able to do the -- administer the anesthesia by themself?

A Correct, without medical supervision.

Q Aside from the operating physician, of course?

A Right. He doesn't -- unfortunately doesn't count for that, for want of better terms.

Q Well, they make their money by some other code --

A Exactly.

Q -- right?

A Absolutely.

Q All right. And the -- on the 1500, then, to the extent it is a CRNA who is performing the administration under that QZ code that you told us about, is -- their name will actually appear as the provider on the Form 1500?

A It should, Block 31, the lower-left-hand corner of the claim form should be the actual provider of services --

Q And --

A -- that actually administer, in this case, the anesthesia. Block 33, which is the far-right-hand corner of the claim -- the 1500, that is the one if this CRNA worked at the -- at the ASC; then in Block 33 you would have the ASC name and their address. That's like who to send the payment to.

Q Okay. So the check goes to the facility, not the individual --

A Usually, yes.

Q -- CRNA?

A Yes.

Q And that would be common in a setting where the CRNA is an employee of the clinic?

A Yes, and then the CRNA would just get a salary or an hourly rate, however they're paid, and they would be paid by the ASC, but the ASC would get the insurance check, so to speak.

Q Just a couple other areas, ma'am. Is the -- do -- on the 15 -- Form 1500 it appears that the provider puts a charge, whether it's anesthesia $560, but am I to understand that it is this formula that we've been discussing for a while that actually determines the amount of the check, not what the provider puts on that block? Do you know what block that's on, by the way?

A No, I would have to count backwards --

Q I've got it --

A -- to get --

Q -- just was testing you. I figured you would know what block on the 1500 Form is the charge of the provider.

A It's probably around Block 28, 29, somewhere around in there.

Q Let's check your credibility. Can't even read this. Pretty small but it's probably you're about right.

That -

A Okay.

Q -- but that charge that the provider puts in whatever block that is that I can't see, it is not that charge that they get. They don't get that amount that they put on the Form 1500, correct?

A It's very rare. It's very rare.

Q Okay. They get what is the bottom line on that equation that we just discussed?

A Based on that formula, so to speak, and based on the fee schedule.

Q Okay. And do some providers, if you know, simply say time doesn't matter, you get a flat fee?

A Well, many services rendered it is a flat fee based on the code. Some services are based on time and other services are -- it is what it is. Whatever that thing is, that's all it is. There's no -- it's not based on time.

Q Is that something that's just determined by the insurance company or agency that instead of using this formula from CMS because it's just too complicated or whatever, we're going to give you a flat fee for anesthesia service?

A I am not familiar with anyone that does that. It may occur, but I am not familiar with that at all.

Q In your experience, do most medical groups have third-party billing companies to deal with all these numbers

and codes and CMS and standards?

A I don't know what the percentage would be. Many groups -- medical groups or medical companies will have a separate billing company. Many employ people within their own facility with the proper credentials that can do the billing right there from their own office or facility or hospital.

Q You know, you reminded me of one more area I needed to cover. Thank you. Credentials. In order for a medical group to -- well, in order for a CRNA, for instance, to be on one of these Form 1500s, do they have to be credentialed?

A Oh, absolutely --

Q Now, what is --

A -- they should be.

Q -- and what does that mean exactly?

A Basically, it means that whatever company that's going to employ any person that has credentials, then they -- I hate to use the word "investigate," but they determine if the credentials are real, that the state did license them to practice under that name, to practice whatever their credentials say they should be doing. They just want to make sure that this person is who they say they are. They check their background for employment history, check with the state licensing boards, and every state has those.

So I guess they vet that person to make sure that

they are who they say they are and that they can practice whatever that is. Like, I'm an RN so they would check me out to make sure that I had an RN license, I was licensed by the state for the practice of nursing.

Q Okay. And what about the medical group itself, the facility that, you know, employs the CRNA? Do -- do insurance companies require them to have some kind -- those facilities to have some kind of credentials? I mean, if I am a doctor with a group, how is it that I get the magnificent Blue Cross/Blue Shield to cover my patients?

A The -- the group would do all this before they would hire you, that yes, you are a physician, let's say, and to make sure that you're licensed as a physician in the state; and then the insurer anticipates that this group and -- has done this. Additionally, the insurer -- the large insurance, they make sure -- and this includes Medicare -- they make sure, once again, you are who you say you are, you are licensed, everything is correct. And then you can become a participating provider with Medicare or any other large insurance -- any insurance group versus -- and most practitioners want to be participating providers because the patients that have that insurance or don't want to go to people for healthcare services if they're nonparticipating because that's a different rate, and then you would have to pick up the difference, so to speak.

Q And are there -- I bet there's requirements for credentialing --

A Absolutely.

Q -- all right. And do you know in the world of GI -- ambulatory surgical centers, is there a particular agency that does the credentialing, if you know?

A There are so many agencies out there with many different acronyms that certify, inspect and then certify all different kinds of places, and it's supposed to indicate then to the insurer, to the public, that quality care would be given if they meet all the standards of care.

Q Well, thank you kindly.

MS. STANISH: I have no further questions.

THE COURT: All right. Mr. Santacroce?

MR. SANTACROCE: I have nothing further to add.

THE COURT: All right. Ms. Weckerly, any redirect?

MS. WECKERLY: Yes. Margaret?

MS. STANISH: Yeah.

MS. WECKERLY: Can I have your value [inaudible]?

MS. STANISH: My -- this thing?

MS. WECKERLY: I -- yeah.

MS. STANISH: No, sure you can.

MS. WECKERLY: Just for a minute.

MS. STANISH: If you can read it, there you go.

MS. WECKERLY: I can read it.

REDIRECT EXAMINATION

BY MS. WECKERLY:

Q Ma'am, you actually examined patient files related to this specific case, correct?

A Yes.

Q Okay. I'm going to bring some of those to you.

MS. WECKERLY: And for counsel's reference -- I'm just using the green files because this is what she reviewed, but it's all the same people.

MS. STANISH: All right.

MS. WECKERLY: May I approach the witness --

THE COURT: Sure.

MS. WECKERLY: -- Your Honor?

BY MS. WECKERLY:

Q I'm going to start with State's 47A, and this is a patient -- it will be 47C, and this is Kenneth Rubino. And can you look at that file and tell me if there are those modifiers noted in here noting the things that, I guess, say that he may be a risky patient for anesthesia or a patient where you could note that in a record and maybe add a unit or something because the -- the patient is a little bit compromised? Is there anything noted for Kenneth Rubino in terms of a modification?

A Yes. On the preanesthesia evaluation the ASA --

Q Mm-hmm.

A -- classification is a 2. Meaning that there is probably some systemic disease process. It also says the patient is hypertensive -- high blood pressure. So that's probably what brought about the -- the ASA classification of 2.

Q And then would that mean that the units are worth more or that you can add a unit or how does that -- how does that work?

A I think a 2 is a -- is one unit, I believe.

Q Under the CMS guidelines?

A Yes.

Q Okay.

A I'm sorry, a 2 is zero units.

Q Okay. So even if you're a 2, you're hypertensive, and you have some sort of disease, you don't get to add anything?

A Right.

Q Okay.

A One unit starts at ASA classification of 3.

Q Okay. So he's a 2 but that doesn't -- but you don't get to add anything for that; is that fair?

A Right.

Q On --

A But you still have to have the classification.

Q Sure. Now, let's --

A The documentation is slim.

Q Brief documentation --

A Brief.

Q -- as to that classification, fair to say. Okay. Let's move to -- this is Sonia Orellana and this is 47D. Can you look at her -- her record and tell me if there's any modifiers on her that would make it possible to charge more for her anesthesia?

A She is listed with an ASA classification of 2. I can't -- the only thing I can see where they came up with a 2 based on their documentation is they just got the word thyroid written.

Q Okay. So another instance of maybe slim documentation for how --

A Yes.

Q -- but she's still a 2 so you wouldn't be able to add anything because she's not yet a 3, right?

A Right.

Q Okay. Let's move on to the next one. This is Gwendolyn -- thank you -- Gwendolyn Martin, and this is for the record 47E. Can you look and see if there was anything that you could add because of her health status?

A Let's see what the date on this is. This was an interesting one that I reviewed. I was -- the date of service in question was 9/21 --

Q Mm-hmm.

A -- so I reviewed 9/21. But as an auditor -- a medical record auditor and reviewer, whatever is there I'm going to review and frequently it's because you want to always give the benefit of the doubt to the provider. So I want to review everything they've got so that I can try to, again, give them every benefit of the doubt that you're documenting -- that your documentation is sufficient --

Q Okay.

A -- to support codes that would be billed. So I looked at 9/21 for --

Q Gwendolyn Martin?

A -- yes, it was an endoscopy with a biopsy. And the ASA classification, anesthesia classification was a 2. There was no documentation of any systemic disease at all, which should be, if it's a 2. So in reviewing the file -- and again, that was 9/21 -- there was 9/20, the day before, the patient had a colonoscopy and the ASA classification was a 1. So it would be very unusual that in 24 hours you would go from a 1 to a 2 as far as anesthesia is concerned, unless the evening of the 20th you had a heart attack or something, I don't -- you know, some catastrophic event would occur.

And I found that in several records, by the way, you know, where just within one week or one day the ASA classification would change. And that lends itself to very

poor, insufficient medical record documentation. And the reason that's so important, and I certainly feel very strongly about this, you don't know who is going to be taking care of you -- who may be doing the next procedure on you.

And this provider, whoever it is, doesn't know -- what if something happened to this provider that did this procedure and then even the person -- let's say the person gave him anesthesia and the GI doctor were in a car going to dinner tonight and they were in a car accident and were killed, but yet, you know, this patient goes in next week for the next procedure, let's say. Then that next provider has got to rely on this.

It is -- it is your health record. Everyone should want it to be as accurate, as thorough as possible for quality healthcare. I feel very strongly about that. And then you've got the billing issue because what's in here should support what you're billing.

Q So if I understand you as to Ms. Martin, her classification as to how risky she was to put under anesthesia changed from the 20th to the 21st, but there's still no documentation of why she was a 2 on the 21st?

A Correct.

Q But even as a 2, under the guidelines you're not allowed to enhance the cost of the anesthesia --

A Correct.

Q -- they give? Okay.

A Because that's a zero --

Q Still a zero.

A -- additional units.

Q Okay. Now, let's move onto 47F, and this is Rodolfo Meana. Can you see how he was classified in terms of a risk for anesthesia?

A I'm looking for the anesthesia form.

Q Is it on the other side or no?

A It shouldn't be.

Q We may have to pull his court record. We can come back to him.

A Probably sort of got stuck somewhere else.

Q Oh, there it is.

A Oh, here it is. It's the very last page. For 9/21 his ASA classification, anesthesia classification was 2. And hypertension is listed.

Q Okay.

A So he -- his classification is a 2. So it would be zero units according to the scoring system --

Q Okay.

A -- if you will.

Q Now, let's look at Patty Aspinwall, and can you see what her classification was?

A Her classification is a 1. And there's no

documentation on the anesthesia preevaluation of any disease. There -- there are certain parts that are just left blank that should have been filled in and they're blank.

Q But still a 1 is no --

A No.

Q -- not allowed to enhance.

A No, no units, correct.

Q All right. Now, let's look at Carole Grueskin, please. And, sorry -- can I just submit that, 47H for the record.

