NEVADA STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

ROY HAN-HUI LOO, M.D.

ADJUDICATION

Public Version

Case No: 23-25326-1

Date: June 7, 2024

INDEX

1. COMPLAINT
2. HEARING OFFICER'S FINDINGS AND RECOMMENDATIONS
3. HEARING TRANSCRIPT
4. EXHIBITS ADMITTED INTO EVIDENCE
5. DOCUMENTS FILED INTO THE DOCKET

1

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against:	**Case No. 23-25326-1**
ROY HAN-HUI LOO, M.D.,	FILED
Respondent.	JUN - 8 2023
	NEVADA STATE BOARD OF MEDICAL EXAMINERS
	By: ______

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Roy Han-Hui Loo, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 10129). Respondent was originally licensed by the Board on April 1, 2002.

2. Patient A[2] was a forty-six (46) year-old female at the time of the events at issue.

3. On the morning of March 13, 2018, Patient A was diagnosed by an optometrist with an acute retinal horseshoe tear in the supertemporal quadrant of the left eye, following complaints of loss of vision.

4. Patient A was immediately referred to Respondent following her diagnosis on March 13, 2018.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Aury Nagy, M.D., Nicola (Nick) M. Spirtos, M.D., F.A.C.O.G., and Ms. Maggie Arias-Petrel.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

5. On March 13, 2018, Patient A presented to Respondent. Respondent did not note a reason for the emergency referral, nor inquire to the referring optometrist for referral paperwork. Respondent documented Patient A had complaints of floaters in the left eye.

6. Respondent examined Patient A and documented the presence of vitreous floaters but failed to diagnose Patient A's retinal tear and intervene.

7. On March 14, 2018, Patient A developed decreased vision and was diagnosed with a retinal tear and detachment of the left eye by a different ophthalmologist. Patient A underwent urgent surgical repair on the evening of March 14, 2018.

COUNT I

NRS 630.301(4) - Malpractice

8. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

9. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

10. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

11. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A by failing to diagnose and treat Patient A's retinal tear, leading to detachment of the retina in Patient A's left eye.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

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14. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment, and care of Patient A, by failing to correctly obtain and note Patient A's reason for referral.

16. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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Nevada State Board of Medical Examiners
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Reno, Nevada 89521
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6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________

IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________
AURY NAGY, M.D.
Chairman of the Investigative Committee

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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and
Complaint Against

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

FILED
MAR - 5 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: [signature]

FINDINGS AND RECOMMENDATION

TO: Ian J. Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq.
8329 W. Sunset Rd., Ste 260
Las Vegas, NV 89113

This matter came for hearing on February 1, 2024. The matter was held remotely via the Zoom application to accommodate the appearance of Respondent Roy Han-Hui Loo's expert witness by remote means. Participating in the hearing were Ian J. Cumings on behalf of the Investigative Committee of the Nevada State Board of Medical Examiners (the "IC"); Chelsea Hueth, Esq. on behalf of Roy Han-Hui Loo, M.D. ("Respondent"), and Respondent. IC witnesses called to testify were Ernesto Diaz, the IC Chief of Investigations, and expert witness Steven Friedlander, M.D. Respondent testified on his own behalf and additionally called expert witness Kirk Hou, M.D. All witnesses were sworn. The rule of exclusion was not invoked by either party.

The Complaint alleges: Count I, NRS 630.301(4), Malpractice; and Count II, NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records. The Malpractice charge is premised upon the allegation that Respondent failed to diagnose and treat a retinal tear, which then led to a retinal detachment. The Failure to Maintain Proper Medical Records charge is premised upon the

allegations that Respondent failed to obtain and note the reason for the patient's referral to his office.

The crux of the malpractice claim falls squarely upon whether Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers when he failed to identify a torn retina for a patient referred to him on an emergency basis by an optometrist who documented such a tear. *See* NRS 41A.015. The relevant underlying findings and facts are as follows.

- On March 13, 2013, the patient was referred to Respondent by an optometrist who, upon examination of the patient just past 2:00 p.m., noted a "supertemporal horseshoe tear with surrounding hemes" located in the patient's left eye. IC Ex. 5, pp. 113 (for date and time) and 118.
- The referenced tear was referred to throughout the proceeding as a retinal tear with respect to which the optometrist noted, "[c]ondition is new. The diagnosis was discussed in detail, and all questions were answered. Refer to retina for evaluation and treatment. Was referred to RCN ASAP." Id.
- RCN is short for Retinal Consultants of Nevada, which is Respondent's practice group.
- The patient presented at RCN the same day and was examined by Respondent. IC Ex. 4, pp. 34-39.
- Upon presentation, the patient reported flashes and floaters. Id., p. 35.
- Respondent did not have referral paperwork from the optometrist nor the benefit of the optometrist's records when he met with the patient, nor did he call the referring optometrist's office to determine the basis of the referral.
- Respondent examined the patient with the intent of examining for "anything substantive," which would include a retinal tear. Trial Transcript ("TT") p. 52, 200, 221. In so doing, Respondent undertook Scleral Depression; a Fundoscopic Exam (referred to as a fundus exam in the record), for which the patient's eyes were dilated; an Optical Coherence Tomography "(OCT"); and a B-Scan Ocular Ultrasound of the patient's left eye. IC Ex. 4, pp. 34, 76.

- Respondent did not identify the retinal tear and concluded that the patient was suffering from floaters. Id.
- Respondent instructed the patient to return if she experienced visual decline. Id.
- The following day, March 14, 2018, the patient returned to RCN, refused to be examined by Respondent (IC Ex. 4, p. 54), and was examined by one of Respondent's practice partners who diagnosed the patient with retinal detachment on the patient's left eye. IC Ex. 4, pp. 79, 81; IC Ex. 5, pp. 105-11.
- The retinal detachment had not been noted the day before by either the optometrist or Respondent, nor did it appear on the B-Scan Ocular Ultrasound, which is a test more apt to show a retinal detachment versus a retinal tear. TT 62, 155, 168, 172-73, 196-97. This indicated that the detachment occurred after the patient was examined by Respondent. While this finding is consistent with the testimony of Respondent's expert (TT 173), it should be noted that the IC's expert believes that the retinal detachment had already occurred when the patient was seen by the optometrist and was missed by both the optometrist and Respondent. TT 107-08.
- The surgical notes related to the repair of the retinal detachment remarked that "[n]o further retinal breaks were found," indicating that the horseshoe retinal tear was the catalyst for the retinal detachment and no further tears were identified in the surgical setting, which utilizes a high powered microscope capable of detecting tears not otherwise able to be identified. IC Ex. 4, p. 81; TT 79, 141, 206, 218. This is also supported by the records at IC Ex. 5, p. 110, whereby the physician who repaired the retinal detachment wrote, "Superior RD [retinal detachment] with horseshoe tear . . ."

Given the retinal tear as noted by the optometrist, the IC's expert testified that Respondent's failure to locate the retinal tear during his examination constitutes malpractice, and that, but for the optometrist having located the retinal tear prompting the referral, a malpractice finding would not be appropriate. TT 70, 129. In particular, the IC's expert testified "I initially did not have Dr. Keel's notes, and without Dr. Keel's notes, I don't believe there's any

malpractice and I don't believe that - - and I believe the retina may not - - may not have been torn, but the fact is that the tear was documented prior to seeing [Respondent]." TT 70.

While I find that the retina had been torn prior to Respondent's examination given it had been noted by the optometrist Dr. Keel; the tear was the basis for the referral to RCN; and the tear was ultimately identified and repaired in relation to the detachment, Respondent likewise did not have the optometrist's notes to aid in his examination; and, while Respondent could have attempted to call the optometrist's office to determine the basis of the referral given the patient presented late in the afternoon but before closing hours (even though the full exam may have extended past business hours), Respondent credibly testified that it would not have altered his exam, the substance of which was not questioned. TT 95, 128, 158, 199. There was also no dispute that, as testified to by the IC's expert, Respondent is an "excellent doctor" and "did as much - - a complete exam as he could." p. 73, 95; *see also* TT p. 156 whereby Respondent's expert also acknowledges a complete exam.

With that, I find that Respondent missed the retinal tear, which was also the conclusion of the IC's expert. TT 55 ("I suspect in this case that the retinal tear was seen by the optometrist, and by the time the patient got to Dr. Loo that it was - - I - - I totally believe it was a different examination in part to see what was going on and that he just didn't see it"). Thus, the question then becomes whether missing the retinal tear despite providing a thorough exam constitutes malpractice.

In relation to his exam, and as alluded to in the IC expert's statement as quoted above, Respondent noted in his response to the IC allegation letter and testified that the patient was anxious during the exam, exhausted from the previous exam earlier that day, and was photosensitive to the light as well as to the pressure from the scleral depressor. TT 192; IC Ex. 2, p. 3. The IC took issue with the representation given it was not noted in Respondent's examination notes; however, the notes were a fill in variety that accommodated findings (*see* IC Exhibit 4, p. 34), and each expert conceded the difficulty of a scleral depression exam in particular when a patient has already been subject to an earlier exam. TT 52-53, 55, 79-80, 142-

43, 169. Other factors could have also impacted the scleral depression exam such as the patient's lens implant as was testified to by both experts. TT 80, 144.

Even putting aside the acknowledged difficulties, Respondent's expert testified that Respondent did not commit malpractice given that it is possible to miss a retinal tear and Respondent undertook a complete exam. TT 156. While one would expect a Respondent's expert to support the defense, what is further persuasive is the testimony of the IC's expert who testified to the effect of missing a retinal tear, even with information that one may be present, is not malpractice so long as the provider instructs the patient to come back for a re-examination "in the near future," which the IC's expert deemed to be within 2-4 weeks. TT 96-99. The IC expert testified that it was his belief that not all missed retinal tears are malpractice and that if you have a difficult exam, you were told something was there, and you did not see it, and you bring the patient back to have another look, that is not malpractice. TT 96-97. The testimony was even clarified as follows:

Q. Or if [the retinal tear] was present on the prior visit, that doesn't necessarily mean malpractice because you didn't see it?

A. Correct

TT 97, lines 13-16.

And clarified again as follows:

Q. I want to just make sure I'm understanding your testimony. In that situation hypothetically that we were describing, you see a patient. You can't find a tear. Optometrist thought they saw one. You can't find it, so you tell the patient to come back in two weeks, for example.

A. Uh huh.

Q. So the patient comes back in two weeks. Now you find the tear. If we assume the tear was there when you first saw the patient, that's not malpractice, is it?

A. That is not malpractice.

TT 98-99, lines 20-5.

Here, after a thorough examination where the retinal tear was not located, the patient was instructed to return if the patient suffered from any visual decline, presumably beyond the diagnosed floaters. IC Ex. 4, p. 34; *see also* IC Ex. 4, p. 76 ("I have discussed these findings with her and have asked her to return for re-evaluation should she note any visual decline"). Sadly, it was only the next day that the patient suffered the detached retina and the patient did indeed return for treatment, although the patient refused treatment by Respondent. IC Ex. 4, p. 54.

Given the testimony from both experts that missing a retinal tear is not malpractice under the circumstances presented - those circumstances being that Respondent undertook a full and competent examination and simply missed the retinal tear, which could have been attributable to factors such as difficulty of the patient to withstand the exam and/or the patient's lens implant, and given that the patient was instructed to return if she suffered from any vision decline - I cannot find that Respondent committed malpractice.[1] *See, e.g.,* Boehm v. Pernoud, 24 S.W.3d 759 (Mo. Ct. App. 2000) (a malpractice case based upon an ophthalmologist's failure to diagnose a retinal hole whereby the Court held that a physician's honest error in judgment in making a diagnosis, absent a failure to use the appropriate degree of skill and learning ordinarily exercised by other physicians in the same or similar circumstances, does not support a claim of malpractice); *see also*, Adams v. Boyce, 99 P.2d 1044, 1049 (Ca. App. 1940) ("The difficulties and uncertainties in the practice of medicine and surgery are such that no practitioner can be required to guarantee results, and all the law demands is that he bring and apply to the case in hand that degree of skill, care, knowledge, and attention ordinarily possessed and exercised by practitioners of the medical profession under like circumstances").

I further find that Respondent cannot be found to have failed to maintain timely, legible, accurate, and complete medical records by having failed "to correctly obtain and note Patient A's reason for referral." IC Ex. 3, p. 3, lines 4-6. The evidence shows that Respondent was not provided from the optometrist the reason for the referral and the noted reason for the referral was

[1] While the IC expert spoke of malpractice when asked in a general way about the situation, when queried about the specific circumstances related to Respondent's examination and treatment, his conclusion was that malpractice did not occur.

what he was told by the patient, which was documented and which were complaints of floaters and flashes. IC Ex. 4, p. 34.

Based upon the foregoing, I do not find that the IC established the stated claims by a preponderance of the evidence. Rather, Respondent made a record of the information he had and utilized reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care in examining the patient and merely missed the retinal tear, which, according to both experts (and cited persuasive case law) is not, by itself, malpractice.

RESPECTFULLY SUBMITTED this 4th day of March 2024.

Patricia Halstead, Esq., Hearing Officer for the
Nevada State Board of Medical Examiners
615 S. Arlington Ave.
Reno, NV 89509
(775) 322-2244
phalstead@halsteadlawoffices.com

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 5th day of March, 2024, I served a file-stamped copy of the foregoing FINDINGS AND RECOMMENDATIONS, via USPS certified mail delivery with postage pre-paid, to the following party:

ROY HAN-HUI LOO, M.D.
c/o Chelsea R. Hueth, Esq.
8329 W. Sunset Road, Suite 260
Las Vegas, NV 89113

Loo Tracking No.: 9171 9690 0935 0241 6240 62

With courtesy copy by email to:

Chelsea R. Hueth, Esq. (crhueth@mcbridehall.com) without exhibits
Patricia Halstead, Esq. (phalstead@halsteadlawoffices.com) without exhibits

DATED this 5th day of March, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

March 11, 2024

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1 BEFORE THE BOARD OF MEDICAL EXAMINERS
2 OF THE STATE OF NEVADA
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4 In the Matter of Charges and) Case No. 23-25326-1
Complaint Against)
5)
ROY HAN-HUI LOO, M.D.,) Before Hearing Officer
6) Patricia Halstead, Esq.
Respondent.)
7 ____________________________)

FILED
FEB 15 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ______

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15 VIDEOCONFERENCE FORMAL HEARING
16 RENO, NEVADA
17 THURSDAY, FEBRUARY 1, 2024
18
19
20
21 Kele R. Smith, NV CCR No. 672, CA CSR No. 13405
22 Job No. 6275548
23
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1 VIDEOCONFERENCE FORMAL HEARING,
2 taken from Las Vegas, Nevada, on Thursday, February 1,
3 2024, at 8:34 a.m. before Kele R. Smith, Certified Court
4 Reporter, in and for the State of Nevada.
5
6 APPEARANCES:
7 Hearing Officer:
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11 For the State Board of Medical Examiners:
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I N D E X

OPENING STATEMENTS

	PAGE
By Mr. Cumings	8
By Ms. Hueth	9

EXAMINATION

WITNESS: ERNESTO DIAZ	PAGE
By Mr. Cumings	14, 28
By Ms. Hueth	21, 31

WITNESS: STEVEN FRIEDLANDER, MD	PAGE
By Mr. Cumings	32, 118, 134
By Ms. Hueth	72, 132

WITNESS: KIRK HOU, MD	PAGE
By Ms. Hueth	137, 174
By Mr. Cumings	165

WITNESS: ROY HAN-HUI LOO, MD	PAGE
By Ms. Hueth	178, 227, 229, 233
By Mr. Cumings	209, 228, 233

1 CLOSING STATEMENTS

2 PAGE

3 By Mr. Cumings 235

4 By Ms. Hueth 239

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1 EXHIBITS

2 MARKED PAGE

3 (Investigative Committee's Exhibits)

Line	Exhibit	Description	Page
4	Exhibit 1	Allegation Letter Dated 3/9/21 - NSBME1-2	6
5	Exhibit 2	Response to Allegation Letter Dated 3/30/21 - NSBME3-5	6
6	Exhibit 3	Complaint - NSBME6-10	6
7	Exhibit 4	RCN Records - NSBME11-89	6
8	Exhibit 5	Center for Sight Records - NSBME90-128	21
9	Exhibit 6	Dr. Friedlander's Curriculum Vitae - NSBME129-133	6

10

(Respondent's Exhibits)

11

Line	Exhibit	Description	Page
11	Exhibit 1	Complaint	6
12	Exhibit 2	Answer to Complaint	6
13-14	Exhibit 3	Response to Allegation Letter Dated 3/30/21	6
14	Exhibit 4	RCN Records	6
15	Exhibit 5	Color Scans of Patient A from RCN	6
16	Exhibit 6	Dr. Hou's Curriculum Vitae	6

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1 RENO, NEVADA; THURSDAY, FEBRUARY 1, 2024

2 8:34 A.M.

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4 (Stipulated IC Exhibits 1, 2, 3, 4, and 6 and

5 Respondent's Exhibits 1, 2, 3, 4, 5, and 6 were

6 previously admitted.) 08:34:05

7 HEARING OFFICER HALSTEAD: This is in the matter 08:34:05

8 of charges and complaint against Roy Han-Hui Loo. 08:34:15

9 I hope I said that right, Dr. Loo. 08:34:23

10 THE WITNESS: Yes. You did. 08:34:23

11 HEARING OFFICER HALSTEAD: Thank you. 08:34:23

12 This is Case No. 23-25326-1. I'm Patricia 08:34:24

13 Halstead. I'm the hearing officer for this matter. Can 08:34:29

14 the parties please state their appearances, starting 08:34:29

15 with you Mr. Cumings. 08:34:33

16 MR. CUMINGS: I'm Ian Cumings, senior deputy 08:34:33

17 general counsel on behalf of the Investigative 08:34:38

18 Committee. 08:34:39

19 MS. HUETH: Good morning. Chelsea Hueth on 08:34:39

20 behalf of Respondent Dr. Loo, and also present is an 08:34:42

21 attorney from my office named Destiny Hooper who will be 08:34:46

22 observing. 08:34:51

23 HEARING OFFICER HALSTEAD: I see Dr. Loo is here. 08:34:52

24 Thank you, everyone, for being here. 08:34:52

25 This is being recorded. We are doing this by 08:34:56

1 Zoom to accommodate the appearance of an expert witness 08:34:58
2 that was pursuant to an order. The Complaint has been 08:35:01
3 filed that we're here about on June 8, 2023. There's 08:35:06
4 two counts: one for malpractice and one for failure to 08:35:10
5 maintain proper medical records. 08:35:13
6 It's my understanding that there has been a 08:35:15
7 stipulation to certain exhibits. 08:35:17
8 Mr. Cumings, do you want to address that? 08:35:19
9 MR. CUMINGS: Yes. Chelsea Hueth and I spoke 08:35:22
10 yesterday. We are stipulating to Exhibits 1 through 4 08:35:25
11 and Exhibit 6 from the Investigative Committee's 08:35:27
12 exhibits, and Exhibits 1 through 6 from the Respondent's 08:35:30
13 exhibits. 08:35:35
14 Did I get that correct, Ms. Hueth? 08:35:35
15 MS. HUETH: Yes. 08:35:38
16 MR. CUMINGS: I believe Exhibit 5 we will be 08:35:39
17 admitting over objection for the IC's exhibits. 08:35:42
18 HEARING OFFICER HALSTEAD: Thank you. Any other 08:35:47
19 housekeeping matters before we commence? 08:35:49
20 MS. HUETH: Not from Respondent. 08:35:52
21 HEARING OFFICER HALSTEAD: Mr. Cumings? 08:35:55
22 MR. CUMINGS: No. 08:35:57
23 HEARING OFFICER HALSTEAD: Did you want to 08:35:59
24 proceed to opening statements? 08:36:00
25 MR. CUMINGS: Yes. 08:36:01