A Okay. This patient on 9/21 the classification was a 2. And this is an example of when you look more -- delve more into the medical record because on the anesthesia preevaluation there's nothing listed indicating there's any type of systemic disease.

Q So the --

A Which a 2 says it is. So then, you know, you go looking and reading every single page trying to find out, you know, what brought about the 2 because this same patient two days before had a procedure and they were also listed as a 2 and also no systemic disease or anything listed to determine how did you get to a 2.

Q So --

A How did you arrive at that as an anesthesia person -- practitioner, how did you arrive at a 2 on both days

two days apart? But at least it was the same classification that time.

Q Right. So she's a 2, no documentation, but also no enhancement because it's not yet a 3.

A Correct.

Q Okay. And just --

A So that really is a -- has to do with a quality-of-care issue rather than a billing issue since no units were added, but, you know, what about the quality of care? You know, on one hand you're saying this person is a little sicker, but yet there's no documentation of why they're sick.

Q And this is 47I, and this is Stacy Hutchinson. And what's her classification?

A She had a -- on 9/21 her classification is a 2. And it's marked hypertension. But no units would be added for that; it would be zero.

Q Okay. And this is Michael Washington. And that's 47J.

A This was July 25th and his classification is a 3. Well, when I see an ASA classification going up, then you definitely need to see documentation of medical history. So one thing I do is I look at the age. That's not always an indicator because this patient was 67 years old, but that doesn't mean that you're sick just because you're 67. You

could be, you know, quite healthy.

They've got hypertension marked, diabetes, the patient had a heart attack, they've got coronary artery disease, and the patient had a stent placed. So, you know, this -- you can see this patient is sicker. At least there's some documentation.

Q He's more compromised, correct?

A Yes, he's a more compromised medical individual. And that kind of documentation -- it even talks about an irregular sinus rhythm, which just means coming out the top of the heart.

Q So that would be one that you could enhance because he's a 3 --

A Yes.

Q -- right? Okay.

A So that would be one unit.

Q And if I could just have you look at one more, please. And this is State's Exhibit 1. And it's the record for Sharrieff Ziyad. Can you look at his classification?

A Classification is a 2 by anesthesia. And they have documented cirrhosis of the liver and hepatitis C. So that patient is compromised. You know, I would -- as soon as I saw hepatitis and cirrhosis, I would start looking further, wondering if maybe this patient should be a 3. You know, that would be my thinking as an auditor and --

Q Sure.

A -- as an RN. This is not one I reviewed. So I don't know if you want me to look at that any further or not.

Q Well, I mean, you can if -- if you want, but in any -- the classification he was given by the CRNA was a 2 --

A Right.

Q -- is that fair?

A It was 2, so there would be no units --

Q Associated?

A -- right.

Q So out of all these files that I just went through, the only one that would be allowed to enhance the anesthesia billing would be the one for Michael Washington because he was the only 3, right? Because he had all those --

A Of those you showed me, yes.

Q -- he had all those health issues.

A Correct.

Q So those modifying units -- I mean, there's various classifications that we went through, but none of that would affect what they could have charged for anesthesia except for Michael Washington?

A Correct.

Q Now, Ms. Stanish showed you this value of anesthesia -- this is a really nice chart she made.

MS. STANISH: I thought so.

BY MS. WECKERLY:

Q And this -- and the -- the timing that she put on it, which is 0 to 15 and 16 to 30, you had discussions with her about how -- like an 18-minute procedure would still be one unit because it's closer to 15 minutes rather than 30 -- that's how I think of it; is that right?

A Yes, the real thing is you would divide it by 15, but because it's 18 you know it's very close to the 15 so --

Q Okay. Yeah, that --

A -- but technically --

Q -- I mean, my way is a lazy --

A -- you would still have to divide it by the 15.

Q Right. Are there some insurers, though, that don't do what Medicare does and do they just say, Look, if you go over 15 we'll give you another unit? Are there some insurers that don't follow the Medicare standard of where you've got to get closer to one unit or the other?

A There may very well be. I'm not familiar in it -- familiar with anybody that does that, but there could be.

Q Okay. But according to the -- the CMS standard or the -- the federal standard, there is some calculation made on the units?

A Correct.

Q Thank you.

THE COURT: And that goes to this next -- a juror question -- were you done? I'm sorry.

MS. WECKERLY: No, if I -- I'm almost done. If you -- you can interrupt me if you want.

THE COURT: Well, okay. Since I already have. So the juror in this just goes into what Ms. Weckerly has said. Anesthesia time in the increments of 15 minutes, 15 minutes equals 1 unit. So say, for example, you had a 22-minute procedure -- impressed the juror did all the math -- that would be 1.4. So would that equal one unit?

THE WITNESS: Well, you bill it with one decimal place.

THE COURT: So it would be --

THE WITNESS: So it would be 1.4.

THE COURT: Okay. Let me make this easy then. Let's just say a unit is equal to $100.

THE WITNESS: Okay.

THE COURT: So for 22 minutes would that be reimbursement at $100 or reimbursement at $140?

THE WITNESS: To tell you the truth, I never got into that end of it.

THE COURT: Okay.

THE WITNESS: You know, I would know that here's the fee schedule --

THE COURT: Okay.

THE WITNESS: -- but do they actually --

THE COURT: Well --

THE WITNESS: -- do these calculations because so many insurers are so different --

THE COURT: Okay.

THE WITNESS: -- I never, you know, there was only so much room in my brain for information and I thought --

THE COURT: Okay.

THE WITNESS: -- I could leave that off.

THE COURT: Okay. And then -- so for it to be 37 minutes -- I'm sorry. So for it to be 3 units, you're not sure if that would be 37 units --

THE WITNESS: Three units?

THE COURT: -- I mean, 37 minutes. I'm sorry.

THE WITNESS: To get to three units, but, you know, you could just kind of multiply 3 times 15 and that brings you to 45. So I would have to literally do the math --

THE COURT: Okay.

THE WITNESS: -- divide 37 by 15 and it would wind up being some kind of a decimal because it -- you can only do one decimal place.

THE COURT: And that -- if I understand you -- depends on the insurer whether it's rounded up or whether they're reimbursing with the decimal? Meaning, like, 1.5, whether that's 2 or whether that would be 1.5?

THE WITNESS: Right.

THE COURT: Okay.

THE WITNESS: Because I just am not familiar --

THE COURT: Okay.

THE WITNESS: -- enough with all the -- there's so many different insurance companies. I guess in a perfect world -- perfect healthcare world -- here's a set of rules and everybody follows them. How I wish that were the case.

THE COURT: That would make it easier?

THE WITNESS: Oh, yes, it would.

THE COURT: All right.

THE WITNESS: It would be a whole lot less gray.

THE COURT: Okay.

THE WITNESS: Be more black and white, which I would far prefer.

THE COURT: Okay. Ms. Weckerly, go ahead.

BY MS. WECKERLY:

Q And so in the Medicare or federal standard, there is that decimal calculation as to the units, at least, based on the time, correct?

A Yes.

Q Okay. But a --

A To arrive at the units. I can't really say how Medicare reimburses. You know, I don't have a fee schedule in front of me, so...

Q Right. And -- but other insurers might just round up to the next unit?

A They might if it's, you know, like, 1.5 or more they may go to 2, or if it's 1 --

Q They could have their own --

A -- a 1.4 or less they might just leave it at 1. They might very well do that.

Q Now, Ms. Stanish asked you a lot about the CPT coding, and my understanding of what you were talking about is how actual procedures, like medical procedures, are coded for billing, correct?

A Correct.

Q And you said that you didn't have the medical procedure codes from 2007?

A Correct.

Q So you don't know what, for instance, the medical procedure code is for a colonoscopy?

A No. It might very well not have changed since 2007, but I don't know that for a fact. Sometimes if something changes they -- it will only change one digit even because of some other code they've added, so...

Q Now, you told us yesterday, I think, that under the CMS standard, anesthesia time is calculated as face time, essentially with the patient from the procedure room until they drop them off in recovery?

A Absolutely.

Q Was that the definition back in 2007?

A Yes, to my knowledge it has been the definition for the start and end of anesthesia since 1994. You know, I didn't find anything prior to that.

Q Okay.

A But after 1994 that was the definition of the start and end of anesthesia time.

Q And you, I think, testified yesterday that you're not allowed to be billing for two patients at the same time, or you can't overlap time in terms of anesthesia except for that one example of a doctor supervising CRNAs?

MR. SANTACROCE: I'm going to object. This has been asked and answered on direct. She's just going through direct all over --

THE COURT: Well --

MR. SANTACROCE: -- beyond the scope of cross.

THE COURT: -- overruled.

BY MS. WECKERLY:

Q It -- your -- my understanding is you can't overlap or bill for two patients at the same time?

A No, you cannot.

Q Was that the rule back in 2007?

A That's -- yes, that's always been the rule.

Q Okay. And you told us that you can't bill for

more hours than there are in the workday?

A Absolutely not.

THE COURT: Yeah, you are exceeding the scope of cross, Ms. Weckerly, so...

BY MS. WECKERLY:

Q Well, I just want to clarify, was that the CMS rule in 2007?

A Absolutely.

Q Thank you.

THE COURT: Still beyond the scope, but --

THE WITNESS: Can I add one clarifying remark?

THE COURT: Sure.

THE WITNESS: It's in regards to the HCFA -- pardon me, that was the old name for CMS. For the 1500 Form, the claim form, the absolute main thing that Medicare and all insurers expect is that that claim form, everything on it, is honest and true. You're even saying when you bill those codes on that claim form, you're even saying that this is the service that was rendered and I have documentation to back that up, to prove that it's correct coding.

So all insurers expect that these claim forms are clean, is what they call them, which means they're honest and everything on it is totally accurate.

RECROSS-EXAMINATION

MS. STANISH: Can I talk to you about what you

mentioned earlier about the benefit of the doubt? As I understood what you said, when you do an audit you try to give the provider a benefit of the doubt to -- when you're doing your review?

A Absolutely.

Q Would it -- you be giving the provider the benefit of -- well, let me phrase it this way. In your experience, are you aware that medical practices sometimes have different charts? Different types of charts?

A Different? They're all different. Every -- no matter where you go --

Q You know, let me interrupt you --

A -- there's very --

Q -- because I -- I'm not -- that -- I know I didn't make that clear. In a particular practice --

A Okay. Oh, okay.

Q -- that a provider has a procedure file, has a doctor file, you know, based on a consultation, has a computer system that has medical information in it. When you do your audits, would you want to have the collection of medical documents pertaining to a particular patient so that you could give them that benefit of the doubt?

A Yes, I would. I would want everything they had. But my first question would be why do you have -- say, a paper record or a partial paper record and part of it is in the

computer. In a -- an electronic system, unless only certain -- like, maybe the dictation report for the procedure may be electronic; but if you have paper records, that is usually printed out and placed in the paper record.

But that would be my first and main question, why do you have part records in paper form and part records in an electronic system? That makes no sense because some auditors -- I always called them the men in black -- the, like, Medicare auditors, DHHS, they won't necessarily from my experience give you the benefit of the doubt.

So if here's a paper record and then, you know, you review it and you said, okay, we're going to deny that claim, but then the provider jumps up and says wait a minute, wait a minute, we've got these four other things here in this computer, some medical record auditors say, sorry, you know, this is what you gave me, this is what I audited, payment denied. Claim denied.

So in other words, that would make no sense to me that you would do that, but yes, I would look at everything to -- when I say give the benefit of the doubt is I want to see all the documentation you have for that patient for this data service that would help me figure out what service was rendered, you know, what all was involved and was all the documentation to -- sufficient to support the billing.

Q And if there were other procedure files or

consultation files, what have you, be it in computer form or in paper form that the anesthesiologist or CRNA would have access to, you would want to know about that document?

A Yes, I would want to know, but why would it be separate from the -- like, those look like patient charts to me. Like those green folders, they look like patient chart. So why would everything not be in there? I mean, that's what I would be asking.

Q If you had -- if the CRNA had access to the other documents, because they were accessible would you want to see those documents before you judged whether the ASA codes were appropriate?

A Yes.

Q In your review you were given these -- did you actually get this -- this file to review, a green folder?

A There was approximately 130 electronic medical records that I reviewed, and there were 11 in green folders that I reviewed.

Q Did you -- do you know that you did not -- you did not receive the medical doctor's consultation form -- document where the doctor visited -- the patient visited with the doctor prior to getting the procedure done? Did you --

A Are you talking about the preanesthesia evaluation or the gastroenterologist's documentation?

Q Gastro.

A Okay. I would read all of that, but if I was looking at auditing for anesthesia coding and billing, then I would expect documentation to be appropriate on the anesthesia form, the preevaluation form, whether it's electronic or paper. In other words, they should document what they need to to support the ASA classification they're giving and not rely on somebody else. It's kind of like -- and we've all worked with people like this, you know, where they don't do part of their job because they know Susy Jane is going to do it because she always will pick up the slack.

So -- and to me it's the same thing, So why if I'm a CRNA or an anesthesiologist I should not be relying on the GI doctor? Do I need his document and read his document, yes, but I'm doing the preanesthesia evaluation, so I should be finding out from the patient and/or family or significant other their health status. And then I should document it because I'm the one that's going to be billing for anesthesia.

Q You don't want your CRNA ignoring what the medical doctor found a few days before the procedure, though?

A Absolutely not.

Q You would want your CRNA to review that as well as make their own judgment.

A Absolutely.

Q And then what you want to see as an auditor is that the assessment is documented?

A Correct.

Q And you don't understand, as I understand your testimony, why a facility would have different files?

A I don't understand different files except in the example I gave, like the procedure report. Because in an auditing I always review, and I did in all the -- the records I reviewed, I also read the actual procedure report that the GI doctor dictated.

Q You didn't get that, though, in this --

A Yes.

Q -- per your evaluation? You got a -- you got something besides the green folder on each of those patients that you just reviewed?

A The electronic files that I had, the majority of them did not have the actual procedure report. But the green folders did have the procedure for the endoscopy --

Q You're saying --

A -- or colonoscopy, so I did review it.

Q -- you're saying separate and apart from the green folders, you got an additional documentation?

A Yes, I only reviewed 11 that were in green folders, hard copy, paper. The other 130 or so were electronic records. So I sat at a computer and scrolled through to read the entire record.

Q Thank you.

MS. STANISH: Court's indulgence.

Your Honor, the parties stipulate that the witness only receive the green procedure files and not the medical doctor's consultation report. There may have been another document in here, the procedure document that the witness was referring to, but --

THE COURT: Right.

MS. WECKERLY: I -- the preprocedure.

THE COURT: Okay. You're stipulating that the consultation files that occurred before the procedure with the gastroenterologists were not transmitted to this witness; is that correct what we're stipulating to, Ms. Weckerly?

MS. WECKERLY: That's correct. These are the files from the medical offices; is that fair?

THE COURT: That she didn't get?

MS. WECKERLY: That she did not get.

THE COURT: Okay.

MS. WECKERLY: She got the procedure.

BY MS. STANISH:

Q With respect to the ASA classification, isn't it the case that -- and I think you -- it was your words, not mine, that in -- the inconsistencies that you noted in the ASA codes indicate either a lack of care in applying the ASA class or -- and possibly lack of complete understanding of the ASA classification system.

A Those are my words, yes.

Q With -- or in bold, in capital?

A They could be either/or.

Q And --

A Or both --

Q -- sure --

A -- I guess.

Q -- is it the -- is it the case that providers, or the people doing the charting do not understand the set of rules that are -- the set of rules by CMS?

A There are many providers that do not understand all the guidelines, rules, and regulations; however, it is incumbent upon them to know them if you're going to be billing.

Q And going back to your comment that as far as you knew the CMS standards for the end time of anesthesia had not changed for many years, do you know whether there had been -- what was the term you called it, like, clarification definitional -- what did you call it before?

A Guidelines?

Q Yeah, guidelines. Let's call it guidelines because am I right to understand from your -- when you had chatted with me earlier on cross-exam that CMS oftentimes revises the guidelines to try to clarify terminology?

A Yes.

Q And the term, personal attendance of a anesthetist or a CRNA has -- do you know -- since you were not able to access anything prior to 2009, do you know if the CMS has over the years had guidelines written to better explain what personal attendance means?

A I can't say -- since I wasn't able to access 2007 anesthesia coding, I can't say whether there has been a specific change in that terminology. They might have explained -- it's possible they could have explained it differently but --

Q You don't know because you --

A -- personal --

Q -- can't access it.

A -- attendance --

Q Yes?

A -- I mean, it is what it is. I mean, that's -- you are attendant with that person. You are face-to-face with that person.

THE COURT: Is there a definition? Is that what you're asking, if there's a definition in the CMS or --

MS. STANISH: My -- I'll clarify it.

BY MS. STANISH:

Q My understanding, ma'am, is that you have a code, but then you have -- almost every year the CMS will author guidelines in an effort to clarify terminology?

A Sometimes they will. Some guidelines, some terminology, some codes remain the same year after year after year without --

Q Right.

A -- change or edification.

Q Right. And I'm not just talking on the number assignment to various procedures, I'm talking the terminology that says something general, like, you can bill anesthesia in accordance with the -- the -- the standards in the community, whatever the broad language is. Then we have a set of guidelines that CMS prepares to clarify these broader terms; is that correct?

A If I understand the question, periodically there can be language clarification, but that doesn't mean they do it every year.

Q Okay. Fair enough.

A Some stay the same.

Q Right. I understand. And all I'm trying to get at is on redirect you had testified that as long as you knew, it's always been personal attendance. All I'm trying to get at, I suppose, is that you didn't have the opportunity to review any CMS guidelines that relate to what is personal -- what constitutes personal attendance?

A Okay. What I couldn't find for 2007 was in -- I could not really find anything about 2007 anesthesia codes.

On the time start and end time for anesthesia from -- effective 2006, it -- once again, it's the CMS transmittal 1324 --

Q Mm-hmm.

A -- effective date January 1, 2006 --

Q Mm-hmm.

A -- and this has not changed at all to my knowledge.

Q Could I --

A It says --

Q -- can I see that?

A -- anesthesia practitioner is present with the patient.

Q Okay.

A So that has to be face-to-face.

Q Where does it say face-to-face?

A Well, if you're -- if you're present with me we're face-to-face --

Q Well, watch this.

A -- aren't we?

Q Watch this.

THE COURT: Keep going. Keep going. I've got some chicken katsu in the back.

THE WITNESS: You're still present with me. You're still present.

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 32

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TRAN

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 36

FRIDAY, JUNE 14, 2013

APPEARANCES:

FOR THE STATE:	MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys
FOR DEFENDANT DESAI:	RICHARD A. WRIGHT, ESQ. MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN:	FREDERICK A. SANTACROCE, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

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LAS VEGAS, NEVADA, FRIDAY, JUNE 14, 2013, 9:34 A.M.

* * * * *

(Outside the presence of the jury.)

MS. WECKERLY: We're asking to please call a witness out of order.

THE COURT: Dr. Nemec?

MS. WECKERLY: Actually, no. He can't come until 2:30. Dr. Perrillo where -- who is here now --

THE COURT: That's fine. I don't care.

MS. WECKERLY: Okay.

THE COURT: Just to let you know, we'll be ending at 5 today.

MS. WECKERLY: Okay.

THE COURT: After Mr. Wright's impassioned plea.

MS. STANISH: Thank you, Your Honor.

MR. WRIGHT: Good. Thank you, Your Honor.

MS. STANISH: Just an issue I have on Dr. Perrillo, the next witness that the State wants to take out of order because of travel issues. He's a neuropsychologist.

THE COURT: Okay.

MS. STANISH: In my review of his report, he is talking about medical issues with hepatitis C causing dementia or being -- possibly causing dementia, as well as the drug treatment of -- as having that. I think that's beyond the scope of his expertise as a psychologist, and I'd like to

limit that testimony.

THE COURT: Well, anybody want to respond?

MS. WECKERLY: Well, I mean, you can have a hearing on his basis of knowledge, but he has studied that and he's an expert and he's looked at all her -- we're only talking about one victim with him.

THE COURT: Right. It's just the one -- the gal who can't testify because she has dementia and they want to link it to this. So, I mean, if he's treated other patients and he's --

MS. WECKERLY: He has even other --

THE COURT: -- and they have hepatitis and they have dementia and he's causally linked the dementia to the hepatitis or it exacerbates the dementia or whatever, then I think he's qualified to testify to that. They just need to lay a foundation. Or if that's part of his training that, you know, treating hepatitis dementia patients, then I think he can testify about that as long as they lay the foundation.

MS. STANISH: All right.

MR. SANTACROCE: And in that regard, Your Honor, he treated some patients that aren't genetically linked to the cluster in this case, and I'm going to ask for -- that he be admonished not to talk about those patients.

THE COURT: Ms. -- were you going to ask about those?

MS. WECKERLY: I wasn't planning on asking him about

it --

THE COURT: Okay.

MS. WECKERLY: -- but --

THE COURT: Well, they're not going to ask him, so --

MS. WECKERLY: -- but -- but I -- I'm just concerned that, you know, some of the symptoms he sees are going to be overlapping, so I don't know if you --

THE COURT: I mean, I -- I mean, here's the thing. If Ms. Weckerly doesn't intend to get into that they were infected at the clinic, but he mentions I'm treating other patients who have been infected with hepatitis and they're exhibiting signs of dementia and they happen to have been also infected patients at the clinic, then as long as he doesn't get into the method of infection, he's fine to talk about other patients because that's part of his basis of knowledge.

So maybe just -- I'm not going to limit him if he mentions other patients because that's how he knows. You know, he --

MS. WECKERLY: Yeah.

THE COURT: -- I mean, he's going to have to say, look, her symptomology is not, you know, totally isolated, it's not completely unique, blah, blah, blah. So if you just mention to him not to do the linking of the other patients to the clinic but that they're, you know, if it's recent onset or something like that or, you know --

MS. WECKERLY: Okay.

MR. SANTACROCE: I'm not talking about the patients in this case, he can talk about those.

THE COURT: No, we get it. Other patients that are --

MR. SANTACROCE: Yeah.

THE COURT: -- that were infected at the clinic but weren't genetically linked or aren't Lakota Quanah or -- right?

MR. SANTACROCE: Correct. The other guy.

MS. WECKERLY: I'll just tell him to kind of --

MR. WRIGHT: Tell him he can talk about other patients, but just don't say where they're from.