Litigation Services
A Veritext Company www.veritext.com

1 HEARING OFFICER HALSTEAD: Okay. Go ahead, 08:36:02
2 Mr. Cumings. 08:36:02
3 OPENING STATEMENT 08:36:02
4 MR. CUMINGS: Firstly, I'd like to thank 08:36:02
5 everybody involved in today's hearing for their 08:36:04
6 participation, especially you, Ms. Halstead -- I know 08:36:06
7 that you've been ill -- Ms. Court Reporter, counsel for 08:36:07
8 Dr. Loo, Dr. Loo, and the witnesses that are testifying 08:36:11
9 today. 08:36:14
10 As Ms. Halstead said, this hearing is to present 08:36:15
11 evidence to determine if Dr. Loo committed malpractice 08:36:18
12 as alleged in Count 1 and failed to maintain proper 08:36:19
13 medical records as alleged in Count 2 of the Complaint 08:36:23
14 filed June 8th, 2023. 08:36:24
15 Throughout this hearing, the evidence will show 08:36:27
16 that Dr. Loo failed to appropriately diagnose and treat 08:36:28
17 Patient A's retinal tear following an emergency referral 08:36:32
18 from an optometrist on March 13th, 2018; that Patient A 08:36:38
19 had been diagnosed with a horseshoe retinal tear from 08:36:38
20 her optometrist, Dr. Keel, prior to the referral to 08:36:42
21 Dr. Loo. Dr. Loo failed to document the reason for the 08:36:45
22 patient's emergency referral. Dr. Loo's records do not 08:36:48
23 adequately reflect the billing codes and exams he 08:36:52
24 purports to have given. Due to this failure, Patient A 08:36:54
25 suffered a detached retina which necessitated emergency 08:36:55

1 corrective surgery on March 14th, 2018. 08:36:59
2 In sum, the testimony and evidence presented here 08:37:02
3 today will establish by a preponderance of the evidence 08:37:05
4 that Dr. Loo committed malpractice and failed to 08:37:07
5 adequately maintain proper medical records. 08:37:09
6 On behalf of the Investigative Committee, we ask 08:37:12
7 the Board to consider the record that will be presented 08:37:13
8 here today and render the appropriate findings and 08:37:14
9 discipline. 08:37:18
10 Thank you once again for all being here today. 08:37:19
11 That will be all. 08:37:23
12 HEARING OFFICER HALSTEAD: Thank you, 08:37:25
13 Mr. Cumings. 08:37:27
14 Ms. Hueth. 08:37:27
15 OPENING STATEMENT 08:37:27
16 MS. HUETH: Good morning. As I mentioned, my 08:37:27
17 name is Chelsea Hueth, and I have the privilege to 08:37:29
18 represent Dr. Loo in this matter. 08:37:33
19 Dr. Loo is a retinal specialist who has enjoyed 08:37:35
20 the privilege of practicing in Southern Nevada for the 08:37:38
21 last 22 years as a member of Retina Consultants of 08:37:42
22 Nevada. After completing a three-year fellowship at the 08:37:45
23 prestigious Bascom Palmer Eye Institute, Dr. Loo saw an 08:37:48
24 expanding population in Las Vegas with a need for retina 08:37:52
25 specialists, so in 2002 he moved to Las Vegas, where 08:37:57

1 he's been practicing ever since. 08:37:59
2 The Complaint alleges that Dr. Loo committed 08:38:02
3 malpractice, defined as "the failure to use the 08:38:05
4 reasonable care, skill, or knowledge ordinarily used 08:38:07
5 under similar circumstances." The Complaint further 08:38:11
6 alleges that Dr. Loo missed a retinal tear, but what the 08:38:14
7 evidence will demonstrate is that when Dr. Loo saw the 08:38:18
8 patient, there was not a retinal tear that could be 08:38:22
9 diagnosed. 08:38:25
10 The evidence will also demonstrate that not 08:38:25
11 seeing a retinal tear, even if one was present, does not 08:38:28
12 constitute malpractice in this case. 08:38:32
13 The evidence will show at that all times Dr. Loo 08:38:37
14 used the reasonable care, skill, and knowledge when the 08:38:40
15 patient was added onto the end of his schedule without 08:38:44
16 an appointment on March 13th, 2018. 08:38:47
17 I anticipate that throughout the hearing there 08:38:50
18 will be evidence regarding some basic medical issues 08:38:52
19 regarding the anatomy of the retina, but simply put, the 08:38:55
20 retina is a tissue that lines the back of the eye and 08:39:00
21 acts very much like the film of a camera. Inside of the 08:39:03
22 eye is a jelly-like substance that has the consistency 08:39:07
23 of a raw egg, which is known as the vitreous, and it is 08:39:11
24 adherent to the retina. As patients and just normal 08:39:15
25 population people go through life, the vitreous 08:39:19

1 liquifies and contracts and at some point separates from 08:39:23
2 the retina in a completely benign way for the 08:39:28
3 overwhelming majority of the patients and takes with it 08:39:33
4 what's called some floaters. 08:39:33
5 The evidence will further demonstrate that 08:39:35
6 floaters are incredibly common and by themselves do not 08:39:37
7 indicate an issue with the retina or indicate that 08:39:41
8 additional treatment is necessary. 08:39:44
9 Dr. Loo will testify that the office protocol in 08:39:46
10 March 2018 would have been for a staff member to ask the 08:39:49
11 referring provider for various information about the 08:39:53
12 patient, including why they were being referred, as well 08:39:57
13 as requesting a written referral or the provider's 08:40:02
14 recent notes. No referral or notes were sent from the 08:40:07
15 patient's optometrist. 08:40:10
16 The patient reported to Dr. Loo and to Dr. Loo's 08:40:11
17 ophthalmic tech that she was there for floaters and 08:40:15
18 flashes when she moved her eyes. The notes clearly 08:40:19
19 document the reason for the patient's visit. Dr. Loo 08:40:22
20 will explain that he performed a retinal exam and what 08:40:26
21 that entails. 08:40:30
22 The evidence will also show that Dr. Loo obtained 08:40:31
23 imaging known as optical coherence tomography to examine 08:40:33
24 the patient's retina. The evidence will further show 08:40:38
25 that the patient had difficulty tolerating the retina 08:40:40

1 exam, so Dr. Loo obtained another type of imaging known 08:40:44
2 as a B-scan ultrasound. 08:40:46
3 After performing the best exam that he could 08:40:48
4 under the circumstances, obtaining multiple images of 08:40:51
5 the retina, Dr. Loo did not see evidence of a retinal 08:40:54
6 tear, a retinal detachment, or other acute issue 08:40:58
7 requiring treatment. However, he discussed with the 08:41:02
8 patient that a potential referral to a 08:41:05
9 neuro-ophthalmologist might be appropriate to see if 08:41:08
10 there was a neurological explanation for the patient's 08:41:11
11 complaint of floaters. 08:41:14
12 Dr. Loo will testify that he also explained to 08:41:17
13 the patient that she should immediately return to his 08:41:19
14 office if her vision got any worse. 08:41:22
15 Around 4:30 p.m. the next day, the evidence will 08:41:25
16 show that the patient returned to the Center for Sight, 08:41:30
17 not Dr. Loo's office, and reported a significant change 08:41:33
18 in her vision. The patient's provider at that visit 08:41:36
19 called another retina specialist at Dr. Loo's office 08:41:40
20 whose name is Dr. Hollifield and explained the 08:41:45
21 situation. 08:41:48
22 The patient returned to Retina Consultants of 08:41:49
23 Nevada, where she was seen by another provider, not 08:41:51
24 Dr. Loo, and the patient's complaints, as the evidence 08:41:55
25 will show, were drastically different than they were the 08:41:59

1 day before when she was seen by Dr. Loo. The patient 08:42:02
2 was diagnosed with a macula-off retinal detachment which 08:42:05
3 was surgically repaired later that day -- early in the 08:42:10
4 morning of the next day. 08:42:14
5 The evidence will demonstrate that Dr. Loo, who 08:42:15
6 is an experienced retina specialist, did not commit 08:42:19
7 malpractice and maintained appropriate records. In 08:42:20
8 short, after completing a thorough exam, Dr. Loo did not 08:42:23
9 see evidence of a retinal tear. 08:42:27
10 The evidence will demonstrate that the 08:42:28
11 Investigative Committee cannot establish by a 08:42:31
12 preponderance of the evidence that Dr. Loo missed a 08:42:34
13 retinal tear, and even if he did miss a retinal tear, 08:42:37
14 that it constitutes malpractice in this case. 08:42:40
15 At the conclusion of the evidence, we believe 08:42:44
16 that the recommendation will be to find that the 08:42:46
17 Investigative Committee has not proven either of its 08:42:50
18 claims. Thank you. 08:42:53
19 HEARING OFFICER HALSTEAD: Thank you, Ms. Hueth. 08:42:55
20 So I have a delay obviously because I'm coughing. I'm 08:42:58
21 staying on mute. Thank you for waiting for me to hit 08:43:03
22 that unmute. 08:43:06
23 Mr. Cumings, do you want to call your first 08:43:07
24 witness? 08:43:10
25 MR. CUMINGS: Certainly. I would like to call 08:43:10

1 Ernie Diaz, chief of investigations. 08:43:13
2 Whereupon, 08:43:13
3 ERNESTO DIAZ, 08:43:13
4 having first been called as a witness, was duly sworn 08:43:13
5 and testified as follows: 08:43:13
6 HEARING OFFICER HALSTEAD: Thank you. Can you 08:43:40
7 please state your name and spell your name for the 08:43:41
8 record. 08:43:41
9 THE WITNESS: Ernesto Diaz, E-R-N-E-S-T-O, 08:43:43
10 D-I-A-Z. 08:43:50
11 HEARING OFFICER HALSTEAD: Thank you. 08:43:50
12 Your witness, Mr. Cumings. 08:43:54
13 DIRECT EXAMINATION 08:43:54
14 BY MR. CUMINGS: 08:43:54
15 Q. Good morning, Mr. Diaz. 08:43:57
16 A. Good morning. 08:43:58
17 Q. Who is your employer? 08:43:58
18 A. The Nevada State Board of Medical Examiners. 08:43:59
19 Q. And what is your job title? 08:44:02
20 A. I am the chief of investigations for the 08:44:04
21 investigations division. 08:44:06
22 Q. How long have you held that position? 08:44:08
23 A. Approximately 3 years and 11 months. 08:44:10
24 Q. Do you have any other investigation experience? 08:44:13
25 A. Yes, I do. 08:44:15

1 Q. And where was that at? 08:44:17
2 A. I was a U.S. Border Patrol agent for 08:44:20
3 approximately four years. I investigated immigration 08:44:23
4 and criminal -- federal criminal violations, and then I 08:44:27
5 was an ATF special agent for approximately 21 years 08:44:31
6 investigating federal -- United States Code federal 08:44:35
7 violations as well. 08:44:39
8 Q. After that, you came to the Board of Medical 08:44:40
9 Examiners? 08:44:44
10 A. That's correct. 08:44:44
11 Q. As chief of investigations for the Nevada State 08:44:45
12 Board of Medical Examiners, what are your duties? 08:44:48
13 A. I review all the complaints that the Board 08:44:50
14 receives per jurisdiction. I assign and open cases to 08:44:54
15 investigators. I also investigate cases myself. I 08:44:58
16 report all formal disciplinary actions to National 08:45:01
17 Practitioner Databank and other entities that we're 08:45:07
18 required to report those actions to. I also liaison 08:45:09
19 with the licensing division as well as the legal 08:45:13
20 division for the overall function of the Board. 08:45:17
21 Q. And when a complaint comes in, what happens? 08:45:19
22 A. I review the complaint or one of the deputy 08:45:23
23 chiefs will review it. If the complaint falls within 08:45:25
24 our jurisdiction, if the individual named in the 08:45:30
25 complaint is a licensee of our board and there's -- 08:45:34

1 allegations fall within the Nevada Medical Practice Act, 08:45:35
2 I open an investigation; I assign it to an investigator; 08:45:38
3 and then a case file is created. A case number is 08:45:42
4 assigned. 08:45:45
5 The investigator will send -- they'll read the 08:45:46
6 complaint. They'll send what's known as an allegation 08:45:50
7 letter to the respondent, which would be the licensee. 08:45:54
8 They'll also send an order to produce health care 08:45:57
9 records. That's the initial part of the investigation. 08:46:00
10 And I can continue if you'd like or let me know. 08:46:02
11 Q. Certainly. 08:46:06
12 A. Once the information is received, the 08:46:07
13 investigator will then prepare it for review by one of 08:46:11
14 the Board's medical reviewers. At that point, the 08:46:14
15 medical reviewer will generate a report. They will make 08:46:17
16 a recommendation. The case is then presented to one of 08:46:20
17 the Board's investigative committees. At that point, 08:46:24
18 the Investigative Committee can determine whether to 08:46:27
19 close the case, whether to send it out for 08:46:31
20 investigation, or send it to a special team peer review 08:46:35
21 or, you know, have the respondent appear in person to 08:46:38
22 answer some questions. At that point, the conclusion of 08:46:41
23 the investigation part is over. 08:46:44
24 Q. So once an investigation is concluded, that means 08:46:46
25 that the medical records that are obtained are 08:46:49

1 aggregated and put into that file? 08:46:52

2 A. That's correct. The investigators obtain medical 08:46:55

3 records from not just the respondent but if, say, there 08:46:58

4 was a hospital involved, they'll request records from a 08:47:02

5 hospital or medical facility as well. 08:47:05

6 Q. Are you familiar with Investigation No. 21-20008 08:47:07

7 regarding Dr. Loo? 08:47:12

8 A. Yes, I am. 08:47:13

9 Q. And just for the record, were you the original 08:47:14

10 investigator on this case? 08:47:18

11 A. No, I was not. 08:47:19

12 Q. Do you know who was? 08:47:21

13 A. Yes. Senior Investigator Don Andrews was the 08:47:22

14 original investigator on this case. 08:47:29

15 Q. He can't be here today, can he? 08:47:30

16 A. No. He's retired now. 08:47:33

17 Q. As chief of investigations, do you routinely fill 08:47:34

18 in for investigators if they're unable to attend or if 08:47:38

19 they have parted from the Board? 08:47:42

20 A. Yes. I do that often as the chief of 08:47:43

21 investigations. 08:47:44

22 Q. As the chief then, you're familiar with the 08:47:44

23 procedure by which the Board can post these 08:47:46

24 investigative files? 08:47:52

25 A. That's correct. As well as my experience in 08:47:53

1 conducting investigations. 08:47:55

2 Q. Have you reviewed the file for this case? 08:47:56

3 A. Yes, I have. 08:47:59

4 Q. Based on your review, does this case appear to be 08:47:59

5 similar to other investigations handled by the Board? 08:48:03

6 A. Yes, it does. 08:48:05

7 Q. For the record, I'm going to ask you about the 08:48:06

8 Board's exhibits in this case. Exhibits 1 through 4 and 08:48:09

9 6 of the IC's exhibits have been stipulated to and 08:48:11

10 admitted. So we're just concerned with Exhibit 5. 08:48:15

11 Would you please turn to what has been premarked as 08:48:18

12 Board's Exhibit 5 in that binder in front of you? 08:48:19

13 A. Okay. 08:48:25

14 MR. CUMINGS: And just the record for everybody, 08:48:27

15 we are not referring to the patient by name. We'll be 08:48:29

16 referring to the patient in this case as Patient A. 08:48:34

17 BY MR. CUMINGS: 08:48:34

18 Q. Do you recognize this document? 08:48:36

19 A. Yes, I do. 08:48:37

20 Q. What is that document? 08:48:38

21 A. It's a Certificate of Custodian of Records which 08:48:39

22 investigators send out when they request medical records 08:48:43

23 to ensure that we receive all records, and they're 08:48:46

24 notarized by the custodian of records before the 08:48:49

25 provider. 08:48:52

1 Q. Are there documents behind that first page? 08:48:53

2 A. Yes, there are. 08:48:56

3 Q. When are those documents? 08:48:57

4 A. These are medical records for Patient A. 08:48:58

5 Q. And what is a certificate of custodian of 08:49:00

6 records? 08:49:06

7 A. It's a basically a certificate that the Board 08:49:07

8 sends out when we request medical records, and the 08:49:10

9 custodian of records will notarize that all the records 08:49:14

10 they are providing to the Board per our order to produce 08:49:19

11 records or letter is -- is complete and accurate. 08:49:23

12 Q. And can you tell from looking at these records 08:49:26

13 how these records were received? 08:49:31

14 A. Yes, I can. 08:49:32

15 Q. How is that? 08:49:34

16 A. They were faxed to our office. We often receive 08:49:35

17 medical records electronically, by mail, or fax. In 08:49:38

18 this case, these were by fax. 08:49:44

19 Q. I'd like you to take a brief moment here and look 08:49:46

20 through Exhibit 5 and make sure that everything is 08:49:50

21 there. 08:49:53

22 A. (Complied.) 08:49:53

23 Yes. Everything's there that we requested. 08:50:03

24 MR. CUMINGS: I'll ask for admission of 08:51:01

25 Exhibit 5. I move to admit Exhibit 5 into the record. 08:51:03

1 HEARING OFFICER HALSTEAD: Ms. Hueth? 08:51:07
2 MS. HUETH: I object as I don't believe that 08:51:09
3 Exhibit 5 contains a complete copy of the patient's 08:51:11
4 medical records from this provider. 08:51:14
5 HEARING OFFICER HALSTEAD: What do you base that 08:51:20
6 on? 08:51:21
7 MS. HUETH: Well, for example, on Bates stamped 08:51:24
8 NSBME 00090, at the top of the page there appears to be, 08:51:27
9 like, fax markings. It starts with "From: Center for 08:51:30
10 Sight" to a phone number, and then it says "Page 6 out 08:51:34
11 of 35," and Pages 1 through 5 are not included in this 08:51:38
12 exhibit. 08:51:42
13 HEARING OFFICER HALSTEAD: Were these records 08:51:44
14 Subpoenaed? 08:51:46
15 MR. CUMINGS: No. They were requested through a 08:51:47
16 typical investigation process, not by letter. 08:51:50
17 HEARING OFFICER HALSTEAD: Can you proffer what 08:51:54
18 Exhibits 1 through 5 were? 08:51:56
19 MR. CUMINGS: I cannot. 08:51:59
20 HEARING OFFICER HALSTEAD: What the pages were? 08:52:01
21 Are they anything you're relying on? 08:52:02
22 MR. CUMINGS: No. Per statute, we only have to 08:52:05
23 admit exhibits that we intend to rely on for the 08:52:07
24 prosecution of our case, and Pages 1 through 5 are not 08:52:11
25 present, but they are not relevant to what the rest of 08:52:14

1 the record states. 08:52:17

2 HEARING OFFICER HALSTEAD: There's no question as 08:52:20

3 to the patient at issue or the records being related to 08:52:21

4 her. Is that correct? 08:52:25

5 MR. CUMINGS: Correct. 08:52:27

6 HEARING OFFICER HALSTEAD: Okay. I'll go ahead 08:52:28

7 and admit the exhibits. So Exhibit 5 will be admitted. 08:52:29

8 (IC Exhibit 5 admitted.) 08:52:29

9 MR. CUMINGS: Thank you, Mr. Diaz. I have no 08:52:35

10 more questions for you at this time. 08:52:37

11 THE WITNESS: Thank you very much. 08:52:40

12 MS. HUETH: Mr. Diaz, oh, I have some questions 08:52:41

13 for you. 08:52:45

14 THE WITNESS: Yes, ma'am. 08:52:46

15 MS. HUETH: Is it okay if I proceed, 08:52:48

16 Ms. Halstead? 08:52:51

17 HEARING OFFICER HALSTEAD: Yes. 08:52:52

18 MS. HUETH: Thank you. 08:52:54

19 CROSS-EXAMINATION 08:52:54

20 BY MS. HUETH: 08:52:54

21 Q. Mr. Diaz, you testified a few minutes ago that 08:52:55

22 the records that are contained within Exhibit 5 from the 08:52:58

23 Center for Sight were faxed to the Board. Is that 08:53:01

24 correct? 08:53:04

25 A. Yes, ma'am. 08:53:04

1 Q. And as part of the Board's investigation and in 08:53:05
2 your experience as an investigator, is it important to 08:53:12
3 obtain a complete copy of a patient's chart from a 08:53:15
4 provider? 08:53:19
5 MR. CUMINGS: Objection. Calls for speculation. 08:53:21
6 HEARING OFFICER HALSTEAD: Overruled. 08:53:26
7 A. Yes, it is. 08:53:27
8 BY MS. HUETH: 08:53:30
9 Q. If you could turn still within Exhibit 5 to 08:53:32
10 what's Bates stamped as NSBME 0120 and then let me know 08:53:37
11 when you're there. 08:53:45
12 A. Yes, ma'am. 08:53:52
13 Q. Is it your understanding that this record also 08:53:53
14 came from the Center for Sight? 08:53:56
15 A. Give me a second while I look at it, please. 08:54:07
16 These records were obtained through the request that the 08:54:28
17 investigator made. I believe they were not faxed 08:54:32
18 though. I believe these were obtained additionally by 08:54:39
19 the investigator. 08:54:44
20 Q. And my question was: Is it your understanding 08:54:45
21 that the record reflected on NSBME 0120, that it came 08:54:49
22 from the Center for Sight? 08:54:56
23 A. Yes. If these items were received by the 08:54:57
24 investigator at the request, then these records were 08:55:02
25 provided by the Center for Sight. 08:55:06

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1 Q. Well, Mr. Diaz, do you know if these records were 08:55:09
2 received by the investigator pursuant to a request to 08:55:14
3 the Center for Sight? 08:55:17
4 A. Yes, ma'am. I believe they were received by the 08:55:18
5 investigator. 08:55:20
6 Q. From the Center for Sight? 08:55:21
7 A. Yes. 08:55:23
8 Q. And why is it that starting on NSBME 0120 through 08:55:25
9 the end of this exhibit do these pages not have fax 08:55:31
10 markings? 08:55:34
11 A. Again, that, I do not know. They don't have the 08:55:35
12 fax markings. Like I said before, there are times we 08:55:39
13 receive records by mail, electronically, or by fax. 08:55:43
14 Q. Okay. So earlier when you said that the records 08:55:47
15 from the Center for Sight were faxed, that's -- not all 08:55:49
16 of the records were faxed. Is that what you're saying? 08:55:52
17 A. That's correct. I'm saying the copies that do 08:55:55
18 not have the top facsimile on there were received by the 08:55:59
19 investigator that were not sent by fax. 08:56:04
20 Q. How were they sent? 08:56:10
21 A. They were sent by mail, I believe. 08:56:12
22 Q. And are you looking at something to make that 08:56:15
23 determination that they were sent by mail? 08:56:21
24 A. Yes. I'm looking at the documents, the records. 08:56:24
25 The last pages that we have were received by the 08:56:28

1 investigator. They were not received by fax. They were 08:56:30
2 received through mail. 08:56:34
3 Q. Okay. But is there something within Exhibit 5 08:56:37
4 that you're looking at that tells you that these were 08:56:41
5 sent via mail as opposed to electronically or otherwise? 08:56:44
6 A. No. 08:56:49
7 Q. Is there anything within Exhibit 5 to indicate 08:56:49
8 when the records starting on NSBME 0120 were sent to the 08:56:58
9 Board? 08:57:05
10 A. These records were sent, I believe, March -- are 08:57:06
11 you talking about the electronic ones, the faxed ones, 08:57:13
12 or the other ones that do not have the facsimile marks 08:57:17
13 on there? 08:57:20
14 Q. The Exhibit 5, starting with NSBME 0120. 08:57:20
15 A. No. In my review of the case file, there was no 08:57:28
16 note when the additional records were received. 08:57:30
17 Q. But it's your testimony, is it not, that 08:57:32
18 Exhibit 5 reflects all of the patient's records that 08:57:39
19 were sent from the Center for Sight? 08:57:43
20 A. Yes. 08:57:46
21 Q. Okay. And, Mr. Diaz, are you a medical doctor? 08:57:47
22 A. I am not. 08:57:52
23 Q. Okay. And you told us earlier you were not the 08:57:53
24 original investigator on this file. Is that correct? 08:57:58
25 A. That's correct. 08:58:00

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1 Q. When were you assigned to this case? 08:58:01
2 A. At the retirement, after the initial investigator 08:58:04
3 retired, I reassigned cases to myself that were still 08:58:09
4 pending any sort of board action. 08:58:15
5 Q. When was that? 08:58:16
6 A. That would have been probably last June or July 08:58:17
7 of 2023. 08:58:19
8 Q. And so it wasn't you who personally requested the 08:58:20
9 records from Center for Sight. Is that right? 08:58:28
10 A. That's correct. 08:58:31
11 Q. If you wouldn't mind, still within this same 08:58:31
12 exhibit, Exhibit 5, turning to Bates stamp Page NSBME 08:58:45
13 0117 and let me know when you're there. 08:58:48
14 A. I'm there. 08:58:56
15 Q. And in the middle of the page, there's a section 08:58:57
16 entitled "Tonometry," and under that it says 08:59:05
17 "Intraocular Pressure." 08:59:10
18 Do you see that? 08:59:11
19 A. I do. 08:59:12
20 Q. And then Items 1 through 6 are dates prior to 08:59:12
21 March 2018. Do you see that? 08:59:18
22 A. Yes. 08:59:20
23 Q. In your review of Exhibit 5, did you see any 08:59:22
24 visit notes for any of those dates prior to March 13, 08:59:26
25 2018? 08:59:31

1 A. Say that date again. Prior to what date, ma'am? 08:59:31
2 Q. March 13, 2018. 08:59:44
3 A. I see a March 13th, 2018 date on here under 08:59:51
4 "Dilation." There's other dates after March. Let's 08:59:55
5 see. March 14th, 2018. 09:00:04
6 Q. Sure. And my question was whether you see within 09:00:06
7 Exhibit 5 any visit notes or encounters with the patient 09:00:10
8 prior to March 13, 2018. 09:00:14
9 A. Yes, I do. 09:00:18
10 Q. Okay. On what page? 09:00:20
11 A. The one you referred to. NSBME Bates stamped 09:00:22
12 0117. 09:00:27
13 Q. Okay. If you can turn back to NSBME 0115. 09:00:28
14 A. Okay. 09:00:41
15 Q. Do you see at the top of the page under the 09:00:42
16 patient's name to the right it says "Exam Date 09:00:44
17 3/13/2018"? 09:00:49
18 A. Bates stamp 105? 09:00:51
19 Q. 115. I'm sorry. 09:00:57
20 A. Okay. Sorry about that. Yes. Exam date 09:00:59
21 3/13/2018. 09:01:12
22 Q. And if you go up a little bit to the right, it 09:01:13
23 appears to say "Page 4 of 8." Do you see that? 09:01:17
24 A. Yes. 09:01:20
25 Q. Okay. And then if you go to the next page, it 09:01:20

1 says "Page 5 of 8." Do you see that? 09:01:25

2 A. Yes. 09:01:28

3 Q. And then to the next page which we were talking 09:01:29

4 about earlier, it says "Page 6 of 8." Do you see that? 09:01:32

5 A. Yes. 09:01:36

6 Q. And so would that indicate to you that these 09:01:36

7 three pages we've been discussing all pertain to a visit 09:01:40

8 on March 13, 2018? 09:01:44

9 A. Yes. That would appear so. 09:01:47

10 Q. Okay. And so if we could just circle back, my 09:01:59

11 original question is whether you see any visit notes for 09:02:04

12 dates of service before March 13, 2018. 09:02:08

13 A. I have to look at each one individually to look 09:02:18

14 at the exam date. Give me a second. No. That's -- 09:02:28

15 March 13, 2018 is -- I do not see any other visits in 09:03:11

16 the records we received. 09:03:16

17 Q. Okay. So when you testified earlier that 09:03:18

18 Exhibit 5 represents the entirety of the patient's chart 09:03:30

19 from the Center for Sight, umm, do you still maintain 09:03:34

20 that testimony having reviewed, like we did on 09:03:38

21 Page 0117, measurements taken prior to March 13, 2018 09:03:43

22 without seemingly corresponding visit notes? 09:03:48

23 A. Yes. These are the records that were provided to 09:03:52

24 us, and we requested any and all records. 09:03:56

25 Q. Okay. But whether or not you were provided with 09:04:00

1 all records, you can't say that with certainty? 09:04:03

2 A. I can say that we received a Certificate of 09:04:13

3 Custodian of Records by the Sight -- Center for Sight 09:04:16

4 notarized and signed and said that they provided all the 09:04:20

5 records to us per our request. 09:04:24

6 Q. Because the request to the Center for Sight 09:04:26

7 wouldn't have been limited to any particular time 09:04:28

8 period, would it? 09:04:32

9 A. No. There was no time period requested as far as 09:04:33

10 visits or whatnot. We request any and all. 09:04:36

11 Q. Okay. At least as far Exhibit 5 goes, you agree 09:04:39

12 there's no visit notes prior to March 13, 2018? 09:04:42

13 A. Based on the records we received, that's correct. 09:05:03

14 MS. HUETH: Those are all my questions. Thank 09:05:07

15 you. 09:05:09

16 HEARING OFFICER HALSTEAD: Thank you, Ms. Hueth. 09:05:11

17 Mr. Cumings? 09:05:14

18 MR. CUMINGS: Certainly. I just have a couple 09:05:15

19 brief questions on redirect. 09:05:17

20 REDIRECT EXAMINATION 09:05:19

21 BY MR. CUMINGS: 09:05:19

22 Q. Mr. Diaz, you were not the original investigator 09:05:20

23 on this case. Correct? 09:05:22

24 A. That's correct. 09:05:23

25 Q. And typically when you receive a set of records 09:05:24

1 such as this, it's not an exhaustive -- is it always an 09:05:27
2 exhaustive history of the patient's records, or can it 09:05:32
3 sometimes pertain to an instance from dates? 09:05:37
4 A. It depends on -- yeah. Sometimes the order will 09:05:39
5 request a certain period of date. For example, if they 09:05:44
6 see a provider one time, then we know we have a starting 09:05:46
7 point there. In this case, the records were requested 09:05:50
8 from Sight for Center for records of this particular 09:05:52
9 Patient A. 09:05:56
10 Q. Okay. I'd like to turn your attention real fast 09:05:56
11 to Page 120 in Exhibit 5. Okay. And move forward from 09:06:00
12 there and flip to Page 126. 09:06:16
13 A. Yes. 09:06:21
14 Q. Do you see Page 126, it's addressed at the top 09:06:23
15 there? 09:06:26
16 A. Yes. 09:06:27
17 Q. Who is that addressed to? 09:06:29
18 A. Danielle Keel, OD. 09:06:31
19 Q. And who is this letter from? Can you see the 09:06:34
20 letterhead at the top there? 09:06:38
21 A. Yes. From Retina Consultants of Nevada. 09:06:38
22 Q. And at the bottom of the letter there, who is the 09:06:42
23 letter authored by? 09:06:45
24 A. Dr. Loo. 09:06:46
25 Q. Is Dr. Loo the Respondent in this case? 09:06:47

1 A. Yes. 09:06:50

2 Q. So is it likely that these records were sent to 09:06:51

3 the Center for Sight by Dr. Loo as they pertain to one 09:06:55

4 of the practitioners there? 09:06:58

5 A. Yes. 09:07:00

6 Q. And does this document -- you see that March 13th 09:07:02

7 date. I'd like you to flip now back towards Page 112 09:07:07

8 and 113. 09:07:11

9 A. Okay. 09:07:19

10 Q. Do you see right there on the images there it 09:07:20

11 says "Exam Date"? 09:07:23

12 A. Yes. 09:07:24

13 Q. What is the date there? 09:07:26

14 A. March 13th. 09:07:27

15 Q. So is it likely that those records from Dr. Loo's 09:07:29

16 office are contained in this record as a complete record 09:07:33

17 for this patient from that date? 09:07:36

18 A. Yes. 09:07:38

19 MR. CUMINGS: I have no further questions for you 09:07:40

20 at this time. Thank you. 09:07:43

21 MS. HUETH: I just have a quick follow-up, if 09:07:44

22 it's okay, Ms. Halstead. 09:07:47

23 HEARING OFFICER HALSTEAD: Go ahead. 09:07:52

24 /// 09:07:52

25 /// 09:07:52

1 RECROSS-EXAMINATION 09:07:52
2 BY MS. HUETH: 09:07:52
3 Q. Mr. Diaz, thank you for your time. I just want 09:07:54
4 to be sure though, when -- you testified earlier that 09:07:55
5 the patient's records from the Center for Sight were 09:07:55
6 requested in their entirety without restriction on date. 09:07:58
7 Is that right? 09:08:02
8 A. Yes. 09:08:03
9 MS. HUETH: That's all. Thank you. 09:08:05
10 HEARING OFFICER HALSTEAD: Thank you. 09:08:07
11 Who is your next witness, Mr. Cumings? 09:08:09
12 MR. CUMINGS: I'd like to call Dr. Friedlander. 09:08:11
13 Thank you, Mr. Diaz. 09:08:27
14 HEARING OFFICER HALSTEAD: Good morning, 09:08:29
15 Dr. Friedlander. 09:08:30
16 THE WITNESS: Good morning. 09:08:32
17 HEARING OFFICER HALSTEAD: Can you see and hear 09:08:33
18 okay? 09:08:35
19 THE WITNESS: Yep. 09:08:36
20 HEARING OFFICER HALSTEAD: My name is Patricia 09:08:38
21 Halstead. I'm the hearing officer in this matter. I
22 appreciate you being here today. Can you please raise
23 your right hand to be sworn.
24 Whereupon,
25 STEVEN FRIEDLANDER, MD,

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1 having first been called as a witness, was duly sworn
2 and testified as follows:
3 HEARING OFFICER HALSTEAD: Thank you.
4 Can you please state and spell your name for the 09:08:46
5 record. 09:08:46
6 THE WITNESS: Steven Friedlander, S-T-E-V-E-N, 09:08:49
7 F-R-I-E-D-L-A-N-D-E-R. 09:08:53
8 HEARING OFFICER HALSTEAD: Thank you. 09:08:57
9 Mr. Cumings. 09:08:58
10 DIRECT EXAMINATION 09:08:58
11 BY MR. CUMINGS: 09:08:58
12 Q. Thank you, Dr. Friedlander, for being here today. 09:09:01
13 I know you're a very busy man. Are you licensed as a 09:09:04
14 medical doctor in the state of Nevada? 09:09:06
15 A. Yes. 09:09:08
16 Q. For how long have you been licensed here? 09:09:08
17 A. Since 1998. 09:09:10
18 Q. And are you licensed anywhere else? 09:09:12
19 A. Currently, no. 09:09:15
20 Q. And where did you go to medical school at? 09:09:17
21 A. Went to Hahnemann University in Philadelphia. 09:09:20
22 Q. And what was your residency in? 09:09:23
23 A. Ophthalmology at University of California San 09:09:25
24 Diego. 09:09:29
25 Q. And are you certified by the American Board of 09:09:29

1 Medical Specialties? 09:09:34
2 A. Yes. 09:09:35
3 Q. What is your specialty? 09:09:35
4 A. Ophthalmology. 09:09:36
5 Q. Where do you practice medicine currently? 09:09:38
6 A. In Reno and Carson City. 09:09:43
7 Q. And how long have you been practicing as an 09:09:46
8 ophthalmologist in total? 09:09:49
9 A. Again, after my training, I came to Reno, so 09:09:51
10 since 1998. 09:09:55
11 Q. So 26 years? 09:09:56
12 A. In my 26th year, yes. 09:09:58
13 Q. Okay. Please turn to what's been premarked as 09:10:01
14 Exhibit 6. This is your CV. Have you seen this 09:10:05
15 document before? 09:10:15
16 A. Yes. 09:10:16
17 Q. What is it? 09:10:16
18 A. I'm sorry? 09:10:18
19 Q. And what is this document? 09:10:20
20 A. This is a CV for myself. 09:10:21
21 Q. Does this appear to be the true and correct copy 09:10:25
22 of your CV? 09:10:29
23 A. Yes. 09:10:30
24 Q. And does this document adequately summarize your 09:10:30
25 experience and your education? 09:10:35

1 A. Yes. 09:10:36
2 Q. And you prepared this document? 09:10:37
3 A. Yes. 09:10:38
4 Q. Is there anything on this document that you'd 09:10:39
5 like to add, or is this document complete? 09:10:41
6 A. I think it's complete. 09:10:44
7 Q. Okay. 09:10:51
8 MR. CUMINGS: As the CV's already been admitted, 09:10:51
9 I'd like to tender Dr. Friedlander as an expert witness 09:10:54
10 in this case. 09:10:57
11 HEARING OFFICER HALSTEAD: Ms. Hueth? 09:10:59
12 MS. HUETH: No objection. 09:11:00
13 HEARING OFFICER HALSTEAD: Thank you. So I'll 09:11:02
14 accept the tender. 09:11:04
15 BY MR. CUMINGS: 09:11:04
16 Q. Dr. Friedlander, have you served as a peer 09:11:06
17 reviewer for the Board before? 09:11:09
18 A. Yes. 09:11:10
19 Q. Approximately how many cases have you reviewed 09:11:12
20 for the Board? 09:11:14
21 A. I'm not exactly sure. I feel like it's about 09:11:14
22 half a dozen. 09:11:18
23 Q. And are you familiar with BME Case No. 23-25326-1 09:11:18
24 regarding Dr. Loo? 09:11:24
25 A. Yes. 09:11:26

1 Q. Based upon your training and experience, do you 09:11:26
2 feel that you're familiar with the standards of care to 09:11:29
3 which practitioners should be held regarding the facts 09:11:32
4 of this case in the state of Nevada? 09:11:35
5 A. Yes. 09:11:36
6 Q. Do you have experience in the subject matter 09:11:36
7 you've been asked to review regarding this case? 09:11:39
8 A. Yes. 09:11:41
9 Q. Were you provided with materials by the Board for 09:11:42
10 your review in this matter? 09:11:45
11 A. Yes. 09:11:46
12 Q. Do you remember what was included in those 09:11:47
13 materials? 09:11:49
14 A. Medical records. 09:11:49
15 Q. Was Dr. Loo's allegation letter included as well? 09:11:54
16 A. Yes. Yes. Yes, allegation, response, medical 09:11:58
17 records. 09:12:02
18 Q. And were you asked at the time those materials 09:12:03
19 were provided to make an objective determination whether 09:12:06
20 any professional medical opinion -- if there was any 09:12:09
21 departure of the proper standards of medical care by 09:12:12
22 Dr. Loo? 09:12:15
23 A. Yes. 09:12:16
24 Q. And did you come to such a determination? 09:12:16
25 A. Yes. 09:12:18

1 Q. What was that determination? 09:12:18
2 A. Umm, my determination was that with the -- with 09:12:20
3 the retinal tear and pursuing retinal detachment that 09:12:27
4 there was malpractice in the case. 09:12:32
5 Q. Thank you, Dr. Friedlander. I'd like to shift 09:12:34
6 gears and ask you some specific questions regarding the 09:12:40
7 facts in this case. Could you please turn to Exhibit 5? 09:12:42
8 We're looking at Pages 112 through 118 right now. These 09:12:46
9 have been admitted as Patient A's medical records from 09:12:52
10 the Center for Sight. 09:12:55
11 Could you please review these documents and look 09:12:56
12 up to me when you're done? 09:12:59
13 A. (Complied.) Okay. 09:13:02
14 Q. Is there a date on this record? Dr. Friedlander, 09:13:12
15 can you see when this record was created? 09:13:23
16 A. This is -- this record was from March the 18th -- 09:13:25
17 March the 13th of 2018. 09:13:31
18 Q. And do you see a time on these records when they 09:13:32
19 were created? If you look at the images on Page 113. 09:13:36
20 A. That says around 2 p.m. A little after 2 p.m. 09:13:52
21 Q. Can you tell from this record who authored these 09:14:00
22 notes? 09:14:03
23 A. These appear to be authored by Dr. Keel. 09:14:04
24 Q. Okay. And can you tell what the reason for the 09:14:09
25 visit was? 09:14:11