MS. WECKERLY: Right.

THE COURT: Yeah, just don't say, oh, they're linked to the clinic --

MS. WECKERLY: Right.

THE COURT: -- because that's beyond -- that hasn't been established yet and it's beyond his expertise.

MS. WECKERLY: Okay.

THE COURT: But he can certainly talk about other patients.

MS. WECKERLY: Okay.

MR. SANTACROCE: The other thing, Your Honor, and I hate to keep bugging you about this. Can you just give me a

quick ruling on the record about his bail because it's --

THE COURT: Yeah, I mean, I'll --

MR. SANTACROCE: -- the bail bondsman is driving me crazy.

THE COURT: -- I'll reduce it to 25,000 on this case.

MR. SANTACROCE: Okay. Can we put that on the record so I have something --

THE COURT: Yeah, Ms. Husted is doing it right now. She's putting it on the record.

MR. SANTACROCE: Awesome. Thank you.

THE CLERK: There's double.

THE COURT: And Ms. -- Ms. Olsen is recording.

THE CLERK: So it's reduced to 25,000?

THE COURT: Right.

THE CLERK: And it's -- so that's the third time it's been on the record at court.

MR. SANTACROCE: What is that?

THE CLERK: Nothing.

(Off-record colloquy.)

THE COURT: Is everybody ready? Would you tell Kenny to --

Oh, just while we're waiting for the jury, did you folks, Ms. Weckerly, have an opportunity to show this memo to Scott Mitchell yesterday?

MS. WECKERLY: Not yet.

THE COURT: Okay.

MS. WECKERLY: I think -- or weren't you just distributing it? So do we need to -- or you -- I thought you were going to disclose it, or you want to wait before --

THE COURT: No, I distributed it.

MS. WECKERLY: -- oh.

THE COURT: Then it's -- it's you guys. I mean, don't disclose it beyond the lawyers --

MS. WECKERLY: Yes.

THE COURT: -- unless, you know, you can obviously talk to Mr. Labus about it --

MS. WECKERLY: Sure.

THE COURT: -- you can talk to Metro about it because the issue is whether or not they got it. According to everything I have from the civil cases Labus got it.

MS. WECKERLY: Okay. We --

THE COURT: And possibly Metro. So possibly Metro based just on the tape, not on what was said in the civil cases, but Labus definitely got it. It's distributed to you guys. I mean, all I'm saying is don't further distribute it unless it's, you know, germane to the case or -- you know.

MS. WECKERLY: I --

MR. WRIGHT: I found something else I want. This is a clue to the other document --

THE COURT: Okay.

MR. WRIGHT: -- that is missing.

THE COURT: Which one is that? Oh --

MR. STAUDAHER: Your Honor, do we -- could -- we don't either have our copy or we can't find it --

MR. WRIGHT: Okay.

THE COURT: Well, I gave one copy to the State, and then I gave copies to Mr. Santacroce and Mr. Wright.

MR. WRIGHT: It's in there. It's in there.

THE COURT: So, Ms. Weckerly, you've got a copy, or...

MS. WECKERLY: I -- I don't --

MR. WRIGHT: Yeah, she --

MS. WECKERLY: -- I mean, I'm not saying you didn't give it to me, I just don't know --

THE COURT: No, I --

MS. WECKERLY: -- where it is.

THE COURT: -- distributed it yesterday.

MS. WECKERLY: Okay.

THE COURT: I had the bailiff distribute it.

MR. WRIGHT: If you look at --

THE COURT: So yeah, you guys have it. I mean --

MS. WECKERLY: Okay.

MR. WRIGHT: -- the bottom of page --

MS. WECKERLY: Well, we may need to make --

MR. WRIGHT: -- 2, do you have --

MS. WECKERLY: -- another copy.

MR. WRIGHT: -- a copy of it?

THE COURT: Yeah, I kept a copy for --

MR. WRIGHT: Okay.

THE COURT: -- a Court's Exhibit and myself.

MR. WRIGHT: Bottom of page --

THE COURT: Jury's coming.

THE CLERK: No, it's just me.

THE COURT: Oh, it's Denise.

MR. WRIGHT: -- bottom of page 2. It says -- on the fourth page of the document titled, Office of District Attorney, Grand Jury lines 14, 15, 16 have a translation transcription error. When Labus quotes me mentioning, They would use the needle once they wouldn't reuse needles, that was my response. It's that portion that -- in his statement he talks about having read --

THE COURT: A transcript.

MR. WRIGHT: -- a transcript.

MR. STAUDAHER: That looks like it's a grand jury transcript of Labus, if that's -- doesn't it sound -- that's what it would sound like --

MR. WRIGHT: Yeah, but that -- but that's pre --

MS. WECKERLY: What year?

MR. WRIGHT: -- but that's pre-grand jury of Labus. I mean, is what --

MR. STAUDAHER: I don't know. We didn't have the Labus -- well --

MR. WRIGHT: I mean --

THE COURT: Yeah, maybe --

MR. STAUDAHER: -- I don't know.

THE COURT: -- Kenny put it on your desk or something, but we -- I had to make copies and we distributed it --

MR. STAUDAHER: That's fine. He's just going to make another copy.

THE COURT: -- yesterday.

MS. WECKERLY: He probably did and we just misplaced it.

THE MARSHAL: We -- Judge, we've got one in the --

THE COURT: Rest room?

THE MARSHAL: -- rest room, everybody else --

THE COURT: Okay. As soon as they're --

THE MARSHAL: -- is lined up so --

THE COURT: -- ready just bring them in and --

(Off-record colloquy.)

THE COURT: Is this an out of state witness the doctor?

THE MARSHAL: Is everybody ready, Judge?

THE COURT: Yes, bring them in.

THE MARSHAL: Ladies and gentlemen, please rise for

the jury.

(Jury entering at 9:45 a.m.)

THE MARSHAL: Thank you, everybody. You may be seated.

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the deputy district attorneys, the presence of the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

Ladies and gentlemen, we're going to have a witness now out of order because that witness is from out of state and to accommodate his schedule he's going to testify before we get into the cross-examination of the last witness. As I told you before the order in which the testimony comes in is irrelevant. That you, you know, have to consider all of the testimony regardless of when you hear it.

So, Ms. Weckerly, why don't you go ahead and call your next witness.

MS. WECKERLY: Thank you. Richard Perrillo.

THE MARSHAL: Can you step right up there for me, please. Remain standing, raise your right hand, and face that lady to your left.

RICHARD PERRILLO, STATE'S WITNESS, SWORN

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

THE WITNESS: My name is Richard John Perrillo, P-E-R-R-I-L-L-O.

MS. WECKERLY: May I proceed, Your Honor?

THE COURT: Yes.

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Sir, how are you employed?

A I'm a forensic, clinical, and neuropsychologist in my own practice.

Q And can you explain your educational background first to the members of the jury.

A Sure. I have a PhD with distinction from the University of Utah in Salt Lake City. I've done my clinical internship at the VA Hospital in Salt Lake City. For a short time I was director of the diagnostic unit for the county attorney's office in Salt Lake City. Afterwards, let's see, I had F.B.I. clearance twice, once in 1980 and 1990 because I was consulting for some 20-years with the sort of industrial military companies.

I've tested literally thousands of people across the United States. I do quite a few military cases with our veterans every year. Let me see. I do the beta testing on neuropsychological instruments which are brain-function instruments and beta testing means that I -- it goes through 10 of us to see if the instruments are okay for public, you

know, public use to my colleagues.

Q And I -- you testified as an expert before in the area of neuropsychology and that sort of testing that's associated with it?

A Yes.

Q In your practice and in -- over the years of -- that you worked since your training have you had the occasion to examine, treat, or even test people who have contracted hepatitis C?

A Yes.

Q And from your overall practice of those -- treatment of those patients and testing of those patients have you seen any associations between hepatitis C and loss of brain function?

A Yes.

Q Can you explain to the members of the jury how it is that hepatitis C would affect the brain?

A Well, it's sort of a complicated process, but hepatitis C is neuro-virulent. It's a virus that affects the nervous system much like AIDS or HIV. And the research clearly shows that you don't have to be in the later stages of liver disease to have brain damage and brain dysfunction. So there's been quite a few studies that show that people were complaining of cognitive impairment even prior to the onset of any liver disease. And those studies clearly showed that

these individuals had sustained some brain damage and brain dysfunction.

I had tested 19 people with hepatitis C in ages ranging from 23 to about 85.

Q And -- in the people that you tested in that group did you test them for -- for what you said, like the -- sort of assessing brain function after contracting hepatitis C?

A Oh, yes. You know, neuropsychological tests are very sensitive to brain damage and brain dysfunction, and even more sensitive than the techno scans like MRIs and CT scans.

Q And then, is the reason why it affects the brain because of, like, impaired liver function and so it's -- the liver isn't functioning properly and then the -- then the brain gets affected?

A Well, there's that and also the brain has a group of cells that are your scavengers, you know, call them microglia cells. And they sort of fight off any foreign, you know, any foreign cells that try to enter it. So your brain is pretty protective actually, you know, it's up there on its own little plain, and -- but then the rest of your body has white bloods, you know, called microcytes. And the thinking is that they get infected, they migrate across the blood brain barrier and then the microglia cells can't fight them off. This is what the thinking is.

And then that creates a metabolic imbalance. And as the metabolic imbalance then that causes brain dysfunction. But you can't do autopsies on live people. And so this -- you know, so this is -- this is -- so this is what the thinking is. And anyway the best we have is neuropsychological test to reveal whether there are abnormalities in one's brain.

Q Now, what about the treatment that some people that contract hepatitis C go through, the Interferon treatment, how does that affect the brain in terms of dementia or causing damage in your -- in your experience with the patients you've dealt with?

A Well, Interferon treatment is like chemotherapy and it's highly toxic. So it's a doubly whammy, you know, and there are numerous, numerous side-effects to Interferon treatment, including memory impairments and all kinds of physiological, you know, stomach, diarrhea, vomiting, nausea, depression, you know, fatigue. I mean, there's just a whole list of side effects with the Interferon treatment.

And so it sort of accelerates, you know, the brain dysfunction.

Q Now, once you --

MR. WRIGHT: I didn't hear that last part.

THE WITNESS: Oh, it accelerates one's brain dysfunction.

BY MS. WECKERLY:

Q Once you've stopped the Interferon treatment, or once the patient stops that does their brain go back to normal function, or can they recover that cognitive ability?

A Well, it doesn't -- that doesn't seem to be the case. Age seems to be a -- there are several moderator variables and age is one. It's like anything else, the younger you are, the better off you have, you know, a better chance of recovery. The older you are, you know, your chances of recovery aren't so good.

The other thing is if people have a co-morbid medical condition -- so let's say they have diabetes or they have something else that's going on with them, well, that's going to make it more difficult for them to recover.

Q So people with more -- that are older or with more compromised health before the onset of the infection don't do as well in terms of recovery after the treatment?

A Exactly. And then, you know, if you think of your liver as sort of your purifier, you know, if it's not able to purify your blood, then that adds to the, you know, to the issue.

Q And is -- and in terms of your liver functioning as a purifier, obviously it would probably function better when you're younger, at least for the majority of the population?

A Right. And so, you know, for example, just as

-- just an example, with normal people, normal people could drink, for example. They could have one or two drinks a day no problem. But if you have a liver dysfunction, it's very difficult for your liver to process that because it can't purify your system. So that's going to then complicate, you know, that also.

Q Nothing works as well as you age.

A Yes, nothing works as well as you age. That's right.

Q I'd like to direct your attention to a woman by the name of Carole Grueskin. Did you meet Ms. Grueskin and do an assessment of her?

A I did.

Q And was that in -- on January the 28th of 2011?

A Yes.

Q At the time you assessed Ms. Grueskin how old was she, approximately?

A 71.

Q And when you examined Ms. Grueskin, how did you -- how did you start your interaction with her?

A Well, a friend brought her to me because she was unable to come by herself, and, you know, just globally she had -- she was demented. She had no sense of progress and time, you know, she -- she was disoriented and confused. So I started off with something pretty simple, I asked her, you

know, what year it was and she didn't know or couldn't retrieve what year it was.

So then I wrote down the years for her and asked her to circle the one because there I was testing recognition. So she couldn't retrieve it which would be a frontal lobe, prefrontal function but recognition would be, you know, temporal. So she was able to recognize the year and -- and then circle it. But --

Q So if -- just if I could ask, in that instance you wrote a couple of different year choices on a piece of paper and asked her to circle which one was correct?

A Correct.

Q And she got it right?

A And she got it right. But it was downhill from there. Most of the tests had to be aborted. She could not do most of the tests. So I then resorted to what's called a simple cognitive status exam. And again, it's very simple, what's the date, what's the time, who am I, where are you, you know, this kind of thing, and -- and she couldn't even go through that.

And so she had severe brain damage, frontal-temporal dementia and she's not likely to recover.

Q And in your -- in your assessment of her were there some tests that you attempted to perform on her in order to make an assessment that -- that it just wasn't possible

because of her cognitive ability or disability, I guess?

A Well, yes. One of -- two of the tests are world renowned and they're called the Trails Making Test A and B. And the Trails Making Test A is a very simple test, a visual scanning and planning. And all you have to do is connect the numbers quickly, all right, on a piece of paper. And she was incredibly slow in doing that. So she was in less than the 1 percentile.

Q And those numbers that you're supposed to be connecting on a piece of paper, are they really high numbers or how -- what are the numbers?

A No, they're very low. They go from like 1 to 13, you know. So you're just connecting the numbers in order. And this is within the context of her having preserved motor ability, her fine motor ability and a grip strength was preserved. So there wasn't any orthopedic injury that could interfere with this. It was white matter, you know, loss, processing speed loss.

And so that was one of the tests. The second test was the Trails Making Test B where you have to shift between numbers and letters. And that's a stronger cognitive load-type activity because you're not just connecting the numbers, now you're shifting between number and a letter.

Q Like 1A, 2B?

A Right.

Q Okay.

A 1A, 2B, 3C. So that -- that is a frontal-lobe activity. Your -- you know, for flexibility. And she couldn't do it. We had to abort it after about 3, 4 minutes. The average person can do Trails Making A within 30 seconds, and the average person could do Trails Making B within 60 seconds and she did Trails Making A in 105 seconds, which is 3 times the average individual for her age, and B, we had to abort after 3 or 4 minutes. She just, you know, she --

Q She couldn't complete it?

A -- right.

Q Now, you said, I think, that her fine motor skills are intact and normal for a woman in -- who is 70?

A Yes.

Q And so there's nothing physically wrong with her in terms of, like, I guess a structural brain damage or a muscular problem or anything like that?

A No, let me rephrase that for you. There's the -- in terms of motor, okay, she's able to grip, she's able to do fine motor ability, but she has organic brain damage. I mean, there is something physically wrong with her and -- and she has organic brain damage, you know, she can't process her world quickly. She's incredibly slow. Both visual and auditory memory is severely impaired.

Q And when you say her memory is severely impaired

can you give us an example of what she had -- what she can or can't remember?

A Well, she didn't remember, for example, where she went to high school. Couldn't remember what degree she had. It turns out she has an AA degree, but couldn't remember, you know, where she went or -- I got that from the medical records. She would leave things on the stove, so much so that she was becoming a danger to herself and others.

The neighbors were reporting that she was wandering in the streets aimlessly, so they called her son. I think he came from San Diego, who I met for a few minutes, actually, and -- or I spoke to him on the phone, and he, you know, reported that she's pretty disoriented and very demented.

Q Now, did you review Ms. Grueskin's medical records for signs of dementia prior to September the 21st of 2007?

A I did.

Q And in your assessment were there signs of dementia before that date?

A No. Her medical records were pretty clean, you know, prior to that date, and then, all of this dementia stuff started when she took the Interferon treatment and then there were numerous notations in the medical records from the Interferon treatment itself, and then afterwards reporting of various doctors that she was demented.

Q And, I mean, how can you tell that the dementia is either accelerated or attributed to hepatitis C versus, you know, some -- I mean, some people just get dementia as they get older, correct?

A Yes, but the epidemiological study showed the following. Only 1 percent of the population gets dementia between 65 and 70 and only 30 percent get dementia by the age of 85. So that means 99 percent of the population do not have dementia between 65 and 70 or 75 and a clear 70 percent don't, you know, by the time they're 85.

And so the probability that this woman would have dementia, you know, at 68 -- that's when she took the treatment and, you know, the Interferon and all that, and then up until 71 it's highly, highly unlikely. In addition to that no one in her family has reported Alzheimer's disease. And in addition to that she had a fairly good educational background which seems to, you know, sometimes interfere with the acquisition of Alzheimer's.

Q And I think you answered this already, but is she likely to improve at all?

A No.

Q Thank you.

THE COURT: All right.

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

THE COURT: Cross, Ms. Stanish?

MS. STANISH: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good morning, sir.

A Good morning.

Q My name is Margaret Stanish. I represent Dr. Desai. You are not a medical doctor, correct?

A Correct.

Q You're a neuropsychologist?

A Yes.

Q And I want to start with your reference to the scientific literature that you state supports your conclusion that hepatitis C caused the demented state in Ms. Grueskin, okay?

A Okay.

Q I have a copy of your report and I see that you cited two articles in that report. Are there more?

A Oh, yes, there's -- and I have them with me. I have about nine hard copy ones, and then I have on my computer, which is with me, about, oh, 20 or 25 further ones.

Q And you could provide -- did you provide copies of those to the district attorney?

A No, they didn't ask for it.

Q Okay. I'm asking.

A All right.

Q Okay. Thank you. And the --

A It's okay to email it to you? I'm happy to --

Q That's fine.

A -- email you the folder.

THE COURT: Doctor, there's a copy machine in the -- I'm kidding.

THE WITNESS: Oh.

BY MS. STANISH:

Q Get to work. The -- moving to -- as I understand your testimony you're saying that the dementia can be attributed to one of two issues. Either the hepatitis C itself or the drug treatment; is that correct?

A Or the combination.

Q Okay. And the -- as far as Ms. Grueskin's medical records, I understand that you said that she had no family history of Alzheimer's. Do you know if her parents -- how her parents died?

A I don't. I can't recall right offhand. I'd have to look at my notes.

Q Isn't it the case that many people who have genes for Alzheimer's die before Alzheimer's even manifests itself?

A Well, that could be true, yeah. But the -- the gene doesn't necessarily play out that you would get Alzheimer's, it's only a -- you know, it's only a, sort of,

one of the factors involved.

Q And let's talk about some of the other factors. Ms. Grueskin did have some, what I believe you called co-morbid --

A Medical conditions.

Q -- medical conditions. Tell us about those conditions that she had.

A Well, she had diabetes type 2 and she had breast cancer -- I think she had the breast cancer in the '90s.

Q And did she have to undergo both chemotherapy and radiation?

A Yes, she did.

Q And do you know for how long she had to undergo that treatment?

A I can't recall actually. There were 900 pages of medical records here.

Q Okay. Do you recall how long the treatment extended?

A No. I -- what I do know though is that -- is that prior to the Interferon treatment she was assessed by a neuropsychologist, who -- you know, with no signs of dementia or cognitive impairment, and then from that time of treatment of the breast cancer up until, you know, the time of the treatment, there was no notations in any of the medical records that she had any sort of cognitive impairment.

Q Let's go -- can we go back and talk about the co-morbid medical condition?

A Sure.

Q So we have -- you've identified the diabetes, you've identified the cancer treatment with radiation, chemotherapy?

A I think so.

Q And then what's the third co-morbid problem that she has?

A I think that -- there was just an allergy. She had some allergy in the mid'90s and that was it.

Q Do you recall your report mentions that she's a heavy daily smoker for over 20 years, smoking --

A Oh --

Q -- one or two packs?

A -- sure.

Q Now, I understand from your testimony that you don't see in her medical records any evidence of dementia prior to that -- the treatment, but I want you to explain to us the -- those three co-morbid conditions in combination do they contribute to dementia?

A I haven't seen that in my practice. People with diabetes don't become demented.

Q I --

A People with --

Q -- in combination?

A In combination? There is nothing I've seen in the literature, and I can -- I'll send you, you know, you'll see the articles I have in my portfolio that says that if you have diabetes and you smoke you're going to get dementia. Chemotherapy could be, you know, problematic if it's -- if the cancer comes back and you have to redo it and it's over and over again.

But the real culprit here is this hepatitis C. I mean, from what I know and the 19 people that I've evaluated.

Q And have you evaluated Stacy Hutchinson?

A I did.

Q Gwendolyn Martin?

A I did.

Q And have you evaluated Rodolfo Meana?

A I did. Michael Washington and --

Q And let me ask you in a -- was there a particular plaintiff's attorney who referred you to the district attorney's office to testify here today?

A I don't know how that came about.

Q Okay.

A I really don't. I got a notice from Mr. Staudaher.

Q Yeah, I don't know the guy.

A I don't know how you say his name, but anyway, I

got a notice from him. And he was interested in the, you know, the work that I had done on those people.

Q Okay. I saw that at the one -- the -- one of the two articles that you cited it was a article from some European medical journal, recall that? It dealt with the treatment of -- the drug treatment, and the effects on the -- the mental-health effects during drug treatment --

A Yes.

Q -- do you recall that --

A Sort of.

Q -- study? Pardon?

A I said sort of. There's quite a bit.

Q Well, here, I'll --

A Let me see if I --

Q -- just -- let me just show you --

A -- may have a hard copy.

Q -- your report. I got it right here.

MS. STANISH: If I may approach, Your Honor.

THE COURT: That's fine.

BY MS. STANISH:

Q Just to refresh your memory. It's -- that's your report, okay?

A Oh.

Q I just want it to go to the part where you cite the two tests.

A Do you mean the two articles?
Q Yeah.
A Oh, it must be in the beginning.
Q Do you know where it is?
A Yeah.
Q All right.
A Sure.
Q There it is.
A Yeah.
Q That's the one from Europe, right?
A Okay. What's it called again?
Q It's a really long title, of course.
A Cognitive impairment, okay. I probably have that on my computer. I don't have it right here as a hard copy, but --
Q Do you -- do you recall that that study ultimately concluded that far more -- more studies are needed in this area before conclusions could be drawn?
A Yes, but I think -- wasn't that -- what was the date of that study, you know, because there's been a -- quite a bit since --
Q I don't --
A -- since that time.
Q -- see a date in your report, so I don't know.
A Let's see. But I'll -- let me look this up and

can you ask your questions, I guess? Let's see here.