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1 A. Umm, yeah. The chief complaint states that her 09:14:12
2 left eye went cloudy. She was seeing floaters, strings, 09:14:29
3 gray strings, and a flash -- circle-like flash in her 09:14:34
4 peripheral vision. Also a flutter in the upper right 09:14:40
5 corner that was constantly there. 09:14:44
6 Q. What is a floater? 09:14:47
7 A. Umm, the notes say the word "flutter." 09:14:48
8 Q. Flutter. But did she say floater on a previous 09:14:53
9 page? 09:14:56
10 A. Yes. So a floater is -- a floater is usually 09:14:57
11 described as material in the vitreous cavity that -- 09:15:02
12 from the -- I think that the opening statement with the 09:15:10
13 description of the eye anatomy and the vitreous was 09:15:13
14 pretty accurate, and so when people have liquefaction of 09:15:18
15 their vitreous, they can have sort of collagen and 09:15:24
16 proteinaceous material in it that can cast shadow on the 09:15:28
17 retina and we see these as objects moving in our eye and 09:15:32
18 they tend to float. We thus call them floaters. 09:15:38
19 Q. And you're referring to Ms. Hueth's opening 09:15:42
20 statements? 09:15:46
21 A. Yes. 09:15:46
22 Q. So the eye itself is filled with this jelly-like 09:15:46
23 material called the vitreous? 09:15:47
24 A. Correct. 09:15:49
25 Q. What is the retina exactly? 09:15:50

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1 A. The retina is highly sensitive, essentially 09:15:51
2 neurological tissue that captures lights and then 09:15:56
3 transmits it via the optic nerve to the brain. 09:16:00
4 Q. Where is the retina located at in the eye? 09:16:03
5 A. It lines the back of the eye, for the most part, 09:16:06
6 the back 75 percent of the eye, 80 percent of the eye. 09:16:10
7 Q. So kind of moving towards the front of it? 09:16:16
8 A. Yeah. Comes around. We have a drawing or model 09:16:21
9 I can show you easier, but yes, comes sort of all the 09:16:26
10 way around the front part of the eye and the retina 09:16:30
11 lines the back of it. 09:16:32
12 Q. Do you have a piece of paper there with you? 09:16:33
13 A. Sure. 09:16:35
14 Q. Could you draw us a diagram real fast? 09:16:36
15 A. Okay. 09:16:40
16 Q. Sorry. It would be easier if it was in person. 09:16:41
17 A. I never -- I never when to art school, so... 09:16:54
18 Q. I don't think anybody's going to hold that 09:17:00
19 against you. 09:17:03
20 A. Anyway, here's my beautiful drawing. The front 09:17:08
21 of the eye here. Light comes in here. The retina kind 09:17:13
22 of goes from here at the -- 09:17:16
23 Q. Could you hold it up more, Dr. Friedlander? 09:17:19
24 A. Can you see that? The anterior insertion here, 09:17:23
25 the ora serrata, and the optic nerve is back here 09:17:26

1 somewhere and the macula is over here. It just lines 09:17:29
2 here. Again, this is a two-dimensional drawing of a 09:17:33
3 three-dimensional structure. The cornea of the lens 09:17:37
4 would be up here. So light comes in this way, gets 09:17:40
5 focused on the retina, gets transmitted to the brain. 09:17:42
6 The vitreous lives in this cavity here. 09:17:44
7 Q. That line out the back, that's the optic nerve? 09:17:48
8 A. Yes. 09:17:50
9 Q. All right. I'd like to turn back to the records 09:17:51
10 here, Page 116. Looking at the ocular history there, 09:17:53
11 did Patient A have any surgeries prior to March 13th? 09:17:58
12 A. Umm, yes. Patient had several intraocular 09:18:01
13 surgeries. Cataract surgery. Patient had implant -- 09:18:14
14 essentially implanted contact lens, which is a 09:18:23
15 refractive procedure. Patient had PRK, which is a laser 09:18:27
16 refractive procedure, and also YAG lasers done at least 09:18:32
17 twice, which is to clean up the posterior capsule when 09:18:36
18 it becomes hazy. 09:18:41
19 Q. And could any of these surgeries be a risk factor 09:18:43
20 for floaters or anything along that nature? 09:18:47
21 A. Well, the patient is described as a high myo, 09:18:51
22 thus highly nearsighted, and it makes sense that someone 09:18:55
23 nearsighted would go through these procedures. And 09:19:01
24 nearsightedness is a major risk factor for retinal tear 09:19:06
25 and detachment, if that's what you're getting at. 09:19:12

1 Q. Yes. Looking at Page 117 through 118, did 09:19:16
2 Dr. Keel perform an eye examination on Patient A at this 09:19:21
3 visit? 09:19:24
4 A. Yes. 09:19:24
5 Q. Could you go through and outline what sort of 09:19:24
6 exam Dr. Keel performed? 09:19:28
7 A. Umm, okay. So they start out with the visual 09:19:29
8 acuity. Umm, they did -- it looks like they did an auto 09:19:44
9 refraction and then a manifest refraction. The pupils 09:19:55
10 and visual fields, motility were checked, were all 09:20:01
11 normal. The intraocular pressure was measured. And the 09:20:08
12 slit lamp and dilated fundus exam were performed. 09:20:15
13 Q. Was the ocular pressure normal? 09:20:20
14 A. The ocular pressure appeared to be elevated 09:20:22
15 initially. They took several readings. They took 09:20:28
16 another reading. This is after the patient was dilated 09:20:32
17 where it had come down a bit. Umm... 09:20:36
18 Q. Looking on that next page, Page 118, the fundus 09:20:44
19 exam. What is the fundus exam? 09:20:50
20 A. That's basically the examination of the -- the 09:20:52
21 vitreous and the retina. 09:20:56
22 Q. And what is a fundus? 09:20:59
23 A. Just another name, essentially, for the retina. 09:21:00
24 Q. Okay. Was there any concerning findings per 09:21:04
25 Dr. Keel on the fundus exam? 09:21:08

1 A. Yeah. The findings here are in the vitreous she 09:21:09
2 notes a positive Shafer's sign, and that has to do with 09:21:14
3 pigmented cells being seen, and that is often seen in 09:21:18
4 the context of a retinal tear. Umm, the other major 09:21:23
5 finding is the superotemporal horseshoe tear with 09:21:28
6 surrounding hemes. 09:21:33
7 Q. On your handy diagram that you drew there, could 09:21:34
8 you sort of demonstrate where that horseshoe tear would 09:21:38
9 be occurring at? 09:21:42
10 A. Well, I can't tell for sure. I -- I can't tell 09:21:43
11 for sure based on just this description. 09:21:49
12 Q. Uh-huh. 09:21:51
13 A. But, you know, it's going to be more in the 09:21:52
14 superotemporal periphery of the left eye. 09:21:55
15 Q. Where is that at? 09:21:59
16 A. Umm, well, on me it would be up here somewhere. 09:22:00
17 Upper quadrant. 09:22:08
18 Q. So towards the front of the eye? 09:22:09
19 A. Now, I'm -- let me do one other sort of quick 09:22:13
20 drawing for you then. 09:22:17
21 Q. Please. 09:22:19
22 A. Umm, we would draw something very quickly like 09:22:24
23 that. 09:22:29
24 Q. Uh-huh. 09:22:31
25 A. This represents the optic nerve. This represents 09:22:32

1 the macular center part of the vision. These are the -- 09:22:35
2 what are called the arcades. 09:22:38
3 Q. Could you hold it up a little bit? 09:22:38
4 A. (Complied.) This represents a tear. 09:22:40
5 Q. Higher, Dr. Friedlander. I'm sorry. 09:22:42
6 A. Sorry. Got it? 09:22:45
7 Q. Perfect. 09:22:47
8 A. Okay. Umm, this tear can be -- when it's 09:22:47
9 described in this quadrant, it basically could be sort 09:22:52
10 of anywhere there. 09:22:55
11 Q. Okay. 09:22:57
12 A. Yeah. 09:22:59
13 Q. And that little dot at the back, that's the optic 09:23:00
14 nerve? 09:23:05
15 A. The optic nerve's the round thing here. And this 09:23:05
16 little X here is the -- represents the fovea or the 09:23:09
17 macula or the center part of the retina. 09:23:14
18 Q. And on your previous diagram, the optic nerve is 09:23:15
19 in the back of the eye. Correct? 09:23:19
20 A. Correct. 09:23:21
21 Q. What exactly is a horseshoe tear? 09:23:21
22 A. So in -- in retina we describe things often just 09:23:24
23 by how they look. So a horseshoe tear is also called a 09:23:29
24 flap tear, and the vitreous is attached to -- to the 09:23:33
25 retina and then -- can you see my hands there? Pulls up 09:23:40

1 like this, and so -- I really should have brought my own 09:23:46
2 artist with me. Can you see that? 09:23:51
3 Q. Yes. 09:24:07
4 A. Okay. So kind of looks like a horseshoe. 09:24:08
5 Q. Uh-huh. 09:24:11
6 A. So vitreous is often attached here still pulling 09:24:14
7 kind of in that direction. The tear is here, this part. 09:24:19
8 Q. That's the separation? 09:24:22
9 A. Yeah. This is a defect in the retina. So this 09:24:23
10 is pulling up like this and sort of opening up that 09:24:26
11 tear. 09:24:30
12 Q. And how do you diagnose a tear? 09:24:31
13 A. You -- you -- you -- you see it. 09:24:34
14 Q. Could it be diagnosed with imaging? 09:24:39
15 A. It can be, yes. The imaging that would be 09:24:41
16 utilized would be usually a wide-field fundus photogram. 09:24:47
17 Q. Could an ultrasound diagnose a tear? 09:24:54
18 A. An ultrasound is used often to diagnose a retinal 09:24:56
19 detachment or to rule out a retinal detachment in cases 09:25:02
20 where the media is not clear. For instance, the patient 09:25:07
21 has a dense cataract and you're unable to view the 09:25:11
22 retina or they have blood in the back of the eye, 09:25:14
23 vitreous hemorrhage, and you can't view the retina. 09:25:18
24 Very skilled practitioners can sometimes identify 09:25:20
25 tears in a attached retina with a B-scan, but in my 09:25:24

1 experience, it's not all that particularly common to do 09:25:28
2 that. Most -- most retinal tears -- the vast majority 09:25:31
3 of retinal tears are diagnosed by direct visualization. 09:25:35
4 Q. So it's easy to miss a retinal tear on just a 09:25:40
5 B-scan? 09:25:44
6 A. Depends -- depends on the size of the tear and 09:25:44
7 the skill of the person doing the ultrasound. 09:25:49
8 Q. If a -- if a tear is caught early, can it be 09:25:51
9 fixed before it detaches? 09:25:56
10 A. Yes, that's -- that's the goal of the treatment. 09:25:57
11 Q. Is that a better outcome for the patient than a 09:26:00
12 reattachment? 09:26:04
13 A. Yes. 09:26:06
14 Q. And why is that? 09:26:07
15 A. Well, you're -- essentially what you're doing is 09:26:08
16 you're sealing the retinal tear. When treating the 09:26:15
17 retinal tear, you treat it with either laser treatment 09:26:18
18 or freezing treatment, and I tell patients it's sort of 09:26:19
19 like spot welding it and you're preventing fluid from 09:26:23
20 getting through the tear and underneath the retina. 09:26:27
21 Once you have a retinal detachment, first of all, 09:26:31
22 it usually requires a bigger, more invasive procedure to 09:26:33
23 fix, and the prognosis is umm, you know, often -- often 09:26:37
24 worse. 09:26:43
25 Q. Could you please turn back to Page 113, and 09:26:45

1 looking through that page, can you tell what these 09:26:50
2 images are? 09:26:54
3 A. Well, these are OCT images of the patient's optic 09:26:55
4 nerve head and retinal nerve fiber layer. 09:27:06
5 Q. What's on OCT? 09:27:10
6 A. It's an optical coherence tomography. It's an 09:27:12
7 imaging modality that's widely used to view the 09:27:17
8 structures in the back of the eye, umm, the macula, and 09:27:22
9 optic nerve. 09:27:30
10 Q. All right. And from these images, can you tell 09:27:31
11 if there's a retinal tear present? 09:27:36
12 A. No. 09:27:38
13 Q. And looking, it says OD and OS. What does OD and 09:27:38
14 OS refer to? 09:27:43
15 A. Right eye and left eye respectively. 09:27:44
16 Q. So OS is left eye? 09:27:49
17 A. Correct. 09:27:50
18 Q. I believe that's where the tear has been 09:27:51
19 diagnosed. Correct? 09:27:53
20 A. Correct. 09:27:54
21 Q. Flipping through to the next page, Page 114 and 09:27:55
22 115. 115 has the OS. You said that was the left eye. 09:27:59
23 Correct? 09:28:04
24 A. Yes. 09:28:04
25 Q. What are these images? 09:28:05

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1 A. These are again OCTs through the macula. 09:28:06
2 Q. And again, no -- no images of a tear present 09:28:11
3 there? 09:28:14
4 A. There's not an image of a -- no. There's no tear 09:28:15
5 seen here. And you wouldn't expect to see -- you 09:28:21
6 wouldn't expect to see a retinal tear in the macula. 09:28:24
7 That doesn't happen. 09:28:27
8 Q. And why not? 09:28:29
9 A. Because the pathophysiology of retinal tears is 09:28:30
10 that they happen in the retinal periphery and not in the 09:28:38
11 macula. 09:28:42
12 Q. You said the best way to diagnose them is to 09:28:42
13 visualize them? 09:28:46
14 A. Correct. Or again, if you had imaging, often 09:28:47
15 people will see retinal tears on wide-field fundus 09:28:49
16 imaging. They can see a tear. Referring doctor will 09:28:55
17 sometimes see a tear and send him over not without 09:28:58
18 necessarily visualizing it. 09:29:02
19 Q. Uh-huh. And turning to Page 118 now, do you see 09:29:05
20 the Assessment/Plan section? 09:29:08
21 A. Yes. 09:29:10
22 Q. What is Dr. Keel's assessment and plan for the 09:29:12
23 retinal tear? 09:29:16
24 A. Umm, was to refer to retina for evaluation and 09:29:17
25 treatment. Will refer to Retinal Consultants Nevada 09:29:22

1 ASAP. 09:29:25
2 Q. And what's it say below that? 09:29:27
3 A. "Discussed the severity of this condition with 09:29:29
4 patient today. Instructed that she visit RCN today for 09:29:33
5 treatment. Patient understands that if she does not 09:29:40
6 seek treatment today, this may lead to a retinal 09:29:40
7 detachment and loss of vision. Patient states 09:29:46
8 understanding." 09:29:46
9 Q. Thank you, Dr. Friedlander. I'd next like to 09:29:46
10 turn to Dr. Loo's response to the Board allegation 09:29:51
11 letter. We can go over his narrative of his treatment 09:29:53
12 of Patient A prior to looking at his records. Please 09:29:54
13 turn to what has been premarked as Exhibit 2. 09:29:57
14 For the record, Exhibit 2 was admitted as 09:30:00
15 Dr. Loo's response to the allegation letter. I'd like 09:30:03
16 you to examine Page Nos. 3 through 5 of the document and 09:30:07
17 look up when you're done. 09:30:11
18 A. Well, I've read the document several times. If 09:30:18
19 there's specific questions, we can address them. 09:30:22
20 Q. Certainly. If you could look at Page 3 09:30:24
21 concerning Patient A's initial presentation to Dr. Loo, 09:30:27
22 could you please read that paragraph beginning with, 09:30:30
23 "The patient first presented" into the record? That 09:30:34
24 second paragraph there. 09:30:37
25 A. "Patient first presented to me on March 13, 2018 09:30:37

1 with complaints of floaters in the left eye. The 09:30:41
2 patient indicated she was referred to my office by her 09:30:45
3 optometrist, but I did not receive any referral 09:30:48
4 paperwork indicating a specific reason for the visit. 09:30:51
5 The patient's past history was significant for high 09:30:53
6 myopia, intraocular lens placement in both eyes, and a 09:30:57
7 YAG laser capsulotomy to the left eye. The patient's 09:31:03
8 visual acuity was 20/25 in the right eye and 20/80 in 09:31:08
9 the left. I performed a" -- this should say "a slit 09:31:14
10 lamp evaluation which revealed white and quiet 09:31:14
11 conjunctiva, clear cornea, deep and quiet anterior 09:31:23
12 chamber, normal iris, and posterior chamber intraocular 09:31:23
13 lens in each eye." 09:31:25
14 "In the right eye, I noticed 1 plus posterior 09:31:26
15 opacification and the left posterior capsule was open in 09:31:29
16 the left eye. A dilated fundus examination was also 09:31:35
17 performed and demonstrated vitreous syneresis, 0.25 cup 09:31:36
18 to disc optic nerve, normal vasculature, and attached 09:31:41
19 periphery on 360 degrees. Unfortunately, my examination 09:31:46
20 was limited as the patient reported she could not 09:31:52
21 tolerate keeping her eye open, light sensitivity, and 09:31:52
22 discomfort. I tried to minimize discomfort as much as 09:31:55
23 possible, but the patient was difficult to examine, 09:32:00
24 resulting in a limited examination." 09:32:01
25 Q. Did Dr. Loo recount why the patient was visiting? 09:32:03

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1 A. In the paragraph I just read? 09:32:08

2 Q. Yes. 09:32:17

3 A. She was referred by her optometrist. 09:32:17

4 Q. And he states that she'd already been seen by 09:32:21

5 another provider that day? 09:32:24

6 A. I don't know that that is specifically in here. 09:32:25

7 Q. I think it's on the next page. Let's come back 09:32:44

8 to that question. 09:32:44

9 Real fast, can you summarize what Dr. Loo's 09:32:47

10 examination of the patient was? 09:32:49

11 A. His examination -- I'm sorry. His findings or 09:32:50

12 what he did? 09:32:53

13 Q. His findings there. He said he performed a slit 09:32:54

14 lamp evaluation. Demonstrated vitreous syneresis? 09:33:00

15 A. Yeah. So really, the only -- the sort of 09:33:06

16 relevant findings is that the visual acuity was 09:33:12

17 decreased to 20/80. There was some -- there was some 09:33:16

18 posterior capsular haze in the right eye. The capsule 09:33:23

19 was open in the left eye. He describes vitreous 09:33:27

20 syneresis, which is the process of the vitreous, the 09:33:31

21 jelly, liquefying. And that the retina was attached. 09:33:35

22 Q. 360 degrees? 09:33:41

23 A. Uh-huh. 09:33:42

24 Q. Okay. Turning to the next page, third paragraph 09:33:44

25 down, see the "I deny"? 09:33:49

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1 A. Yeah. 09:33:51

2 Q. Could you read that and the following fourth 09:33:53

3 paragraph into the record? 09:33:55

4 A. "I deny the allegation that the patient presented 09:33:56

5 to me on March 13, 2018 for a horseshoe retinal tear to 09:34:01

6 the left eye superotemporally with surrounding 09:34:06

7 hemorrhages. The patient did not report any specific 09:34:10

8 reason for her evaluation. In addition, I did not 09:34:13

9 receive any referral paperwork or other information from 09:34:16

10 the referring provider suggesting there was a specific 09:34:19

11 finding or reason for the patient's visit other than her 09:34:20

12 stated complaints. At the time of my care, it was my 09:34:23

13 understanding (based on the information I had) that the 09:34:26

14 patient presented for evaluation complaints of floaters 09:34:29

15 when her eyes moved. Neither the patient nor her 09:34:33

16 referring provider indicated she had been diagnosed with 09:34:37

17 possible retinal tear or hemorrhages." 09:34:39

18 "It is further alleged that I failed to identify 09:34:42

19 and diagnose the patient's retinal tear, which I also 09:34:46

20 deny. The patient was examined and multiple images of 09:34:48

21 her eye were obtained. Specifically, we obtained a 09:34:52

22 B-scan ultrasound and macular optical coherence 09:34:55

23 tomography (OCT), which allows high-resolution 09:34:56

24 cross-sectional imaging of the retina. These imaging 09:35:00

25 tests are very reliable in identifying possible retinal 09:35:02

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1 tears or vitreous detachment, neither of which showed 09:35:05
2 evidence of retinal detachment. Scleral depression also 09:35:08
3 did not reveal detachment or tear. Unfortunately, my 09:35:12
4 examination was quite limited by the patient's inability 09:35:16
5 to tolerate the exam. The imaging also is dependent, in 09:35:18
6 part, on the patient's cooperation. However, based of 09:35:22
7 the examination I was able to perform and the imaging, 09:35:25
8 there was no evidence of retinal tear. I specifically 09:35:30
9 told the patient that I did not find evidence of retinal 09:35:30
10 tear and was never told that any prior provider found 09:35:33
11 evidence of a retinal tear. I instructed the patient to 09:35:38
12 return if she noticed any visual decline. This 09:35:40
13 information was also provided to the referring 09:35:41
14 provider." 09:35:44
15 Q. So looking at those two paragraphs, was Dr. Loo 09:35:45
16 actually looking for a retinal tear? 09:35:49
17 MS. HUETH: Objection. Calls for speculation as 09:35:51
18 to what Dr. Loo was looking for. 09:35:56
19 BY MR. CUMINGS: 09:35:58
20 Q. Did Dr. Loo perform an examination to rule out a 09:35:58
21 retinal tear? 09:36:02
22 MS. HUETH: Same objection. 09:36:03
23 HEARING OFFICER HALSTEAD: I would like to make a 09:36:05
24 ruling. I think your first question was sufficient. It 09:36:07
25 was based upon the document and what was indicated in 09:36:07

1 the document. I'm going to overrule the objection. 09:36:14
2 A. Can you repeat the question? 09:36:16
3 BY MR. CUMINGS: 09:36:19
4 Q. Was Dr. Loo looking for a retinal tear, based 09:36:19
5 upon what he's written there? 09:36:25
6 A. Umm, well, he's looking for any retinal 09:36:26
7 pathology, which would include a retinal tear. 09:36:32
8 Q. Okay. And Dr. Loo mentions an OCT? 09:36:35
9 A. Yes. 09:36:44
10 Q. And a B-scan? 09:36:44
11 A. Yes. 09:36:45
12 Q. You previously testified that those cannot 09:36:45
13 definitively rule out a tear? 09:36:49
14 A. Correct. Correct. I would add -- I would add 09:36:51
15 that, you know, in the macular OCT, it does show quite 09:36:55
16 well a condition called macular hole, which is sometimes 09:37:02
17 associated with retinal detachment but very different 09:37:06
18 than a peripheral tear as being described in this case. 09:37:10
19 Q. And you stated that Dr. Loo performed a scleral 09:37:13
20 depression? 09:37:18
21 A. Correct. That's what it says. 09:37:20
22 Q. And he also stated this was a limited exam. 09:37:22
23 Correct? 09:37:25
24 A. Yes. 09:37:25
25 Q. Why was that? 09:37:26

1 A. Umm, the implication is the patient was not 09:37:27
2 tolerating the exam. A, you know, patient who has been 09:37:36
3 already dilated and examined pretty thoroughly by one 09:37:44
4 doctor and then goes to another doctor on the same day, 09:37:49
5 it's a lot of bright lights in your eyes, and scleral 09:37:54
6 depression, if you've ever had that, is not the most 09:37:59
7 comfortable diagnostic evaluation in the world. You're 09:38:02
8 taking a metal tool and literally pressing on the 09:38:13
9 eyelids so that you can visualize the entire retina. So 09:38:18
10 it's not all that uncommon, like in this situation, that 09:38:22
11 an examination might be limited or difficult, certainly. 09:38:27
12 Q. But you testified previously that Dr. Keel had 09:38:31
13 already confirmed a tear around 2, 2:30 in the 09:38:34
14 afternoon. Correct? 09:38:40
15 A. Yeah. That's -- that's what the notes say. 09:38:41
16 Q. And you just read in Dr. Loo's response that he 09:38:43
17 was not aware of the tear, nor was he aware that Patient 09:38:46
18 A had received -- why Patient A had received a STAT 09:38:50
19 referral from Dr. Keel? 09:38:50
20 A. Correct. 09:38:51
21 Q. In your experience as an optometrist, if you 09:38:52
22 receive a STAT referral -- or as an ophthalmologist. 09:38:56
23 Excuse me. I'm sorry. 09:39:00
24 Ophthalmologist, if you receive a STAT referral 09:39:00
25 from an optometrist, what is that usually for? Is there 09:39:04

1 certain conditions that require a STAT referral? 09:39:08
2 A. Yeah. There's a long list. 09:39:10
3 Q. And if a patient presented without any paperwork 09:39:14
4 or any knowledge, is it reasonable to call that 09:39:18
5 referring provider to see what they were referred for? 09:39:21
6 A. Yeah. Definitely. 09:39:24
7 Q. Whose responsibility -- 09:39:27
8 A. If the patient is unable to provide you with that 09:39:28
9 information. 09:39:31
10 Q. Whose responsibility is that? Is that a tech or 09:39:35
11 is that on the physician? 09:39:38
12 A. Well, in my practice in a case like this, 09:39:40
13 which -- which does happen where -- I guess the more 09:39:48
14 common thing is that an optometrist thinks they see a 09:39:53
15 retinal tear and I can't find it, and at that point I am 09:39:57
16 concerned that maybe I'm missing it and I will try to 09:40:06
17 get ahold of that optometrist and ask them -- the first 09:40:10
18 question is: Did you actually see a tear or are you 09:40:15
19 just concerned there might be one, because those are two 09:40:18
20 different things. And then, you know, go back and take 09:40:21
21 another look and just make sure. 09:40:28
22 Again, if the optometrist is adamant that there's 09:40:30
23 a tear and I don't see it, I will try to get another set 09:40:32
24 of eyes on the patient or will do follow-up in a short 09:40:36
25 period of time to take another look. 09:40:40

1 Q. So in a clinical presentation such as Patient A's 09:40:42
2 where it's a difficult exam, do you think that there was 09:40:47
3 enough done to rule out the possibility of a tear? 09:40:50
4 A. Umm, I -- I suspect in this case that the retinal 09:40:53
5 tear was seen by the optometrist, and by the time the 09:41:00
6 patient got to Dr. Loo that it was -- I -- I totally 09:41:05
7 believe it was a difficult examination in part to see 09:41:13
8 what was going on and that he just didn't see it. 09:41:18
9 Q. Does this record -- does Dr. Loo's response say 09:41:22
10 that he attempted to contact Dr. Keel? 09:41:26
11 A. No. 09:41:28
12 Q. Okay. So let's turn now to the records from 09:41:29
13 Dr. Loo on March 13th reflecting that he documented 09:41:34
14 three years earlier from the date of this letter. 09:41:37
15 Please turn to Exhibit 4 which has been admitted as the 09:41:41
16 records from Retina Consultants for Nevada for Patient 09:41:43
17 A, specifically Pages 34 and 35. 09:41:46
18 Please review this document and look up when 09:41:59
19 you're done. 09:42:01
20 A. (Complied.) Okay. 09:42:02
21 Q. All right. What does this document appear to be? 09:42:03
22 A. This is -- this looks like the initial visit at 09:42:06
23 Dr. Loo's office for this patient on March 13th. 09:42:14
24 Q. And does this record indicate that Dr. Loo 09:42:18
25 examined Patient A? 09:42:22

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1 A. Yes. 09:42:24
2 Q. Looking at Page 35, what does Dr. Loo note as the 09:42:25
3 chief complaint for the patient? 09:42:31
4 A. "Flashes when eyes move," and I -- I have trouble 09:42:32
5 making out the next two -- next two words there. 09:42:43
6 Q. And can you tell from this document what sort of 09:42:52
7 exam Dr. Loo performed? 09:42:57
8 A. Umm, Dr. Loo did -- they measured visual acuity, 09:42:59
9 confrontational visual fields, pupils, motility, 09:43:10
10 intraocular pressure, a slit lamp examination and 09:43:19
11 dilated examination of both eyes, as well as he notes an 09:43:23
12 ultrasound being done. 09:43:28
13 Q. Okay. Could you summarize the findings? 09:43:30
14 A. So the impression was floaters in both eyes and 09:43:33
15 an inferior blind spot in the left eye. 09:43:52
16 Q. In the ultrasound note there it says, "Ultrasound 09:43:55
17 left eye" -- 09:44:03
18 A. The ultrasound states that there was no retinal 09:44:03
19 detachment in the left eye. 09:44:06
20 Q. So that would indicate Dr. Loo was suspicious of 09:44:07
21 a tear or ruling one out? 09:44:11
22 A. It just indicates he was sus- -- that he didn't 09:44:13
23 see a retinal detachment. 09:44:16
24 Q. And what's his diagnosis according to this? Just 09:44:18
25 floaters? 09:44:21

1 A. A -- floaters, and again, there's this notation 09:44:22
2 of an inferior blind spot. 09:44:27
3 Q. Does Dr. Loo note anything in this examination 09:44:31
4 about it being difficult as characterized in his 09:44:35
5 response? 09:44:38
6 A. No. 09:44:39
7 Q. Does he note who the referring provider was? 09:44:39
8 A. Yes. 09:44:41
9 Q. Okay. Is the difficulty in the exam, is that 09:44:45
10 something that should be included in a record such as 09:44:51
11 this? 09:44:54
12 A. I -- I generally note it. 09:44:54
13 Q. And does Dr. Loo note that he performed a scleral 09:45:02
14 depression that you can see on this? 09:45:08
15 A. Not from this note. 09:45:09
16 Q. Okay. And finally, looking at the bottom of 09:45:11
17 Page 34, it says "DNP" and that's circled. What is DNP? 09:45:15
18 A. I don't know. But it seems to have something to 09:45:24
19 do with the follow-up visit. It just doesn't appear 09:45:27
20 that one was scheduled. So... 09:45:34
21 Q. Is that standard procedure for a patient with a 09:45:39
22 suspected detachment or tear? 09:45:42
23 A. Patients with new onset floaters that have 09:45:44
24 significant syneresis or posterior vitreous detachment, 09:45:50
25 we generally see them back at least once in a -- 09:45:56

1 somewhere between two and four weeks. There are some 09:46:00
2 late-developing retinal tears that can occur. 09:46:05
3 Q. So if somebody's referred to you, you would 09:46:08
4 schedule a follow-up if it was a STAT referral? 09:46:12
5 A. In this case, I would have -- I would have 09:46:15
6 scheduled follow up for this patient in that 09:46:18
7 two-to-four-week period. 09:46:22
8 Q. Could you briefly turn to Page 19 also on 09:46:23
9 Exhibit 4? What does this document appear to be? 09:46:27
10 A. This is a -- a bill. 09:46:36
11 Q. What does this document tell us about Patient A's 09:46:43
12 examination on 3/13? 09:46:46
13 A. Umm, this was a new patient examination. The 09:46:47
14 B-scan, the ultrasound was done. The OCT was done. And 09:46:56
15 then he's got what's called extended ophthalmoscopy in 09:47:01
16 each eye. 09:47:08
17 Q. When is an extended ophthalmoscopy? 09:47:08
18 A. That's generally when you have been doing scleral 09:47:12
19 depression and you provide a visual record of your 09:47:17
20 findings. 09:47:20
21 Q. Was that record present in the 3/13 record we 09:47:21
22 just reviewed, any documentation of that? 09:47:25
23 A. The -- you know, what we're looking for is a 09:47:28
24 fundus drawing. 09:47:31
25 Q. Uh-huh. 09:47:33

1 A. I can't recall what the standards were in 2018, 09:47:34
2 but traditionally this was done with several colors that 09:47:43
3 represented different parts of the retina or different 09:47:49
4 things going on. 09:47:56
5 Q. Please turn to Page 76 still on Exhibit 4 there. 09:47:57
6 Please review this document and look up when you're 09:48:01
7 done. 09:48:04
8 MS. HUETH: I'm sorry, Counsel. What page? 09:48:04
9 MR. CUMINGS: 76, Ms. Hueth. 09:48:08
10 MS. HUETH: Thank you. 09:48:11
11 A. Okay. 09:48:16
12 BY MR. CUMINGS: 09:48:16
13 Q. What is the date of this document? 09:48:17
14 A. March 13th, 2018. 09:48:18
15 Q. And looking at the bottom of the document there, 09:48:20
16 can you tell when this letter was dictated? 09:48:24
17 A. Umm, it -- it says 3/14/18, if DT means dictated. 09:48:26
18 Q. And this isn't a long letter. Would you mind 09:48:36
19 reading this letter into the record for us? 09:48:40
20 A. "Dear Dr. Keel: I had the pleasure to evaluate 09:48:42
21 Patient A. As you know, this charming lady has noted 09:48:51
22 floaters. She does also have a history of high myopia 09:48:52
23 and has undergone intraocular contact lens placement to 09:48:57
24 each eye and YAG laser capsulotomy to the left eye." 09:49:01
25 "Today her acuity measures 20/25 in the right eye 09:49:03

1 and 20/80 in the left eye, and she arrives already 09:49:08
2 dilated with an intraocular pressure of 22 and 21 in 09:49:09
3 each eye, respectively. Her slit lamp examination 09:49:14
4 demonstrates a white and quiet conjunctiva, clear 09:49:17
5 cornea, deep and quiet anterior chamber, normal iris, 09:49:21
6 and posterior chamber intraocular lens in each eye. 1 09:49:23
7 plus posterior capsular opacification is present in the 09:49:26
8 right eye and the left posterior capsule is open." 09:49:31
9 "Dilated fundus examination demonstrates vitreous 09:49:32
10 syneresis, a 0.25 cup to disc optic nerve, normal 09:49:37
11 vasculature, attached periphery on 360 degree of scleral 09:49:40
12 depression, and OCT which demonstrates normal macular 09:49:45
13 profile." 09:49:45
14 "B-scan ultrasound of the left eye today 09:49:49
15 demonstrates an absence of retinal detachment." 09:49:51
16 "My impression is that Patient A presents with 09:49:55
17 floaters in each eye." 09:49:56
18 "I have discussed these findings with her and 09:49:57
19 have asked her to return for reevaluation should she 09:50:00
20 note any visual decline." 09:50:04
21 "If you have any questions or concerns regarding 09:50:06
22 this patient, please feel free to contact me. Again, 09:50:08
23 thank you for allowing me to participate in her care. 09:50:08
24 Sincerely, Roy H. Loo, MD." 09:50:12
25 Q. So it looks like per his letter here that he was 09:50:14

1 look for a retinal detachment in the left eye? 09:50:18

2 A. Umm, again, he did an ultrasound and the findings 09:50:21

3 showed absence of retinal detachment. 09:50:27

4 Q. Would that be indicative that he was likely 09:50:30

5 informed that there was a diagnosed tear? 09:50:34

6 MS. HUETH: Objection. Calls for speculation. 09:50:36

7 BY MR. CUMINGS: 09:50:42

8 Q. Given that -- 09:50:42

9 MR. CUMINGS: I'll wait for the ruling. 09:50:43

10 HEARING OFFICER HALSTEAD: It can be inferred 09:50:45

11 from the document itself. I don't think he needs to 09:50:47

12 speculate. 09:50:49

13 MR. CUMINGS: Okay. 09:50:50

14 A. I'm sorry. Can you repeat that? 09:50:53

15 BY MR. CUMINGS: 09:50:56

16 Q. I don't think we're going to have to cross that 09:50:56

17 bridge there. 09:50:59

18 A. Okay. 09:51:00

19 Q. So looking at the document, do you see anything 09:51:02

20 here that would lead you to believe that he had missed 09:51:04

21 the retinal tear, given that he was looking for a 09:51:09

22 detachment in the left eye? 09:51:12

23 A. Umm, I don't -- again, I don't know that Dr. Loo 09:51:14

24 was looking for a retinal -- was specifically looking 09:51:21

25 for a retinal detachment in the eye. I mean, that's 09:51:24

1 part of the examination. That's a finding that could -- 09:51:27
2 could be present, but he's -- I'm sure he's doing a -- 09:51:30
3 you know, an eye exam and he's going to report whatever 09:51:35
4 findings he reports. 09:51:41
5 Q. And you stated you can see the B-scan is testing 09:51:42
6 for retinal detachment but it can miss a retinal tear. 09:51:47
7 Correct? 09:51:52
8 A. In general, that's correct. 09:51:52
9 Q. Okay. And if you look at the previous page, 09:51:54
10 Page 75, what does this document appear to be? 09:52:02
11 A. Umm, these are, again, macular OCTs done on 09:52:04
12 March 13th. 09:52:11
13 Q. And what is the date of this? March 13th? 09:52:12
14 A. March 13th. 09:52:18
15 Q. Do the black-and-white prints make it a little 09:52:19
16 bit harder to visualize? 09:52:22
17 A. Yes. 09:52:23
18 Q. Could you please turn to Defendant's Exhibit 5 09:52:24
19 and please read the first page of that? 09:52:28
20 A. This? 09:52:30
21 Q. Yes. Do you see the baseline 3/13 -- the 3/13 09:52:44
22 exam? 09:52:49
23 A. Yes. 09:52:49
24 Q. Is that consistent with what was in black and 09:52:49
25 white on that page, on the previous page, Page 75? 09:52:53

1 A. Sorry. What was the previous page? 09:53:00
2 Q. Page 75 in IC's exhibits. 09:53:02
3 A. Well, I don't think that it is clinically 09:53:19
4 relevant, but the images in the left eye appear to be 09:53:52
5 slightly different based on the thickness measurements 09:53:58
6 that are here. 09:54:01
7 Q. Uh-huh. 09:54:03
8 A. Just looking at the right eye, that one looks to 09:54:04
9 be the same in the color and the black and white, the 09:54:08
10 two exhibits. But again, it's not -- it's not anything 09:54:14
11 relevant. 09:54:20
12 Q. What do these images show you? 09:54:20
13 A. Umm, basically normal macular anatomy in both 09:54:23
14 eyes. 09:54:29
15 Q. So looking at that picture on the defense 09:54:29
16 exhibit, the color picture, the -- on OS, the left eye 09:54:32
17 side, that black dot, you said that's the optic nerve. 09:54:37
18 Correct? 09:54:41
19 A. You're going to have to point out if you want -- 09:54:41
20 Q. (Complied.) 09:54:50
21 A. Yes. That's the optic nerve. 09:54:52
22 Q. That's just an image of the back of the eye? 09:54:55
23 A. Yes. 09:54:58
24 Q. Is this extended or wide fundus imagery here? 09:54:58
25 A. No. 09:55:02

1 Q. This is just looking at that back part of the 09:55:02
2 eye? 09:55:05
3 A. Correct. 09:55:06
4 Q. So it's unlikely to be able to see the retinal 09:55:06
5 tear from this image? 09:55:10
6 A. More than unlikely. 09:55:12
7 Q. And lastly, looking back at page -- let's go to 09:55:13
8 IC's exhibits, Page 76. Does Dr. Loo note the 09:55:17
9 difficulty of the exam that he had in this note here? 09:55:23
10 A. No. 09:55:26
11 Q. Okay. I'd like you to next look back to 09:55:33
12 Exhibit 5. That's Pages 105 through 111 in what has 09:55:40
13 been admitted as the Center for Sight records. 09:55:44
14 A. Uh-huh. 09:55:49
15 Q. What does this document appear to be? 09:55:50
16 A. The document starting on Page 105? 09:55:53
17 Q. Yes. I believe it goes all the way to Page 111. 09:56:02
18 A. Right. This is the -- the visit notes that were 09:56:08
19 done by Dr. -- sorry. Okay. These are the notes from 09:56:17
20 the next day, from March the 14th. 09:56:43
21 Q. Okay. And can you tell looking at Page 106 there 09:56:45
22 what time this visit was? 09:56:51
23 A. The images says 4:29 p.m. 09:56:52
24 Q. All right. On Page 107, what's the current 09:57:00
25 condition listed as for the patient's visit? Why are 09:57:06