Q I've never had a witness whip out an iPad during testimony.

THE COURT: Well, it's a new world --

MS. STANISH: Yeah, it --

THE COURT: -- Ms. Stanish.

MS. STANISH: -- really is.

THE WITNESS: I used to come with boxes and boxes.

THE COURT: It's a brave new world.

MS. STANISH: So long as he's not playing Scrabble up there.

THE WITNESS: I used to come with boxes.

MS. STANISH: What Angry Bird.

MR. WRIGHT: Are we going to make a record of what he's looking at?

MS. STANISH: I'll join him up there.

THE COURT: Ms. Stanish, you can move freely about the courtroom.

MS. STANISH: Thank you.

THE WITNESS: Okay. And --

THE COURT: And, Doctor, if you'd just kind of tell us without telling us the content there on your iPad, would you just -- say just for the record so we all know, and -- what it is you're looking at.

THE WITNESS: All right. I'm looking at the original

article called, Cognitive impairment in patients --

THE COURT: Okay.

THE WITNESS: -- with chronic hepatitis treated with Interferon, results from the --

THE COURT: And that was your -- I'm sorry, I didn't mean to -- that was referred to in your report?

THE WITNESS: Yes.

THE COURT: Okay. Now, don't tell us the content of the -- that article unless Ms. Stanish asks you something about it --

MS. STANISH: All right.

THE COURT: -- okay?

THE WITNESS: Okay.

BY MS. STANISH:

Q And so that -- the year was 2000 and what did you say?

A It was received in 2004, and it was accepted 2004 and available online in 2005.

Q And are you aware of whether additional studies were done in the United States on that issue that is raised in that European medical journal?

A Oh, yeah, you'll see them here. Robin Hilsabeck and others -- and I think the name was Fortin [phonetic] they've done additional studies since then, 2009, and '10 and '11.

Q Okay. Why -- can I ask you why aren't -- why didn't you cite any of these 11 or numerous studies in your report? Because you only cite this one that you have there on your iPad and -- from 2005 and then one additional one that looks like it's dated in 2009, but I don't know what the publication is?

A I don't know. I -- you know, I've done 19 reports plus a master grid and you just can't, you know, cite everything.

Q Okay.

A You know, I was trying to deal with the issue at hand. This study was important because it said that there were -- I'm not supposed to read from it -- it said that there were, you know, disturbances in the prefrontal cortex and the hippocampus.

Q That -- I don't -- all I really asked was why you didn't cite it, and I understood your answer to be that you -- you did -- wrote a bunch of other reports and you didn't think it was necessary; something to that effect?

A Well, not that it wasn't necessary. You just have a certain amount of time available, you know, and so --

Q Correct. And you were doing these -- Ms. Grueskin was -- and a plaintiff's attorney hired you to represent her in a lawsuit; is that correct?

A Yes.

Q And can you tell us how much fees you earned in the representation -- or the assessment of Ms. Grueskin, Hutchinson, Martin, Washington, Meana, those five people; can you estimate?

A Well, depending upon the level of testing, it was 10 to $15,000 per person roughly, but each person, like, Ms. Grueskin had over 900 pages or 1000 pages of medical records, and all those medical records had to be gone through and --

Q Okay. By the way, do you know from your review of her medical records what her liver function test, her most recent liver function test showed as far as the hepatitis C virus; do you know?

A I may have known at the time, but I can't remember right now.

Q Okay. I'm about done. Hold on. Okay. I have nothing further. Thank you, sir.

A Thank you.

THE COURT: All right. Mr. Santacroce?

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Doctor, can you tell me a little bit about what your employment practice consists of right now?

A Well, I -- let's see. I do quite a few military cases. I do a lot of forensic work.

Q Okay. Now, let me stop you there. When you say you do a lot of cases, I'm a little confused. Are you talking about court cases or are you talking about diagnosis of certain ailments?

A Well, everyone gets tested that comes to my office, and so the forum is just the forum. So there's the forensic forum, there's the military forum, I am doing research on neuro exercise and putting them in various communities. In fact, I put one here in Las Vegas. Once in a while I go to Berkeley and teach the pre and post doctoral students on updates of testing and I do the beta testing on neuropsychological instruments.

Q And what do you --

A I mean, that's roughly --

Q -- mean when you say forensic? What is the forensic aspect of your work?

A Well, forensic is sort of, you know, when there's a dispute and -- and then the forensic scientists would come in and try to resolve the dispute in some way.

Q When you say dispute you're talking about court dispute?

A I guess you would call it a court dispute or some sort of, you know, dispute over damage or dispute --

Q Money damages?

A Well, not -- not so much money damages, but, you

know, the actual damage to the person. Sometimes there's a dispute where a person may claim they're injured when they're not or they're severely injured and there has to be verification of it. And so I guess the neuropsychologist, in terms of brain functions, would be the verifier.

Q So when you talk about forensic does that have to do with court?

A Yes, it has to do with court, but there are different levels. I mean, there's, you know, in the military cases, I guess you can call that forensic too but it's not a courtroom like this if there's a military tribunal consisting of doctors and surgeons that I report to and I send my reports to and that kind of stuff.

Q But it's still a judicial process whether it's under the UCMJ or if it's under civil law?

A Sort of, yeah.

Q Okay. And how many times have you testified in court regarding your expertise?

A Actually at trial? About -- I want to say over 30.

Q And you've testified mostly for plaintiff's in those cases?

A Mostly.

Q Or prosecution?

A Well, I only did one other criminal case in

Bethel, Alaska --

Q Okay.

A -- but I didn't --

Q But when you worked for the county attorney's office in Salt Lake City, what did you do?

A Oh, there we were designing an alternative-treatment program to incarceration. So the idea was, you know, if we could test these people -- I tested them, and -- and if there were some other factors involved and they were candidates for rehabilitation maybe that was a viable alternative to then imprisoning them and that's what I did.

Q Okay. So you didn't work for the prosecution and the county attorney's office in Salt Lake City?

A It was -- yeah, it was the -- it was the county attorney's office of Salt Lake City. And then the county attorney's office of Santa Clara hired me once as a consultant for a case.

Q In this particular outbreak in Clark County Nevada, you were retained on Carole Grueskin, Patty Aspinwall; is that fair?

A No, Patty who?

Q Okay. Well, then you have Stacy Hutchinson?

A Yes.

Q Rodolfo Meana?

A Yes.

Q Gwendolyn Martin?

A Yes.

Q And those other individuals that you were retained for -- and we're not talking about Carole Grueskin now, but the ones I just mentioned, okay?

A Yes.

Q Did any of those have any cognizant deficiencies that you noted?

A Oh, yes, they all did.

Q Okay. And isn't it a fact that most hepatitis C patients have some cognitive problems?

A Well, it appears that way and the literature appears to say that -- that you don't have to have a full-blown liver disease to have the cognitive issues. That's why they think it's neuro-virulent.

Q I see.

A That it affects your brain even before the evidence comes forward that -- that your liver has been damaged.

Q Well, there was no dementia for Stacy Hutchinson, Gwendolyn Martin, was there?

A No, but Stacy Hutchinson was pretty impaired actually. Gwendolyn was better -- she did better. But Carole Grueskin is -- was the fully demented one. They -- the other two or those other people that they mentioned could complete

their exams, but she was so impaired that she couldn't even complete it.

Q And don't some of the studies indicate that they're not quite fully understanding how it's related to the hep C? That it may be related to the fatigue from the hep C?

A No, just the opposite is true. When I send your colleague my file on hep C literature, you'll see that the cognitive impairment is independent of depression, independent of fatigue, independent of all of these sort of psychiatric problems that happened. There's been several studies with regard to that issue.

Q Are you familiar with the July 2012 study that was reported in the HCV Advocate newsletter? Are you familiar with that study?

A What's the title?

Q That's the title. It's by Alan Franciscus.

A I can't say I recall it.

Q Okay. In that study he indicates that a possibility is due to the constant state of fatigue that these hep C patients have as a symptom of their disease; do you disagree with that?

A Well, it seems to be contradicted by the studies that show that prior to getting, you know -- you know, outright liver disease, so in other words, the subclinical people, they also have cognitive impairment. And so no

question that, you know, Interferon creates fatigue and a hose of other things. You know, it is a complicated process, but there seems to be some -- some research that indicates before your liver even progresses to the point where, you know, it's noticeable these individuals are suffering from brain dysfunction.

Q Well, is it the disease or the treatment of the disease that causes the problem?

A Well, it's both. It's the disease and the treatment of the disease that causes the problem.

Q Okay. What's brain fog?

A Some people describe brain fog as, you know, they're not thinking clearly and they can't, you know, literally see clearly -- not vision-wise, but they just can't put things together clearly, and it sounds, you know -- it feels to them as if their brain is in a, you know, sort of like in a fog state.

Q So a possible loss of concentration?

A Loss of concentration, loss of attention, you know, loss of the ability to process your world quickly.

Q Okay. And don't the studies indicate that that's what most -- or that's what the people experience as this brain fog and not dementia due to the hep C virus?

A Well, brain fog is not dementia, you know. People that report brain fog are able to, you know, where they

went to high school. They're able to know the year. They're able to know -- it was 4:00 in the afternoon and I asked her to draw a clock and she wasn't able to do it and she put, you know, 10 minutes to 10.

People that have brain fog don't wander around the neighborhood, you know, confused and disoriented. And in addition to that, you know from my report that after this treatment, including the report of the treatment that the medical records reported dementia. There were several entries in her medical records where it said, dementia, dementia, dementia, dementia. It wasn't just me, you know. Before she even saw me all the practitioners reported that she was demented.

Q Are you familiar with the University of Alberta Canada's study of 2000 -- October 7, 2010?

A I'm sure that --

Q I mean, there's a lot of studies --

A -- I'm sure there's hundreds of --

Q -- I'm not -- I'm not trying --

A -- studies.

Q -- to put you on the spot, I'm just trying to understand this, you know.

A Does it have a title?

Q The lady might have dementia. I'm just trying to understand it, I don't know, so in my research of this

subject which is very limited, I don't have the expertise that you do and I don't pretend to have that, okay?

A All right.

Q So I'm just trying to get some information from you.

A Does it have a title, maybe I have it?

Q That's all I have is the site, the University of Alberta, October 7, 2010, study.

A You don't have a title or a --

Q No, I don't. Are you familiar with any Canadian studies?

A Not off the top of my head because I don't look at where the --

Q Okay.

A -- studies are published.

Q Well, you understand -- I mean, you don't confine your study and resource just to studies out of the United States, do you?

A No.

Q And you look at things from all over the world --

A Well, sure.

Q -- to get a big picture?

A Sure.

Q And in Canada it's reported that, at least in

this study there was -- there's 300,000 people with hep C walking around, and they tested, at least according to this study and found that only 13 percent of those people had any kind of brain impairment.

And I guess what I'm trying to understand, is that 13 percent some sort of secondary problem, or is it -- can you attribute it directly and are you medically certain that it comes from the hep C and doesn't come from the Interferon or the ribavirin or something else?

A Well, first of all, you don't have a title of the study, so I can't even look at the study right now and tell you -- and answer your question. Secondly, the 13 percent that they report is inconsistent with what the Americans report and Robin Hilsabeck at UCLA because it's more like 39 or 40 percent.

Thirdly, in the 19 people that I've seen it's about 50 percent that have some sort of a cognitive impairment. Fourthly, I would have to see the way the research was conducted. What neuropsychological test they gave. I would have to see the battery of tests. I would have to see whether they actually did a thorough and comprehensive job. Whether they tested all the issues at hand, including white matter and the processing speed loss and verbal and visual memory as well as frontal and prefrontal, you know, kinds of issues.

But without giving me the evidence to look at, it's

very hard to answer --

Q Okay. I'm just --

A -- your question.

Q -- I'm just asking you to comment on what they found.

A Well, how do I know what they found when you don't --

Q Okay. Well, I'm --

A -- have it?

Q -- telling you if that's what the study says. If you don't trust me on that that's fine. You know, that's fine. You want to --

A Well, you can't pluck a statement from a study that seems to be comprehensive and I'm supposed to rely on the way you represent it, you know, that's not proper and that's not science, you know. And so any questions that you have related to that my answers would be nonsensical. You know, the general question is does the hep C cause brain damage? The answer is yes.

Does the Interferon combination with hep C cause brain damage? The answer is yes. And so, you know, Carole Grueskin is an unfortunate. She's demented.

Q How many people in the United States have hepatitis C to your knowledge?

A I don't know. I'm not sure.

Q Four percent of the population?

A And?

Q I'm asking you, as a person that studies this, can you tell me how many people in the United States are walking around with hepatitis C?

A I don't know.

Q You told me you studied 19 people, and from 19 people you're telling me that's a scientific study or sampling?

A Well, it's not a -- it's not a random sampling. It's a sampling of people from this community, you know. It's not a -- it's not a -- I didn't go out and sample, you know, the American population who have hep C, you know. It was a random -- it was a sample from this community of 19 individuals that I happened to test. And there was a remarkable consistency amongst these genetic strangers in terms of their brain dysfunction.

Q So I'm supposed to accept that as scientific data that you studied 19 people, and the jury is supposed to accept that as scientific data that you studied 19 people?

A Well, you don't have to accept anything. I'm not asking you to accept anything. The point of the matter is is that Carole Grueskin is demented, okay? And out of this context, if I told you that she was demented, you wouldn't challenge it. She's demented. And all the medical people

that have seen her has labeled her as demented. Percipient witnesses, her neighbors, her son have labeled her as demented.

And her neuro-cognitive, you know, impressions shows that she's demented, okay? You weren't there with her all day, I was.

Q I'm not denying she's demented, Doctor. You're drawing the conclusion that she's demented because of the hep C virus. That's what I'm challenging with you, and I'm challenging it based on the 19 people you studied and the conclusions you drew from those 19 people when there's hundreds of thousands of people in the United States walking around with hepatitis C that you didn't study.

A But those hundreds of thousands of people around the United States aren't relevant for the individual, okay? You know, scientific psychology studies individual differences not group differences. It doesn't matter to me, you know, whether there's 10 people that aren't demented but she's the one that is, okay?

The pattern of results and the literature seems to indicate that individuals with hep C and combination Interferon treatment makes it worse and they become -- they have cognitive impairments. In her case, she's an unfortunate, you know. She has more cognitive impairment than some others and she's fully demented.

Q Well, it may not matter to you, sir, but it matters to me and it matters to my client.

MR. SANTACROCE: I have nothing further.

THE COURT: All right. Redirect?

MS. WECKERLY: Just briefly.

REDIRECT EXAMINATION

BY MS. WECKERLY:

Q Dr. Perrillo, you actually tested the 19 people that you're talking about, correct?

A Yes.

Q So you performed all those tests on them and concluded that there was some impairment that you actually personally saw from your testing results?

A Yes.

Q But you're also aware of wider studies or the scientific literature that show the association between hepatitis C and cognitive impairment?

A Yes. I must have -- I must have, I don't know, 30 or 40 studies here just on hepatitis C alone.

Q Okay. And specifically, in terms of Carole Grueskin, her level of cognitive disability and dementia occurred after she contracted hepatitis C and did the Interferon treatment?

A Yes.

Q Thank you.

THE COURT: Ms. Stanish?

MS. STANISH: Just a few.

RECROSS-EXAMINATION

BY MS. STANISH:

Q Based on the testing that was referred to, did you -- you test -- did you say you tested Ms. Martin?

A Yes.

Q And what was your conclusion with respect to Ms. Martin? Did she have brain fog or dementia?

A I'd have to --

Q Okay.

A Just give me a moment.

Q Okay. I'll get up there -- I want to look at the iPad.

A Let's see. Those are her medical records. Hold on. Here we are. She didn't have brain fog, I'll tell you that.

Q What did she have?

A Well, she had brain damage, you know. Ms. Martin was -- these are her predictive results. These are her actuals. And you can see what the base rates are and the differences.

Q When did you evaluate her?

A Let's see. August 26, 27, 2009.

Q So you're saying Ms. Martin has some kind of

permanent dementia?

A No, I didn't say she had dementia. I just --

Q Oh, okay.

A -- I didn't say dementia. Let's see what the diagnosis -- what I wrote in the diagnosis here. She had moderate brain dysfunction. Well, she had frontal, temporal, and occipital dementia also, but not to the same degree as Ms. Grueskin.

Q And does that mean --

A And she had post traumatic stress disorder.

Q Your eyes are better than mine.

A Here, I can make it bigger --

Q Yeah, do that.

A -- for you.

Q Yeah, that's good. And --

A I don't know if I can --

Q -- oh, no, that's okay. I got it. That -- this frontal, temporal occipital --

A Occipital.

Q Yeah, that's what I said. Dementia?

A Yes.

Q Is that permanent?

A It's permanent. Well, she was permanently disabled at the time that I saw her. Is it permanent? Let's see. You know, the brain has plasticity. It can improve over

time if you do neuro exercise when you're younger.

MR. WRIGHT: I can't hear you when you're talking to her.

THE WITNESS: Oh. The brain has what's called plasticity. It can improve over time, especially if you're younger and you do neuro exercise, but I don't -- I can't remember how old she was. I think she was fairly old actually. Let's see. She was 62.

Q And what about Stacy Hutchinson? What was your diagnosis of her?

A Well, Stacy Hutchinson was younger. She was like 35 or 38, and she had a host of cognitive, emotional, and psychological issues, including not being able to consummate her marriage because people get spooked and so she was spooked and her husband got spooked and they just -- at the time that I saw them they --

Q Yeah.

MR. WRIGHT: They got what?

MS. STANISH: Spooked.

MR. WRIGHT: Spooked?

THE WITNESS: Spooked?

MS. STANISH: It's a medical term, spooked.

THE WITNESS: Well, it's not a medical term, but it's a --

MR. WRIGHT: Spooked?

BY MS. STANISH:

Q A psychological term.

A No. It's not a psychological term, but it's meant to convey the idea that if you have an infection, you know, people get concerned and they get scared. And so they think that it's highly contagious and can be contagious, you know, in ways that aren't contagious.

Q Okay.

A And so I say in quotes, they get, "spooked".

Q Okay. We get it. Can we get back to talking about dementia and brain damage?

A Sure.

Q And I guess what I'm interested in knowing, sir, is to the extent that you've made diagnoses of these people, who has permanent dementia amongst them with respect to -- I see on your iPad here that you also evaluated Lakota Quanah. Did he have dementia?

A No.

Q Okay. And I -- let's see who else you got there.

A Well, Rodolfo Meana didn't have dementia but his cognitive impairment was so -- it was so impaired that his prognosis was, you know, extremely poor and subsequently he died, as you know.

Q And can I ask you something else? How about

Sonia Rivera? Is that a Oriental?

A Yes. No, she didn't have dementia either. She was continuing to work, but having some difficulties. I forgot what she did. I think she was like an accountant type, or something within the hotels here.

Q Okay. Okay. Thank you.

MS. STANISH: I have nothing further.

THE COURT: All right. Mr. Santacroce, anything else?

MR. SANTACROCE: Nothing further.

THE COURT: Mr. -- I'm sorry, Ms. Weckerly?

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

THE COURT: All right. We have a couple juror questions up here.

THE WITNESS: Oh.

THE COURT: A juror would like to know: How can you differentiate between regular dementia due to age and dementia caused by liver function due to the treatment of hepatitis C?

THE WITNESS: Well, I think, you know, one way to determine it is the onset and its temporal or time, you know, contiguousness. In other words, with the genetic type of dementia it's usually a slow, progressing, you know, process so the person make -- we call them mild cognitive impairment. And they may complain of just some mild issues, and then it slowly progresses over time.

In Ms. Grueskin's case it seemed to be almost at the time that she took the treatment -- the Interferon treatment, that's what the medical records say, it was at the time that she took the treatment. In fact, she had to stop the treatment because it was noted as one of its side effects, you know, in the medical records that she became demented as a result of that treatment.

There is a bit of overlap. Individuals, for example, with traumatic brain injury will have -- they could become demented too in quote, like the NFL players could have early dementia. But the pattern of results, brain function results are different. The genetic variety affects all functions, including reading ability, vocabulary and comprehension. You know, your language stuff, left hemisphere stuff.

Some of the other types of dementia will only, you know, pick and choose so to speak, but not affect all functions.

THE COURT: Okay. And a juror wants to know: Does the type of dementia you're talking about affect just the frontal lobe or the whole brain function?

THE WITNESS: Well, in -- you mean specifically Ms. Grueskin or --

THE COURT: Well, talk about Ms. Grueskin and then also hepatitis C related dementia, the -- what part of the

brain -- if that's isolated to a particular part of the brain or it could be --

THE WITNESS: A very, very good question. The -- the literature and my understanding of Ms. Grueskin and the other people that I evaluated, the brain dysfunction affects the white matter tracks. So that's -- that's your corpus callosum superhighway between the hemisphere. Think of your brain as wires, okay, and it affects the speed at which you could process your world and information, so white matter.

It affects the frontal area of your brain. That's your executive functions, your ability to plan and anticipate and integrate information. And it appears to affect the, you know, sometimes the temporal and then the occipital area -- your visual memory tracks. But it doesn't appear to affect motor and the cerebellum

And so in Ms. Grueskin's case, for example, she had, you know, within expected results on all of her motor ability. She was able to do fine motor and grip strength and things like that.

So it seems to affect the higher cortical functions, not necessarily the cerebellum and below.

THE COURT: Okay. That --

THE WITNESS: With other types of dementia though, everything gets affected, you know, the whole thing pretty much shuts down.

THE COURT: All right. And that's a great segue into the next juror question, which is, does this kind of dementia cause you to, you know, forget to breathe or to not -- you lose your ability to talk or walk?

THE WITNESS: Usually not, you know, but -- but, you know, it could affect balance. You know, there could be balance issues and, you know, dizziness and things like that. But usually the involuntary motor functions are preserved. Breathing, you know, those things are preserved.

But what gets most affected is -- is, you know, memory aspects, you know, like visual and verbal memory and attention concentration. Some of the frontal areas get affected, primarily attention concentration, and your -- your ability to process your world quickly.