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1 they there? 09:57:10

2 A. Umm, well, it's a "46-year-old female patient 09:57:10

3 here for established patient urgent visit. Patient was 09:57:25

4 seen yesterday and was sent to RCN for a horseshoe tear 09:57:29

5 in the OS towards the nose (indoors it's black and 09:57:34

6 outdoors it is like a brown beer bottle color). Patient 09:57:39

7 states she is seeing a flash around the missing vision. 09:57:45

8 Very frustrated with questions because she's being asked 09:57:48

9 the same questions. Denies any headaches. The vision 09:57:51

10 in the OD" -- right eye -- "is fine. Closing the eye 09:57:54

11 and sees white. Still getting headaches since these 09:57:57

12 episodes." 09:58:01

13 Q. And can you look forward to Page 110? Now 09:58:02

14 looking at the assessment, does the provider note that 09:58:08

15 Patient A saw Dr. Loo there? 09:58:12

16 A. Yes. Down in No. 4. "Patient saw Dr. Loo 09:58:14

17 yesterday." 09:58:23

18 Q. Can you read that whole paragraph of "Condition 09:58:27

19 is worsening"? 09:58:30

20 A. "Condition is worsening. The diagnosis was 09:58:31

21 discussed in detail and all questions were answered. 09:58:34

22 Referred to retina for evaluation and treatment. 09:58:37

23 Patient saw Dr. Loo yesterday who said no further 09:58:41

24 treatment was indicated and sent her home." 09:58:44

25 Q. Briefly, could you turn back to Page 107 looking 09:58:46

1 at the left eye, those images? Do those images look 09:58:50
2 different from the previous day's visit? Can you tell 09:58:56
3 something else is going on? 09:58:59
4 A. Are these the best images that we have of this? 09:59:01
5 Q. Unfortunately, yes, sir. But you can compare 09:59:08
6 them, if you'd like, to the previous visit, which was 09:59:12
7 the day before, and that's on Page 115. 09:59:14
8 A. Okay. So yeah. This on Page 107 does look like 09:59:36
9 there is subretinal fluid into the macula coming from 09:59:44
10 the superotemporal quadrant. 09:59:49
11 Q. And that indicates detachment? 09:59:54
12 A. Yes. 09:59:55
13 Q. All right. Please turn now briefly to Page 111. 09:59:56
14 HEARING OFFICER HALSTEAD: I'm sorry. That 10:00:00
15 indicates what? 10:00:01
16 MR. CUMINGS: Retinal detachment. 10:00:03
17 BY MR. CUMINGS: 10:00:03
18 Q. Looking at Paragraph 7 there, "Retinal detachment 10:00:07
19 total," could you read that section? 10:00:10
20 A. Yes. "Retinal detachment total (old). Condition 10:00:12
21 is worsening. I called and spoke to Dr. Hollifield and 10:00:18
22 explained the situation. Appears to be a macula-on RD. 10:00:23
23 Will get to RCN at Green Valley (Pezda) office right 10:00:28
24 now. Patient has not eaten since 11:30, will stay NPO 10:00:33
25 until evaluated." 10:00:38

1 Q. What does that refer to, "Patient has not eaten 10:00:38
2 since 11:30"? Why is that important? 10:00:41
3 A. The implication is the patient is going to need 10:00:44
4 to go to surgery and patients how shouldn't eat before 10:00:47
5 surgery. 10:00:50
6 Q. Okay. Let's turn back to Exhibit 4, Page 79. 10:00:51
7 Please review this document and look up when you're 10:01:02
8 done. 10:01:05
9 A. Okay. 10:01:15
10 Q. What does this document appear to be? 10:01:16
11 A. This is a letter from Dr. Pezda to Dr. Keel on 10:01:18
12 March 14th with his findings and plan. 10:01:22
13 Q. Is this letter in regards to the referral that we 10:01:27
14 just looked at on Page 111? 10:01:33
15 A. Yes. 10:01:35
16 Q. What is Dr. Pezda's impression of Patient A's 10:01:39
17 clinical presentation with respect to her left eye? 10:01:44
18 A. That she had a macula-off retinal detachment with 10:01:45
19 count fingers vision and she wished to proceed with 10:01:51
20 surgical repair. 10:01:55
21 Q. Pages 81 through 82 still on Exhibit 4 there, 10:02:00
22 please review this document and look up when you're 10:02:04
23 done. 10:02:07
24 A. (Complied.) Okay. 10:02:07
25 Q. What is this document? 10:02:08

1 A. It's an operative note for the vitrectomy which 10:02:10
2 was done to repair the retinal detachment 10:02:18
3 March 14th/15th. 10:02:23
4 Q. And who authored the note? 10:02:23
5 A. Dr. Pezda. 10:02:26
6 Q. Can you tell what time the document is dictated? 10:02:29
7 Should be on Page 82 there. 10:02:39
8 A. Umm, well, it looks like it was signed at 12:44 10:02:40
9 a.m. on the 15th. 10:02:47
10 Q. And the surgery was performed immediately prior? 10:02:48
11 A. Yes. 10:02:53
12 Q. And you said that what surgery was performed 10:02:54
13 there, you said it was a core vitrectomy? 10:03:01
14 A. It was a vitrectomy with endolaser and placement 10:03:01
15 of intraocular gas. 10:03:06
16 Q. Can you explain what that is? 10:03:08
17 A. Umm, sure. So instruments are placed into the 10:03:10
18 eye and the vitreous is removed. The -- let's see what 10:03:15
19 he did exactly. So he was able to drain fluid out from 10:03:24
20 underneath the retina through the -- he identified a 10:03:38
21 retinal tear or break. Drained fluid out through that. 10:03:41
22 Did laser around that break and then exchanged the air 10:03:45
23 for perfluoropropane gas, which the gas sort of acts 10:03:49
24 like a hand or a splint inside the eye, holding the 10:04:00
25 retina in place while the laser heals and the detachment 10:04:03

1 heals. 10:04:06
2 Q. Okay. This is the same day as the 10:04:06
3 second referral from Dr. Keel. Correct? 10:04:11
4 A. This was done on the night of March 14th. 10:04:13
5 Q. And would you consider this an emergency surgery? 10:04:16
6 A. Based on the -- yeah. Based on the fact that he 10:04:23
7 saw the patient and then took her immediately to the 10:04:28
8 operating room, yes. 10:04:31
9 Q. Why is it important that the retina is reattached 10:04:32
10 quickly after the detachment? 10:04:35
11 A. So we divide retinal detachments often into 10:04:37
12 whether the macula, the center part of the retina is 10:04:45
13 affected. So patients with macula-on detachments, those 10:04:48
14 are more urgent usually than patients with macula-off 10:04:52
15 detachments because you want to keep -- you want to 10:04:57
16 preserve the central vision and keep the macula from 10:05:01
17 detaching. So those patients are often treated, again, 10:05:04
18 more urgently. 10:05:04
19 Patients who have had recent macula-off 10:05:04
20 detachments are often treated the same way. Recent 10:05:14
21 being in, you know, number of days. Whereas if a 10:05:15
22 patient shows up and they've had a macula-off detachment 10:05:18
23 for a month, then it probably doesn't matter whether you 10:05:22
24 fix them that day or a week hence. 10:05:25
25 Q. Concerning Dr. Loo's care, is it possible that 10:05:27

1 the retina was not torn when he examined the patient? 10:05:32
2 A. So when I reviewed this case, I initially did not 10:05:43
3 have Dr. Keel's notes, and without Dr. Keel's notes, I 10:05:47
4 don't believe there's any malpractice and I don't 10:05:53
5 believe that -- and I believe the retina may not -- it 10:05:56
6 may not have been torn, but the fact is that that tear 10:06:00
7 was documented prior to seeing Dr. Loo. 10:06:03
8 Q. Is it possible that a tear could occur and then 10:06:07
9 result in a detachment the same day? 10:06:10
10 A. Yes. 10:06:13
11 Q. Do Dr. Loo's notes accurately reflect the exam he 10:06:17
12 performed in the letter to Dr. Keel? 10:06:24
13 A. I'm sorry. Can you refer me to which one? 10:06:26
14 Q. Certainly. It was page, I believe, 34 and 35. 10:06:28
15 And Page 76. Do you recall the billing codes that he 10:06:37
16 utilized? 10:06:40
17 A. Yes. 10:06:41
18 Q. Does this note accurately reflect the billing 10:06:41
19 codes -- 10:06:45
20 A. The thing that's missing is a diagram of the ora 10:06:46
21 serrata, which is generally indicative of performing 10:06:54
22 360 degrees of scleral depression. That's -- that's 10:06:59
23 missing from the fundus drawing. 10:07:05
24 Q. In your reasonable professional medical opinion 10:07:07
25 after reviewing all the facts in this case, the medical 10:07:11

1 records, and in your own experience, did Dr. Loo fail to 10:07:13
2 appropriately diagnose Patient A? 10:07:16
3 A. Yeah. She had a torn retina. Was sent to him. 10:07:19
4 He didn't see it. She developed a retinal detachment 10:07:23
5 and had to go through that. Yes. 10:07:26
6 Q. Lastly, do you opine that Dr. Loo committed 10:07:28
7 malpractice? 10:07:31
8 A. Based on what I just said, yes. 10:07:32
9 MR. CUMINGS: Thank you. I have no further 10:07:34
10 questions at this time. 10:07:36
11 HEARING OFFICER HALSTEAD: Thank you. Let's go 10:07:40
12 ahead and take a small break. How long would everyone 10:07:41
13 like to take? 10:07:45
14 MR. CUMINGS: Want to do 15 minutes? 10:07:46
15 HEARING OFFICER HALSTEAD: Ms. Hueth, are you 10:07:55
16 fine with that? 10:07:52
17 It's 10 after. Let's come back at 25 after. 10:07:56
18 Does that work for everyone? 10:07:59
19 MS. HUETH: Yes. 10:08:02
20 MR. CUMINGS: Yes. 10:08:03
21 HEARING OFFICER HALSTEAD: We'll be back at 10:08:04
22 10:25. 10:08:06
23 *** 10:08:07
24 (RECESS TAKEN FROM 10:08 A.M. TO 10:26 A.M.) 10:08:07
25 *** 10:26:11

1 HEARING OFFICER HALSTEAD: We're back on the 10:26:11
2 record. 10:26:13
3 Dr. Friedlander, I remind you that you remain 10:26:13
4 under oath. 10:26:17
5 Mr. Cumings, you'd completed your Direct. 10:26:17
6 Correct? 10:26:22
7 MR. CUMMINGS: Correct. 10:26:22
8 HEARING OFFICER HALSTEAD: Ms. Hueth, your turn 10:26:22
9 for cross-examination. 10:26:22
10 MS. HUETH: Thank you. 10:26:23
11 CROSS-EXAMINATION 10:26:23
12 BY MS. HUETH: 10:26:23
13 Q. Good morning, Dr. Friedlander. My name is 10:26:26
14 Chelsea and I'm Dr. Loo's attorney. 10:26:29
15 A. Morning. 10:26:33
16 Q. You and I have never met before. Correct? 10:26:34
17 A. Don't think so. 10:26:34
18 Q. Earlier you testified, did you not, that when you 10:26:36
19 first reviewed this case, you did not have Dr. Keel's 10:26:38
20 note. True? 10:26:42
21 A. That's correct. 10:26:42
22 Q. And when you first reviewed this case without 10:26:43
23 Dr. Keel's note, you felt that there was no malpractice. 10:26:46
24 Correct? 10:26:49
25 A. Correct. 10:26:49

1 Q. When you first reviewed this case, did you have 10:26:53
2 Dr. Loo's chart? 10:26:56
3 A. Can you be more specific? Are you referring to 10:26:59
4 the notes that we are looking at today? 10:27:06
5 Q. Dr. Loo's visit note as well as any other visit 10:27:08
6 notes from Dr. Loo's office. 10:27:12
7 A. I believe I did, yes. 10:27:15
8 Q. Okay. Including Dr. Pezda's note from March 14, 10:27:16
9 2018? 10:27:22
10 A. Yes. 10:27:22
11 Q. And even having Dr. Pezda's note, you still felt 10:27:22
12 there was no malpractice when you first reviewed the 10:27:27
13 case? 10:27:30
14 A. Correct. 10:27:30
15 Q. Do you consider yourself to be a retina 10:27:31
16 specialist? 10:27:37
17 A. Yes. 10:27:37
18 Q. Are you aware that Dr. Loo spent three years 10:27:38
19 completing his retina fellowship at the Bascom Palmer 10:27:45
20 Eye Institute? 10:27:50
21 A. I am. I have respect for Dr. Loo. Stipulate 10:27:51
22 Dr. Loo's an excellent doctor. 10:27:55
23 Q. The Bascom Palmer Eye Institute, does that have a 10:27:57
24 good reputation in the community? 10:28:04
25 A. It does. 10:28:05

1 Q. Doctor, would you agree that a posterior vitreous 10:28:09
2 detachment can be a risk factor for developing a retinal 10:28:13
3 tear? 10:28:18
4 A. Yes. 10:28:18
5 Q. Can you just briefly describe what a posterior 10:28:18
6 vitreous detachment is? 10:28:22
7 A. Sure. Although I think you did a pretty good job 10:28:25
8 of it before. 10:28:29
9 Q. Thank you. 10:28:30
10 A. Again, what I tell patients is that the eye is 10:28:30
11 filled with jelly called the vitreous; that the vitreous 10:28:34
12 when we're younger, is kind of gooey like egg white, and 10:28:38
13 that as we get older, it starts to liquefy. And that 10:28:42
14 once it sort of liquifies enough, it eventually 10:28:46
15 collapses on itself and separates from the retina where 10:28:49
16 it's loosely attached. And there's usually when this 10:28:52
17 happens a sudden onset of floaters and sometimes flashes 10:28:56
18 from the jelly essentially tickling the retina as it's 10:28:59
19 separating from it. That's essentially posterior 10:29:03
20 vitreous detachment. 10:29:05
21 Q. A patient can have a posterior vitreous 10:29:08
22 detachment without having a retinal tear. True? 10:29:13
23 A. Thankfully the vast majority of posterior 10:29:15
24 vitreous detachments are not related -- are not with a 10:29:17
25 retinal tear. 10:29:20

1 Q. Can you tell by examining a patient, if there is 10:29:21
2 a retinal tear present, how long it has been present? 10:29:28
3 A. There are certain things you can see that can 10:29:30
4 help ascertain that, but not -- you can't say that about 10:29:38
5 every retinal tear with certainty. 10:29:47
6 Q. Similarly, you can't tell, based upon an exam, 10:29:50
7 how long a retinal detachment has been present. True? 10:29:53
8 A. Again, there are signs of chronicity in the 10:29:57
9 retinal detachment sometimes. 10:30:02
10 Q. Not always? 10:30:04
11 A. Not always. 10:30:06
12 Q. You briefly discussed earlier that one possible 10:30:08
13 treatment for a retinal tear is laser. Is that right? 10:30:17
14 A. Yes. 10:30:20
15 Q. And is that -- you said laser or freeze. Are 10:30:20
16 they two different types of treatment? 10:30:25
17 A. Yes. You can do a laser treatment or, in some 10:30:27
18 cases, a freezing treatment. 10:30:30
19 Q. Are the laser and the freeze both done in the 10:30:32
20 office setting? 10:30:36
21 A. Usually, yes. 10:30:37
22 Q. But you would agree, would you not, that a laser 10:30:42
23 treatment of a retinal tear does not guarantee that the 10:30:44
24 patient won't go on to have a recurrent tear? 10:30:47
25 A. I'm sorry. When you say "a recurrent tear," are 10:30:50

1 you referring to the same tear? 10:30:57

2 Q. Or have another tear? 10:30:59

3 MR. CUMINGS: I'd object. Calls for speculation. 10:31:01

4 HEARING OFFICER HALSTEAD: Overruled. He's an 10:31:06

5 expert so he can testify as to whether -- 10:31:08

6 A. I'm sorry. Can you just please repeat the 10:31:13

7 question? 10:31:15

8 BY MS. HUETH: 10:31:15

9 Q. Sure. Would you agree that laser treatment does 10:31:16

10 not guarantee that the patient won't go on to develop 10:31:19

11 another retinal tear? 10:31:22

12 A. Yeah. I agree. That's true. 10:31:23

13 Q. Laser treatment of a retinal tear does not 10:31:25

14 guarantee that the patient will not go on to develop a 10:31:29

15 retinal detachment. True? 10:31:32

16 A. There's very few guarantees in medicine. That's 10:31:35

17 true. 10:31:39

18 Q. You've testified earlier -- but please, always 10:31:40

19 throughout correct me if I'm misquoting you or 10:31:46

20 misparaphrasing you -- that in your experience, there 10:31:49

21 are times where an optometrist thinks they found a 10:31:54

22 retinal tear that you can't find on exam. Correct? 10:31:58

23 A. True. 10:32:01

24 Q. Okay. If you can't see the retinal tear but the 10:32:02

25 optometrist says it's there, does that mean you've 10:32:09

1 missed it? 10:32:14

2 A. If I can't see the retinal tear that the 10:32:14

3 optometrist says was there, I've missed it. If there's 10:32:22

4 a retinal tear, I missed it. 10:32:26

5 Q. Okay. But you said that occasionally you'll try 10:32:29

6 and call the optometrist and say, "Did you see it or did 10:32:33

7 you just think you saw a retinal tear?" Correct? 10:32:37

8 A. Correct. 10:32:39

9 Q. What do you mean when you say you'd ask "Do you 10:32:40

10 just think you saw it?" 10:32:44

11 A. Well, optometrists want to get the patient seen 10:32:45

12 by the specialist and they are often concerned in this 10:32:49

13 setting where you've got a patient with risk factors for 10:32:56

14 developing a retinal tear that they may have a retinal 10:33:00

15 tear, and the referral sometimes comes, "Yes, they have 10:33:03

16 a retinal tear," and sometimes it comes "I'm highly 10:33:06

17 suspicious. Can you rule out a retinal tear?" 10:33:10

18 Q. Do those referrals sometimes come -- you know, 10:33:13

19 they're suspicious. They're trying to get the patient 10:33:17

20 seen by a retina specialist such as yourself and the 10:33:22

21 referral comes as "I see a tear," but you're not able to 10:33:26

22 see it, Dr. Friedlander? 10:33:31

23 A. That does happen. 10:33:33

24 Q. Is that malpractice on your part when you can't 10:33:35

25 see it? 10:33:39

1 A. Depends if there's a retinal tear there. 10:33:40
2 Q. If there is a tear there but you can't see it, is 10:33:43
3 that malpractice? 10:33:48
4 A. If it's -- can you rephrase the question for me? 10:33:48
5 Q. Sure. The optometrist sends you a patient that 10:33:55
6 they suspect of having a retinal tear. The optometrist 10:33:58
7 sees a retinal tear but you don't see it and it's there. 10:34:02
8 Have you committed malpractice? 10:34:06
9 A. I'm going to say it depends. 10:34:08
10 Q. Okay. So it's not your testimony here today that 10:34:19
11 missing a retinal tear is automatically malpractice. 10:34:23
12 True? 10:34:27
13 A. Missing a retinal tear is not automatically 10:34:27
14 malpractice. 10:34:33
15 Q. Are some retinal tears only able to be seen under 10:34:34
16 the microscope in an OR, for example? 10:34:48
17 A. Umm, yes. That's probably true, yes. 10:34:51
18 Q. For example, have you ever taken a patient who 10:35:01
19 you found a retinal tear, you take the patient to 10:35:05
20 surgery, and under the surgical microscope you found 10:35:07
21 more than the tear you saw in the clinic? More tears. 10:35:10
22 A. You're referring to a patient with a retinal 10:35:15
23 detachment at this point. Right? 10:35:18
24 Q. Sure. 10:35:20
25 A. So the question is: When you have a patient with 10:35:21

1 a retinal tear that you've identified and an associated 10:35:31
2 retinal detachment, do they have more tears that you 10:35:36
3 didn't see in the office that you now see under the 10:35:40
4 microscope? 10:35:42
5 Q. Correct. 10:35:43
6 A. Yes, that's true. That can happen. 10:35:44
7 Q. Because some retinal tears are only visible under 10:35:46
8 the surgical microscope? 10:35:50
9 A. Some retinal tears are identified in the 10:35:52
10 operating room that were not identified in the office, 10:35:56
11 yes. 10:35:59
12 Q. And that's not necessarily malpractice, is it? 10:36:00
13 A. In the setting you're describing, the retinal 10:36:06
14 detachment is being repaired, and the additional retinal 10:36:12
15 tears are being treated, so no. That's standard of 10:36:19
16 care. 10:36:24
17 Q. Can you briefly describe how scleral depression 10:36:24
18 is performed? 10:36:38
19 A. Umm, yes. You take a metal instrument which is 10:36:39
20 called a scleral depressor and you have the -- use an 10:36:45
21 indirect ophthalmoscope with a condensing lens to 10:36:50
22 examine the retina. And what you're looking at is the 10:36:56
23 anterior parts of the retina where often retinal tears 10:36:59
24 will occur. Umm, and you -- you apply a small amount of 10:37:05
25 pressure usually through the patient's eyelid to move 10:37:15

1 the anterior retina into the field of view through the 10:37:20
2 dilated pupil so that you can see it. 10:37:25
3 Q. And do you do that in just one position on the 10:37:28
4 eye, or do you move the depressor around the eye? 10:37:31
5 A. Yeah. So we generally talk about 360 degrees of 10:37:34
6 scleral depression, implying that we've looked all the 10:37:38
7 way around. 10:37:42
8 Q. You testified earlier that it's not surprising or 10:37:43
9 it's not uncommon that patients can find the scleral 10:37:46
10 depression uncomfortable? 10:37:51
11 A. It's uncomfortable. 10:37:53
12 Q. You would agree that the patient's ability to 10:37:54
13 tolerate the exam could impact what you're able to see 10:38:01
14 upon scleral depression. True? 10:38:07
15 A. True. 10:38:08
16 Q. Would you also agree that a patient with an 10:38:09
17 artificial lens, that that could potentially limit your 10:38:14
18 findings during a retina exam? 10:38:18
19 A. Yes. It can make it more difficult to see. 10:38:20
20 Q. And this patient had an artificial lens in the 10:38:23
21 left eye. Correct? 10:38:27
22 A. Yes. 10:38:28
23 Q. Earlier I think you testified that the exam is 10:38:29
24 sort of the gold standard or how a retinal tear is 10:38:31
25 diagnosed most often. Correct? 10:38:35

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1 A. I don't think I used those words. 10:38:37
2 Q. Oh, no. I'm paraphrasing. I'm not trying to 10:38:42
3 represent those are exactly your words. 10:38:45
4 A. Okay. Umm, yes, retinal tears are found these 10:38:48
5 days either by direct visualization or often they'll be 10:38:55
6 seen on wide-field fundus imaging. 10:39:00
7 Q. And that wide-field fundus imaging, do you have 10:39:02
8 any evidence before you that in March 2018 the Center 10:39:06
9 for Sight had the wide-field fundus imaging 10:39:11
10 capabilities? 10:39:14
11 A. No. I didn't see that in the record. 10:39:15
12 Q. Did you see anything in the record to indicate 10:39:19
13 that in March of 2018 that Dr. Loo had wide-field fundus 10:39:21
14 imaging to him at his office? 10:39:27
15 A. It's not mentioned. 10:39:28
16 Q. Okay. And if Dr. Loo testified that he did not 10:39:29
17 have that wide-field fundus imaging camera in March of 10:39:37
18 2018, you would no reason to disagree with that, would 10:39:41
19 you? 10:39:44
20 A. No. 10:39:44
21 Q. Would you agree that a physician, a retina 10:39:44
22 specialist such as yourself and Dr. Loo, can't offer a 10:39:48
23 laser treatment of a retinal tear if you don't actually 10:39:52
24 see the retinal tear? 10:39:57
25 A. Correct. 10:39:59

1 Q. You can't offer treatment for a retinal tear 10:39:59
2 based solely on what an optometrist thinks they saw, can 10:40:02
3 you? 10:40:06
4 A. You have to be able to see the tear to treat the 10:40:07
5 tear. 10:40:09
6 Q. Umm, do you have from the Investigative 10:40:10
7 Committee's exhibits Exhibit 5 we've been discussing, 10:40:20
8 which are the records from Center for Sight? 10:40:23
9 A. Okay. 10:40:29
10 Q. Can you please turn to Bates stamped Page 115? 10:40:30
11 A. Okay. 10:40:35
12 Q. The last sentence on this page starts with "OD 10:40:44
13 vision," and that's the right eye. Right? 10:40:47
14 A. Yes. 10:40:50
15 Q. Okay. "OD vision is clear and is seeing a 10:40:50
16 flutter" -- going on to the next page in the upper right 10:40:55
17 corner -- "that is constantly there." 10:40:58
18 Do you see that? 10:41:03
19 A. Yes. 10:41:03
20 Q. Okay. That's referring to the right eye. True? 10:41:04
21 A. Umm, yeah. It appears to be referring to the 10:41:07
22 right eye. 10:41:14
23 Q. So now we're on Bates stamp page NSBME 0116. Are 10:41:15
24 you on that page, Doctor? 10:41:22
25 A. Yes. 10:41:24

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1 Q. Thank you. Under ocular medications it says, 10:41:25
2 "Finished Pred-Moxi-Ketor OD QD." 10:41:28
3 And first of all, what is Pred-Moxi-Ketor? 10:41:37
4 A. Umm, I believe what they are talking about is -- 10:41:37
5 this sounds like a combination -- this is either three 10:41:47
6 different eye drops or a combination eye drop, which is 10:41:50
7 a steroid, an antibiotic, and a nonsteroidal. 10:41:56
8 Q. And OD being the right eye? 10:42:02
9 A. Correct. 10:42:04
10 Q. QD meaning what? 10:42:05
11 A. Once a day. 10:42:07
12 Q. And then in parentheses it says "now using 10:42:08
13 Pred/Ketor." Did I read that correctly? 10:42:14
14 A. Yes. 10:42:15
15 Q. Why was the patient using that in her right eye 10:42:16
16 as of March 13, 2018? 10:42:18
17 A. Well, this is likely that she had some type of 10:42:22
18 procedure in that eye at some point previous to that, 10:42:32
19 but I would have to take a closer look. So it's not 10:42:37
20 clear to me why the patient was on those drops. 10:43:38
21 Q. Based upon your review of the Center for Sight 10:43:41
22 records that are contained within the Investigative 10:43:45
23 Committee's Exhibit 5, did you see any visit notes prior 10:43:50
24 to March 13, 2018? 10:43:53
25 A. Umm, the only notes were the previous notations 10:43:55

1 regarding tonometry and dilation and previous visual 10:44:07
2 acuities where they list the past findings. 10:44:13
3 Q. Those appear to be kind of autopopulated on 10:44:17
4 subsequent visit notes and that's how they appear? 10:44:21
5 A. Probably so, yes. 10:44:21
6 Q. Okay. But you didn't see -- for example, under 10:44:22
7 "Visual Acuity" Entry 12 and 13 from June 6, 2016, you 10:44:24
8 don't recall seeing a visit note for that date, did you? 10:44:31
9 A. No. No. No. 10:44:33
10 Q. Are you still on that Page NSBME 0116? 10:44:35
11 A. Yes. 10:44:45
12 Q. Okay. And so I just used an example of that 10:44:46
13 June 6, 2016 that's entered Lines 12 and 13. Then the 10:44:51
14 next entry is March 13, 2018. Do you see that? 10:44:56
15 A. Yes. 10:45:01
16 Q. Do we have any information as to whether the 10:45:01
17 patient had any ophthalmic exams in the almost two years 10:45:06
18 from June 6, 2016 to March of 2018? 10:45:12
19 A. No. I don't believe so. 10:45:14
20 Q. In other words, what I said was correct? 10:45:36
21 A. Yes. 10:45:39
22 Q. If you can turn in the next page, 117, do you see 10:45:39
23 the IOP, or the intraocular pressure measurements? 10:46:08
24 A. Yes. 10:46:13
25 Q. Prior to March 13, 2018, when was the last 10:46:13

1 time -- according to this note -- that the patient's 10:46:17
2 intraocular pressure was measured? 10:46:20
3 A. June 6th, 2016. 10:46:23
4 Q. And do you see Line Entry No. 10 pertaining to 10:46:26
5 March 13, 2018, the intraocular pressure? 10:46:43
6 A. Yes. 10:46:45
7 Q. And what time is that recorded as having been 10:46:45
8 taken? 10:46:48
9 A. The last one at 2:31 p.m. 10:46:49
10 Q. At least according to this note -- let me take a 10:46:56
11 step back. I apologize. I got ahead of myself. 10:47:00
12 If you turn back to Page 115 -- and let me know 10:47:03
13 when you're there. 10:47:15
14 A. Yes. 10:47:16
15 Q. The exam date is March 13, 2018. Correct? 10:47:16
16 A. Yes. You're looking at the date on the OCT? 10:47:21
17 Q. Yeah. 10:47:27
18 A. Okay. 10:47:28
19 Q. Okay. And it start -- at the top it says Page 4 10:47:29
20 of 8 and then it goes on to Page 5 of 8 and then the 10:47:32
21 page we were just discussing is Page 6 of 8. 10:47:36
22 A. Okay. 10:47:39
23 Q. You understand this all refers to the March 13, 10:47:39
24 2018 visit at the Center for Sight? 10:47:43
25 A. Yes. 10:47:45

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1 Q. Okay. So we know that at least as of 2:31 p.m. 10:47:46
2 the patient was still at the Center for Sight. True? 10:47:52
3 A. According to their notes, yes. 10:47:55
4 Q. And if you turn to Page 119, the note was signed 10:47:58
5 by Danielle Keel. Do you see that? 10:48:08
6 A. Yes. 10:48:11
7 Q. And is Danielle Keel, is she an optometrist or an 10:48:14
8 ophthalmologist? 10:48:19
9 A. She's an optometrist. 10:48:20
10 Q. And how do you know that? 10:48:22
11 A. How do I know that? Umm, she uses the 10:48:24
12 designation "OD" -- or Dr. Loo uses the designation OD 10:49:25
13 when he's writing the letter to her on Page 71. 10:49:31
14 Q. Umm, if you can turn back to Page NSBME 118 and 10:49:36
15 let me know when you're there. 10:49:42
16 A. Okay. Yep. 10:49:43
17 Q. Dr. Keel does not document a posterior vitreous 10:49:50
18 detachment on March 13, 2018. True? 10:49:54
19 A. She does not. 10:49:57
20 Q. And what are Shafer's sign or Shafer cells? 10:50:10
21 HEARING OFFICER HALSTEAD: I'm sorry to 10:50:19
22 interrupt. Can you go back to that question just for 10:50:21
23 purposes of my notes? I know I'll get the transcript, 10:50:23
24 but you said she doesn't note a what? 10:50:28
25 MS. HUETH: Posterior vitreous detachment. 10:50:30

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1 HEARING OFFICER HALSTEAD: And refer to the 10:50:35
2 exhibit again, please. 10:50:37
3 MS. HUETH: The Investigative Committee's 10:50:38
4 Exhibit 5 Bates stamped Page NSBME 0118. 10:50:42
5 HEARING OFFICER HALSTEAD: Sorry to interrupt. 10:50:47
6 Thank you. 10:50:48
7 A. Shafer's sign is pigment in -- usually seen in 10:50:48
8 the anterior vitreous and is often associated with a 10:50:54
9 retinal tear. 10:51:02
10 BY MS. HUETH: 10:51:03
11 Q. And Shafer's sign -- let me take a step back. 10:51:03
12 Can manipulation of the iris during a lensectomy 10:51:09
13 and intraocular lens placement release pigmented cells 10:51:13
14 into the vitreous? 10:51:18
15 A. Yes. 10:51:20
16 Q. And having not seen any records prior to 10:51:21
17 March 13, 2018, you can't say whether this plus Shafer's 10:51:25
18 is a new finding, can you? 10:51:30
19 A. I cannot. 10:51:32
20 Q. Would you agree that you can't tell from 10:51:33
21 Dr. Keel's note when it was transcribed? 10:51:41
22 A. My -- if I look at Page 112 and 113, there's some 10:52:15
23 numbers that are cut off on the bottom of the page. I 10:52:21
24 don't know if that has any relevance or not. But to 10:52:24
25 your question, the fact that I can't see it, no, I 10:52:27

1 cannot tell you when it was transcribed. 10:52:30
2 Q. It's cut off on mine too. 10:52:32
3 A. Okay. 10:52:34
4 Q. But at least from what we can see for the 10:52:35
5 March 13, 2018 visit, you can't tell when this note was 10:52:40
6 ultimately transcribed, can you? 10:52:43
7 A. No. 10:52:45
8 Q. You can't tell from this note when Dr. Keel 10:52:51
9 signed it, can you? 10:52:55
10 A. No. Also, I'm not sure what you mean by the word 10:52:56
11 "transcribed." This is a -- this is a printout of an 10:53:12
12 electronic medical record. 10:53:16
13 Q. You don't know in this note from March 13, 2018 10:53:18
14 when the note was typed? 10:53:21
15 A. I -- I don't know -- no. I don't know. But... 10:53:22
16 Q. You don't know when Dr. Keel signed this note, do 10:53:32
17 you? 10:53:35
18 A. No, I don't. 10:53:35
19 Q. Did you see anywhere in Dr. Keel's March 13, 2018 10:53:36
20 note where she documents calling Dr. Loo's office to 10:53:40
21 refer the patient? 10:53:44
22 A. No. I don't believe that there's an entry like 10:53:45
23 that. 10:54:01
24 Q. In your review of Investigative Committee 10:54:01
25 Exhibit 5, the records from Center for Sight, there was 10:54:08

1 not a written referral that was sent to Dr. Loo's 10:54:11
2 office, as far as we can tell. True? 10:54:14
3 A. That's correct. 10:54:16
4 Q. But you also agree there's no indication in the 10:54:17
5 record that a copy of Dr. Keel's note was sent to 10:54:26
6 Dr. Loo's office on March 13, 2018? 10:54:29
7 A. Sorry. Can you just repeat that a second? 10:54:32
8 Q. Of course. You can't tell from Exhibit 5 or you 10:54:45
9 would agree that based upon what's contained within 10:54:50
10 Exhibit 5, there's no indication that Dr. Keel's 10:54:54
11 March 13, 2018 note was sent to Dr. Loo's office? 10:54:57
12 A. Umm, no. I'll agree with you. I can't tell. 10:55:04
13 Q. Okay. And nowhere in Exhibit 5 does it reflect 10:55:13
14 if anybody from the Center for Sight called Dr. Loo's 10:55:19
15 office to refer the patient on March 13, 2018, does it? 10:55:22
16 A. No. 10:55:27
17 Q. If I want you to assume -- 10:55:33
18 A. It says the patient was referred. 10:55:36
19 Q. That wasn't my question though. My question was: 10:55:38
20 Is there anything in Exhibit 5 to reflect that anybody 10:55:41
21 from Center for Sight called Dr. Loo's office? 10:55:44
22 A. No. 10:55:47
23 Q. Assume hypothetically, please, Doctor, that 10:55:47
24 Dr. Loo will testify that his office staff was trained 10:55:54
25 to request that a referring provider send a copy of 10:55:57

1 their note and/or a written referral. You would have no 10:55:59
2 reason to disagree with that, would you? 10:56:03
3 A. No. 10:56:06
4 Q. If we assume that somebody from the Center for 10:56:06
5 Sight called Dr. Loo's office on March 13, 2018, you 10:56:12
6 would agree that we don't know what that person would 10:56:16
7 have conveyed to the other person at Dr. Loo's office. 10:56:18
8 True? 10:56:21
9 A. I -- I -- you're -- 10:56:22
10 MR. CUMINGS: Calls for speculation. I mean, 10:56:28
11 this is outside the realm of what's in the medical 10:56:31
12 records. 10:56:35
13 MS. HUETH: Exactly. 10:56:36
14 BY MS. HUETH: 10:56:36
15 Q. That's my question, Doctor. 10:56:37
16 MR. CUMINGS: That's speculation. Let her rule 10:56:38
17 on the objection first, please. 10:56:40
18 HEARING OFFICER HALSTEAD: So the question is you 10:56:42
19 would have no way of knowing what was said in the 10:56:46
20 referral call. Is that the gist of the question? 10:56:49
21 MS. HUETH: Yeah. If we assume a call was made. 10:56:51
22 HEARING OFFICER HALSTEAD: I don't know. He's 10:56:54
23 not speculating. He would just say whether or not he 10:56:56
24 could tell from the records what was said in the 10:56:59
25 referral call, so he can either tell from the records or 10:57:03

1 he can't. 10:57:09

2 MR. CUMINGS: If I may, she's asking if there was 10:57:10

3 a referral call made speculatively, could you then 10:57:15

4 speculate what was said in that speculative phone call 10:57:16

5 that she is saying didn't -- 10:57:20

6 HEARING OFFICER HALSTEAD: Here's the bottom 10:57:20

7 line. We all know the answer. It's sort of a 10:57:21

8 rhetorical question. He wasn't there for the call. He 10:57:24

9 wouldn't have any personal knowledge of it. If it's not 10:57:29

10 noted in the records, that's another question that 10:57:32

11 you've already asked. With that, I hope that can keep 10:57:35

12 everyone on a track past this question. 10:57:38

13 MR. CUMINGS: So sustained? 10:57:42

14 HEARING OFFICER HALSTEAD: I don't know that it's 10:57:44

15 an unfair question. I just think that it's sort of a 10:57:46

16 rhetorical question. So, I mean, he -- she's allowed to 10:57:50

17 present a hypothetical. So if they made the call, he 10:57:54

18 can't tell from the records what would have been in the 10:57:57

19 call. 10:58:01

20 Is that accurate, Ms. Hueth? 10:58:01

21 MS. HUETH: Yes. 10:58:04

22 HEARING OFFICER HALSTEAD: Thank you. You can go 10:58:05

23 ahead. 10:58:06

24 A. Okay. Well, if they made a call, they would have 10:58:06

25 said, "I'm sending this patient over with a retinal 10:58:09

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1 tear. Can you please see them now?" 10:58:12
2 BY MS. HUETH: 10:58:14
3 Q. What do you base that on? 10:58:15
4 A. The -- the notes on Page 118. "Refer to retina 10:58:16
5 for evaluation and treatment. Will refer to RCN ASAP." 10:58:22
6 So in your hypothetical, that's what they would have 10:58:29
7 said. 10:58:32
8 Q. But you don't know one way or the other if that 10:58:32
9 was -- No. 1, if a call was actually made? 10:58:35
10 MR. CUMINGS: Objection. Asked and answered. 10:58:36
11 She's already asked this question and he's already 10:58:38
12 answered. 10:58:41
13 HEARING OFFICER HALSTEAD: She's summarizing. 10:58:42
14 Go ahead, Ms. Hueth. 10:58:44
15 BY MS. HUETH: 10:58:46
16 Q. Doctor, you do not know whether a call was made 10:58:46
17 or not? 10:58:48
18 A. I do not know. 10:58:49
19 Q. If a call was made, you don't know what was 10:58:50
20 conveyed to Dr. Loo's office, do you? 10:58:53
21 A. I don't. I'm not clairvoyant. 10:58:55
22 Q. At this March 13, 2018 visit that we've been 10:58:58
23 discussing on Page 116 -- sorry. Let me take a step 10:59:13
24 back. I apologize. 10:59:41
25 It starts at the bottom of Page 115. And you see 10:59:42