THE COURT: Now --

THE WITNESS: So --

THE COURT: -- I'm sorry. I didn't mean to --

THE WITNESS: -- so by the time you're attending to one item you lose the rest. And -- and so then you don't remember the rest. And, you know, in her case -- in Ms. Grueskin's case it obviously is more complicated in that her whole brain seems to be, you know, seems to be shutting down.

But Mr. Meana is a good contrast case in point because he didn't have the typical type of -- of demented behavior as you would think demented, you know, wandering

around aimlessly. But he was severely impaired. And his prognosis was extremely poor, and subsequently he passed away, you know.

And I -- unfortunately, I don't think Ms. Grueskin is going to last much longer either.

MR. SANTACROCE: Your Honor, I'm going to move to strike that.

THE COURT: Yeah, I would ask the jury to disregard that. I think that's beyond the scope of what this expert is here to talk about.

Now, regular dementia, meaning age-related dementia or Alzheimer's type dementia, does that cause people to forget to breathe or does that cause them to lose the ability to do things like talking, walking?

THE WITNESS: Well, I don't -- it doesn't -- no. I mean, Alzheimer's doesn't affect, you know, people's -- they don't forget to breathe because breathing is, you know, involuntary. And in the early stages of Alzheimer's an individual could still drive. And individual could still retain what's overlearned. And driving is over, you know, is overlearned.

But eventually in the severe later stages of Alzheimer's your whole -- your whole brain shuts down, and then you don't breathe anymore and you can't walk and talk and you -- or you just speak nonsensical things, and so...

THE COURT: All right. Thank you. Does the State -- Ms. Weckerly, do you have any follow-up to anything?

MS. WECKERLY: No.

THE COURT: The last juror questions or where Ms. Stanish left off?

MS. WECKERLY: No, thank you.

THE COURT: All right. Ms. Stanish, do you have any follow-up to those last juror questions?

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

THE COURT: Mr. Santacroce.

MR. SANTACROCE: No.

THE COURT: Any additional juror questions before we excuse the witness? All right. I see no further juror questions. Thank you for your testimony. You are excused at this time.

THE WITNESS: Thank you.

THE COURT: And the State may call it's next witness. Everybody okay? Or does anybody need a break? No?

MS. WECKERLY: Your Honor, it's Ms. Syler, and I -- she's on cross, but I'll get her.

THE COURT: Okay.

MS. WECKERLY: Just -- just so --

THE COURT: All right.

MS. WECKERLY: -- where we're at.

THE COURT: And, ladies and gentlemen, we're now

going to resume with the witness that we left off with yesterday. As you'll recall, the State had concluded its direct examination, and we took our evening recess.

Ma'am, come on back up here by me, please. Have a seat, and you are still under oath; do you understand that?

THE WITNESS: Yes, ma'am.

THE COURT: All right. Thank you.

Ms. Stanish?

MS. STANISH: Thank you, Your Honor.

CROSS-EXAMINATION

JOAEN SYLER, STATE'S WITNESS

BY MS. STANISH:

Q Good morning, ma'am.

A Good morning.

Q My name is Margaret Stanish; I represent Dr. Desai. I hope that you can start off by educating us a bit about the world -- the wonderful world of medical building -- billing. As I understand your testimony, the CMS -- Center for Medicare -- and what's the S?

A And Medicaid Services.

Q Services. Why isn't it CMMS?

A I've wondered --

Q That's my first --

A -- that myself.

Q -- question. CMS is -- sets -- provides some

standards that insurance companies can either elect to adopt or not; is that correct?

A Yes, to a certain extent. If it's a Medicare patient, then -- and the private insurer is the secondary insurance, then they have to follow Medicare rules and secondary insurance doesn't pay until Medicare or Medicaid is paid.

Q And so my -- just to clarify, whenever there's a patient that gets some kind of government reimbursement for medical services, there's going to have to be reliance on the CMS standards?

A Yes.

Q And is that the case with the Veterans Administration; if you know?

A Yes, usually with the VA if they're the primary insurer, then the VA pays. Sometimes the private insurance will then pick up the rest. Sometimes the provider will accept what VA pays, and then there is no further payment at all. So it just depends on different circumstances.

Q Is it safe to say that medical billing reimbursement is quite complicated?

A It can be. It can be.

Q And when it comes to the CPT codes -- and what does CPT stand for?

A CPT is current procedural terminology. It's a

physician-based coding book that AMA and CMS with some input from private -- large private insurers contribute to have this book of codes for services and procedures.

Q And these CPT codes, do they often get revised?

A There are revisions -- the book is published annually, then there may be a few revisions once during that year. But when the book is published annually, the vast majority of the codes remain the same.

Q And is there -- is -- in your experience as a, what sounds like a long experience in dealing with the world of medical billing, I understand that you have done audits for Blue Cross and Blue Shield?

A Yes, I have. Many.

Q And have you been part of that process that deals with trying to recoup overpayments from providers?

A Yes, many times.

Q And have -- do you find -- have you done that in the context of anesthesia billing?

A Yes, I have.

Q Okay. And in preparation, by the way, for your testimony here today, did you review the anesthesia billing requirements of CMS?

A The review I did was a medical-record review of approximately 140 records. I did not see any claims or any of the actual billings.

Q Okay. I was wondering about that. So thanks for answering that without me asking. But the -- what I -- what I was trying to get at was whether you reviewed the CMS -- the CPT codes that relate to anesthesia?

A I -- for my personal review I did, but I did not review any codes associated with those records that I reviewed.

Q I guess what I'm trying to understand -- I want to -- you discussed yesterday how anesthesia billing works, and I'm going to discuss that with you in a moment. I just want to understand what your foundation was for that testimony, what you studied in order to testify about the base units, the timing, et cetera.

A Basically, it's my experience and a quick review on research, just to ensure that my knowledge base was still as it should be.

Q Fresh?

A Fresh.

Q And did you specifically look at the CMS requirements, the CPT codes that were in place in the year 2007?

A I attempted to -- to locate those codes because I no longer have my book from 2007. So I researched trying to find 2007 anesthesia codes. I could easily locate the 2007 codes for the actual GI procedure, such as the endoscopy or

the colonoscopy, I could easily find those, but I could not find the anesthesia codes for 2007.

Q Right. That -- the CMS has a website where some of their codes are available or the current codes, correct, but to do historical --

A It's difficult.

Q -- code research you can't do that prior to, I think, 2009; is that correct?

A Yes.

Q And the -- I guess this question you've already answered it, you don't know what the requirements were for -- or the standards were, I should say, for CMS and the CPT codes back in the calendar year of 2000?

A No, I could not say for sure.

Q Is it possible that from the year 2000 to 2007 the -- there has been changes in the standards for calculating the value of anesthesia services?

A From 2000 to 2007?

Q Yes, ma'am.

A There's a good chance that there could have been revisions, but I do not know that for a fact.

Q Based on your experience with billing for over the years, is it common that there would indeed be revisions?

A Most of the revisions that occur in CPT come about because of physician input. And frequently the

revisions involve further explanatory remarks to describe the code, or a sentence or two added to the guidelines affecting those codes to try to help physicians as well as coders to determine the correct code. So frequently the revisions are only explanatory remarks rather than a complete change in the code.

And the other more common thing that occurs with CPT annually is they add codes. For example, I began working with coding in the mid-'80s, and the book at that time was probably a quarter of an inch to a half an inch thick, and now the book is approximately an inch and a half thick. And that's because of codes continually being added, again because physicians have input, and, you know, new procedures and new technology have come along.

Q Right. And it's interesting what you said about how the explanations have to be further elaborated on in order to assist providers and billers. And I -- I want to stem from that concept there.

As part of the evolution of the standards of billings, does it -- does the evolution of the healthcare come into play? So -- and I know this is -- I'm getting wordy here, but to get to the question does the evolution from hospital-based procedures to ambulatory surgical centers, does that relate to further clarifications or the need for revisions of the code?

A Through the years as ASC, Ambulatory Surgery Centers, have come along, there has been some revisions to specifically speak to whether something is hospital-based or ASC-based.

Q All right. And by the way, too, do you know from your research if you were able to see whether there were changes in the standards for anesthesia building -- billing -- from the year 2007 to 2013?

A I can't say for sure from my research that I can actually put my finger on specific changes. Since I could not locate 2007, I could not say whether there had been a lot of changes from '7 to '13.

Q And going back more now to what you touched -- we touched on earlier, and that is how insurance companies interplay with CMS and the CPT. I guess I understand everybody uses the CPT codes to identify the procedure, whether it's a colonoscopy plus the anesthesia service. But the -- the CMS, as I understand it, is kind of the decoding book, how you're actually going to put a price tag on that service that's rendered. Is that -- oh, like a real simple explanation for it?

A Well, Medicare does have a fee schedule.

Q Right. And I -- and that's what I want to get at next, is the -- the fee determination by private insurance companies.

A They use the Medicare fee schedule as a guideline. Sometimes the fee will be the same, sometimes it's different, but they do utilize the Medicare fee schedule as a guide.

Q All right. And as I understand it the -- you had mentioned yesterday that part of this equation is contract negotiations, correct?

A Yes.

Q And so to the extent that you have a provider who might be a -- a large, private group there's going to be negotiations between the medical group and the insurance company to define how the procedure should be reimbursed?

A They have contract negotiations, but as to what all that entail,s, I've never actually been involved in contract negotiations so I couldn't say what it entails but there are contract negotiations. Usually they're done annually.

Q And is that -- when they are negotiating, does that necessarily -- it can affect the rate of reimbursement?

A It's possible. You know, like I said --

Q You're not sure --

A -- I've never been involved --

Q -- okay.

A -- in contract negotiations, so...

Q All right. So pleasant to have a witness from

the South, it's -- instead of L.A.

A I sound perfectly normal to myself.

Q You do. That is so --

THE COURT: And to everyone else from the South.

THE WITNESS: It's you guys that have the accent.

BY MS. STANISH:

Q You got that right.

A Let me just point that out.

Q All right. I -- I want you to help us through the -- I want to go through the formula that the CMS -- that you discussed yesterday with the CMS, okay? And you are familiar with Form 1500s, I assume?

A Oh, yes.

Q Okay. And so real basic, we're trying to determine the value of anesthesia service, and so we have to resort to the CMS standards, the formula that you discussed yesterday with base units, correct?

A Yes.

Q Now -- but I'm making an assumption when I do this. I'm assuming that the private insurance company has actually adopted in whole the CMS formula, all right?

A The major insurers that I'm familiar with, yes, they have.

Q All right. And you -- we've -- so I'm just going to jot value of [inaudible]. You mentioned first that

we start with the base unit, and I -- as I understand your -- well, explain that to me again so I make sure I have it correct.

A The formula basically is the base unit plus time units plus modifying units.

Q Modify -- modifier units?

A Modifying units, it's usually called.

Q Okay. And in anesthesia do you know what the base unit is for colonoscopies?

A No, I do not.

Q All right. Let's just assume for this hypothetical that it's 5. Do you know how the time units are calculated according to the CMS standards?

A 15-minute increments, I guess is the simplest answer.

Q And so I'm just going to try to fit that here. 0 to what, 14 or 15?

A 15.

Q And then the next increment would be 16 to 30?

A Yes, to my knowledge that's the way it would work.

Q And then 31 to 45; is that right?

A I would assume that's correct. So I'll say yes because, you know, I think in terms of -- I don't think of it that way. I think of it in terms of, you know, is 18