1 the heading where it says "CC/HPI"? 10:59:47
2 A. Yes. 10:59:52
3 Q. What does that stand for? 10:59:53
4 A. Chief complaint and history of present illness. 10:59:54
5 Q. Earlier you testified -- please correct me if I'm 10:59:59
6 wrong -- that the chief complaint is another way of 11:00:06
7 saying the reason for the visit, the reason why the 11:00:08
8 patient's there? 11:00:11
9 A. I don't recall saying that, but that's correct. 11:00:12
10 Q. Okay. 11:00:18
11 A. It's true. It's a fact. That's why the 11:00:19
12 patient's there. 11:00:22
13 Q. If you can turn to the Investigative Committee's 11:00:23
14 Exhibit 4, specifically Page NSBME 0035 and let me know 11:00:30
15 when you're there. 11:00:39
16 A. Okay. 11:00:43
17 Q. And do you see at the third line from the top the 11:00:44
18 line that starts with "Chief Complaint"? 11:00:52
19 A. Yes. 11:00:54
20 Q. Okay. So that's the reason why the patient 11:00:56
21 reports she's there. Correct? 11:00:59
22 A. Yes. 11:01:01
23 Q. Do you see any reference in the page that the 11:01:02
24 patient reported the flutter in the upper right corner 11:01:12
25 of her right eye? 11:01:15

1 A. No. 11:01:17

2 Q. Do you see any indication from either Page 35 or 11:01:24

3 34 that the patient reported headaches? 11:01:28

4 A. No. 11:01:30

5 Q. On Page 34, you'd agree that it indicates that 11:01:51

6 Dr. Loo or someone from his office dilated the patient's 11:02:01

7 eyes. Correct? 11:02:05

8 A. Yes. 11:02:06

9 Q. And next to the intraocular pressure it says "OS 11:02:06

10 21" and then next to it do you see that little @ symbol? 11:02:16

11 A. Yes. 11:02:22

12 Q. If I represented to you that that says "at 3:53," 11:02:22

13 and it represents that that's when the patient was 11:02:26

14 administered dilation drops, would you have any reason 11:02:29

15 to dispute that? 11:02:33

16 A. I think that means that's when the intraocular 11:02:34

17 pressure was taken. 11:02:37

18 Q. Okay. Thank you. 11:02:38

19 In your experience, is the intraocular pressure 11:02:40

20 taken typically before the patient's eyes are dilated? 11:02:44

21 A. Typically, yes. 11:02:50

22 Q. So in this situation we know intraocular pressure 11:02:55

23 is taken at 3:53. And if Dr. Loo testified that the 11:03:05

24 intraocular pressure is typically measured before 11:03:12

25 dilating the eyes, you would have no reason to disagree 11:03:16

1 with that, would you? 11:03:19

2 A. No. 11:03:20

3 Q. The note reflects that Dr. Loo performed a 11:03:20

4 dilated exam. Correct? 11:03:24

5 A. Yes. 11:03:26

6 Q. He also obtained optical coherence tomography or 11:03:26

7 OCT. Correct? 11:03:34

8 A. Yes. 11:03:35

9 Q. And that was reasonable for him? 11:03:36

10 A. Yes. 11:03:38

11 Q. Dr. Loo also obtained B-scan ultrasound. 11:03:39

12 Correct? 11:03:48

13 A. Yes. 11:03:48

14 Q. Was that reasonable? 11:03:49

15 A. I think in the setting it was, given that the 11:03:51

16 examination was difficult and he was trying to make sure 11:03:56

17 that he did as much -- a complete exam as he could. 11:04:00

18 Q. I want you to assume for purposes of this 11:04:05

19 question, Doctor, that Dr. Loo obtained the B-scan 11:04:08

20 ultrasound after the patient's IOP was measured, after 11:04:14

21 she was given dilating drops, after his exam. That's 11:04:19

22 when he obtained the ultrasound. Okay? Do you have 11:04:23

23 that hypothetical in mind? 11:04:26

24 A. That makes sense. 11:04:28

25 Q. Okay. And we know the IOP was checked at 3:53. 11:04:29

1 So if I represented to you that by the time Dr. Loo is 11:04:36
2 getting the B-scan ultrasound, it's now 5 o'clock, if 11:04:39
3 not later, would you have any reason to dispute that? 11:04:43
4 A. I -- I don't know how busy Dr. Loo was in the 11:04:47
5 clinic, how many other patients he had, but it's not 11:04:55
6 without -- it's within reason, yes. 11:04:59
7 Q. Do you have knowledge of in March of 2018 at what 11:05:01
8 time the Center for Sight office closed? 11:05:11
9 A. I do not. 11:05:15
10 Q. And do you know whether or not Dr. Loo had the 11:05:20
11 optometrist, Dr. Keel's, telephone number? 11:05:24
12 A. I do not. 11:05:28
13 Q. Umm, earlier you testified that not all missed 11:05:29
14 retinal tears are malpractice. Right? 11:05:35
15 A. That's my belief, yes. 11:05:38
16 Q. What's an example of a missed retinal tear that 11:05:41
17 would not constitute malpractice? 11:05:44
18 A. Umm, well, I think one that you're going to find 11:05:47
19 later on examination. So you have a difficult exam. 11:05:53
20 You're not -- you're not sure. You know, you were told 11:05:58
21 something's there. You don't see it. Bring the patient 11:06:03
22 back again on another day when she's not so tired and 11:06:06
23 take another look. 11:06:10
24 Q. Have the patient come back the next day. Try and 11:06:11
25 examine her -- 11:06:15

1 A. It might not -- it may be not the next day, but 11:06:16
2 sometime in the near future. 11:06:19
3 Q. "Near future" meaning what? 11:06:21
4 A. Well, as I said before, patients in this 11:06:23
5 situation we would see back in two to four weeks. 11:06:27
6 Q. And if the patient comes back in two to four 11:06:31
7 weeks, now you see a retinal tear, that doesn't 11:06:33
8 necessarily mean you missed it at the prior visit, does 11:06:37
9 it? 11:06:40
10 A. It doesn't mean you missed it at the prior visit, 11:06:40
11 no. It could have -- it could have happened in that 11:06:44
12 interval. 11:06:46
13 Q. Or if it was present on the prior visit, that 11:06:47
14 doesn't necessarily mean malpractice because you didn't 11:06:51
15 see it? 11:06:54
16 A. Correct. 11:06:55
17 Q. In this case, if Dr. Loo had instructed the 11:06:55
18 patient to come back in two to four weeks, potentially 11:07:03
19 the patient would have gone a week and a half to three 11:07:08
20 weeks with a retinal detachment? 11:07:12
21 A. I don't think that would have happened, umm, 11:07:18
22 because the patient lost vision the next day and 11:07:23
23 re-presented with significant loss of vision. 11:07:27
24 Q. Do you have in front of you NSBME 34? 11:07:29
25 A. Yes. 11:07:44

1 Q. Okay. And do you see sort of the bottom of the 11:07:44
2 page on the right there is -- says "Report" and then 11:07:47
3 there's a colon? 11:07:57
4 A. I'm sorry? Where are you referring? 11:07:58
5 Q. On NSBME 0034, the bottom of the page. It's the 11:08:15
6 second line under like the last underline, and it says 11:08:23
7 "Report"? 11:08:27
8 A. Oh. Uh-huh. 11:08:28
9 Q. And then if you go over, do you see "loss of 11:08:31
10 vision" is circled? 11:08:36
11 A. Yes. 11:08:37
12 Q. Do you have an understanding as to what that, in 11:08:38
13 the note, is indicating? 11:08:41
14 A. The patient is to report loss of vision. 11:08:44
15 Q. And if Dr. Loo testified that he told the patient 11:08:46
16 that if her vision worsened in any way, to come back to 11:08:51
17 his office, you wouldn't have any reason to disagree 11:08:56
18 with that, would you? 11:09:00
19 A. No. I'm sure he did that. 11:09:01
20 Q. I want to just make sure I'm understanding your 11:09:03
21 testimony. In that situation hypothetically that we 11:09:05
22 were describing, you see a patient. You can't find a 11:09:08
23 tear. Optometrist thought they saw one. You can't find 11:09:11
24 it, so you tell the patient to come back in two weeks, 11:09:14
25 for example. 11:09:18

1 A. Uh-huh. 11:09:18
2 Q. So the patient comes back in two weeks. Now you 11:09:19
3 find the tear. If we assume the tear was there when you 11:09:21
4 first saw the patient, that's not malpractice, is it? 11:09:26
5 A. That's not malpractice. 11:09:30
6 Q. Can you turn to Exhibit 5 of the Investigative 11:09:32
7 Committee's exhibits, specifically NSBME 107? 11:09:38
8 A. Okay. 11:09:43
9 Q. Do you have an understanding that this is the 11:09:50
10 visit note from March 14, 2018? 11:09:56
11 A. Yes. 11:09:58
12 Q. When the patient returned to the Center for Sight 11:10:00
13 on March 14, 2018, what provider examined her? 11:10:05
14 A. That's a good question. 11:10:08
15 Q. Thank you. 11:10:41
16 A. Someone with a star-shaped signature. 11:10:41
17 Q. Umm, are you still on Page 107? 11:10:45
18 A. I'm looking at the signature on Page 111. 11:10:49
19 Q. Oh. Okay. If you can, when you're done looking 11:10:54
20 at the signature, turn back to Page 107 and let me know 11:11:04
21 when you're there. 11:11:08
22 A. Okay. So possibly someone with the initials KJH 11:11:09
23 was the -- 11:11:32
24 Q. What are you looking at to say that? 11:11:33
25 A. Page 108 where it says in the middle of the page 11:11:35

1 "Medical history reviewed with no significant changes" 11:11:37
2 on 3/14. 11:11:42
3 Q. Okay. If you turn to Page 109 and look at the 11:11:43
4 dilation under entry 5 and do you see the tech column? 11:11:46
5 A. That's a tech. Yeah, that's a tech. You're 11:11:55
6 right. That's a tech. Yep. 11:11:57
7 No. I don't know is the answer to your question. 11:12:15
8 Q. Thank you. 11:12:16
9 Can you turn back to Page 107 and let me know 11:12:17
10 when you're there? 11:12:20
11 A. Okay. 11:12:21
12 Q. And under the chief complaint says "46-year-old 11:12:22
13 female patient here for established patient urgent 11:12:27
14 visit. Patient was seen yesterday and was sent to RCN 11:12:30
15 for a horseshoe tear in the OS towards the nose." 11:12:34
16 Did I read that correctly? 11:12:40
17 A. Yes. 11:12:42
18 Q. And when Dr. Keel documented that she thought she 11:12:42
19 saw a horseshoe tear the day before, did she describe it 11:12:48
20 as being towards the nose? 11:12:52
21 A. No. 11:12:54
22 Q. Towards the nose, is that sometimes referred to 11:12:55
23 as superonasal? 11:12:57
24 A. Towards the nose would just be nasal. 11:13:01
25 Q. Okay. And when Dr. Keel documented that she 11:13:05

1 thought she saw a horseshoe tear, she said it was 11:13:08

2 superotemporal. Correct? 11:13:13

3 A. Correct. 11:13:15

4 Q. Away from the nose? 11:13:16

5 A. Yes. 11:13:17

6 Q. If you could turn to the next page, please, 108. 11:13:17

7 A. Okay. 11:13:32

8 Q. Okay. The first full sentence on this page, 11:13:33

9 "Denies any headaches and the vision in the OD is fine. 11:13:44

10 Closing the eye and sees white. Still getting the 11:13:48

11 headaches since these episodes." 11:13:53

12 Did I read that correctly? 11:13:55

13 A. Yeah. 11:13:56

14 Q. Does that appear, at least on its face, 11:13:57

15 inconsistent to you as to whether or not she's having 11:14:00

16 headaches? 11:14:03

17 A. Yes. 11:14:03

18 Q. Under the Visual Acuity chart that's on the same 11:14:05

19 page, there is a column and the heading is "Int w/o RX." 11:14:13

20 Do you see that? 11:14:20

21 A. Yes. 11:14:21

22 Q. Does that refer to intermediate without RX? 11:14:22

23 A. I believe so. 11:14:26

24 Q. All right. And according to the visual acuity in 11:14:28

25 the left eye for the intermediate without RX on 11:14:36

1 March 14, 2018 was 20/20? 11:14:41
2 A. That's what it says. 11:14:43
3 Q. The note to the right of that states "Needs to 11:14:45
4 look around the black spot to see the letters down and 11:14:49
5 to the out." 11:14:53
6 Did I read that correctly? 11:14:53
7 A. Yes. 11:14:55
8 Q. And was that a change from the day before? 11:14:55
9 A. Umm, that notation was not there on the day 11:14:57
10 before. 11:15:04
11 Q. And you didn't see where the patient reported a 11:15:04
12 black spot that she needed to look at the letters "down 11:15:08
13 and to the out"? 11:15:12
14 A. On the 13th, no. 11:15:12
15 Q. If you could turn to the next page, please, 109. 11:15:15
16 A. Okay. 11:15:26
17 Q. What time, according to the note, was the 11:15:35
18 intraocular pressure measured on March 14th? 11:15:38
19 A. 4:25. 11:15:41
20 Q. So at least that gives us a time frame that she 11:15:42
21 presented to the Center for Sight around 4:25 on the 11:16:04
22 14th. Would you agree with that? 11:16:08
23 A. I'm not sure what time she presented. Her eye 11:16:10
24 pressure was measured at that time, according to the 11:16:13
25 note. 11:16:16

1 Q. Okay. Well, if we go back a couple pages, we see 11:16:16
2 the OCT exam time is 4:31? 11:16:21
3 A. Okay. 11:16:29
4 Q. So is the distinction that you're drawing is 11:16:30
5 you're saying we don't know when she first got to the 11:16:33
6 Center for Sight on the 14th? 11:16:38
7 A. I'm not saying anything like that. 11:16:39
8 Q. When you say we don't know -- 11:16:41
9 A. You asked me -- you asked me what time she got 11:16:44
10 there. I don't know what time she got there. 11:16:46
11 Q. Okay. Well, we do know that this OCT was done at 11:16:49
12 4:31 and that the intraocular pressure was measured at 11:16:52
13 4:25. Correct? 11:16:56
14 A. According to the record, yes. 11:16:57
15 Q. If you could turn to the next page, Page 110, 11:17:01
16 please? 11:17:11
17 A. Okay. 11:17:12
18 Q. Do you see the chart for the fundus exam? 11:17:12
19 A. Yes. 11:17:15
20 Q. And under the right eye, the first entry, what 11:17:15
21 does it say? 11:17:19
22 A. The view "not examined." 11:17:20
23 Q. Okay. Do you have an understanding one way or 11:17:28
24 the other if it was just the view that was not examined 11:17:35
25 in the right eye or if none of these entries for the 11:17:38

1 fundus exam for the right eye were done that day? 11:17:42
2 A. So on Page 109, under dilation on the 14th it 11:17:46
3 indicates that just the left eye was dilated, so I 11:18:02
4 don't -- I believe they wrote "not examined," and then 11:18:09
5 the rest of their exam was autopopulated as, 11:18:14
6 unfortunately, many electronic medical records do. 11:18:19
7 Q. At the time that the provider assessed the 11:18:24
8 patient on the 14th, it's noted there was a "superior 11:18:34
9 RD" -- that means retinal detachment? 11:18:38
10 A. Yes. 11:18:42
11 Q. -- "with horseshoe tear. Macula appears to be 11:18:43
12 on." 11:18:48
13 Did I read that correctly? 11:18:49
14 A. Yes. 11:18:50
15 Q. Would you agree that in this note there's no 11:18:50
16 reference to hemorrhage? 11:18:53
17 A. There's no reference to hemorrhage. 11:18:55
18 Q. No reference to a posterior vitreous detachment. 11:18:57
19 True? 11:19:03
20 A. True. 11:19:04
21 Q. And then turning to the next page, 111 -- 11:19:04
22 A. Okay. 11:19:09
23 Q. -- and under No. 7, the retinal detachment, it 11:19:09
24 says, "I called and spoke to Dr. Hollifield and 11:19:13
25 explained the situation. Appears to be a macula-on RD." 11:19:17

1 Did I read that correctly? 11:19:24
2 A. Yes. 11:19:25
3 Q. If I represented to you that Dr. Hollifield is in 11:19:26
4 the same group as Dr. Loo, would you have any reason to 11:19:29
5 dispute that? 11:19:32
6 A. No. 11:19:33
7 Q. Do you know Dr. Hollifield? 11:19:34
8 A. Yes. 11:19:37
9 Q. There is no note like this -- we went through 11:19:38
10 that -- from the day before indicating "I called and 11:19:41
11 spoke with someone and explained the situation." We 11:19:46
12 didn't see that on the visit the day before, did we? 11:19:49
13 A. Correct. 11:19:53
14 Q. Doctor, if you can turn to the Investigative 11:19:56
15 Committee's Exhibit 4, Bates stamped Page 33 and let me 11:20:02
16 know when you're there. 11:20:07
17 A. Okay. 11:20:09
18 Q. And you'd agree this is the patient's visit note 11:20:10
19 from March 14th, 2018. True? 11:20:19
20 A. Yes. 11:20:21
21 Q. Okay. And the chief complaint, "Patient refers 11:20:23
22 that this morning the vision in OS was totally black. 11:20:28
23 The black spot is getting bigger." 11:20:32
24 Do you see that? 11:20:34
25 A. Yes. 11:20:35

1 Q. That's a change from the day before. True? 11:20:36
2 A. Yes. 11:20:40
3 Q. And on Page NSBME 0032 -- do you have that in 11:20:41
4 front of you, Doctor? 11:21:04
5 A. Okay. 11:21:05
6 Q. Next to the intraocular measurements, do you see 11:21:05
7 another "@" and then it says 6:37? 11:21:14
8 A. The pressure measurements, yes. 11:21:22
9 Q. Like we talked about earlier, that would indicate 11:21:24
10 when the pressure measurements were taken? 11:21:27
11 A. Correct. 11:21:30
12 Q. So this is about -- I'm sorry. Did I interrupt 11:21:34
13 you? 11:21:38
14 A. (Moved head.) 11:21:38
15 Q. This was about two hours after the measurement 11:21:39
16 taken at the Center for Sight. True? 11:21:42
17 A. I'm sorry. What time was the Center for Sight 11:21:45
18 again? 11:21:50
19 Q. 4:35. 11:21:50
20 A. That would be about two hours, yes. 11:21:52
21 Q. Okay. And according to this note, two hours 11:21:54
22 later the macula's off. Correct? 11:22:00
23 A. Correct. 11:22:03
24 Q. In your opinion, can the macula go from being on 11:22:06
25 to being off within a couple of hours? 11:22:10

1 A. It's unlikely. 11:22:13
2 Q. And why is that? 11:22:21
3 A. A couple of hours -- it's -- fluid often doesn't 11:22:23
4 move that quickly. But also, it depends how close to 11:22:34
5 the macula it was on the first examination. Umm, you 11:22:38
6 know, and based on the OCT, it looked like the macula 11:22:42
7 was already off in the optometrist's office. 11:22:48
8 Q. So when the provider, whoever it was, that saw 11:22:51
9 the patient on the 14th said that the macula appeared to 11:22:54
10 be on, what your testimony is -- correct me if I'm 11:22:58
11 wrong -- is that that's perhaps not correct? 11:23:00
12 A. I think that's probably not correct, but I 11:23:03
13 don't -- I can't say for certain. 11:23:08
14 Q. Okay. The fact that the provider on March 14, 11:23:11
15 2018 at Center for Sight said that the macula appeared 11:23:16
16 to be on, was that malpractice of them? 11:23:19
17 A. No. 11:23:22
18 Q. Can a patient develop a retinal tear within just 11:23:26
19 a couple of hours? 11:23:32
20 A. Yes. 11:23:33
21 Q. On NSBME 0032 under the Impression Section, No. 2 11:23:34
22 says "PVD OS." Do you see that? 11:23:46
23 A. Yes. 11:23:49
24 Q. That, like we've talked about, posterior vitreous 11:23:50
25 detachment in the left eye. Correct? 11:23:55

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1 A. Correct. 11:23:57
2 Q. And the provider who saw the patient at the 11:23:58
3 Center for Sight two hours earlier did not document a 11:24:07
4 posterior vitreous detachment. True? 11:24:10
5 A. Correct. 11:24:15
6 Q. Do you think or do you have an opinion as to the 11:24:15
7 likelihood that the patient developed a posterior 11:24:17
8 vitreous detachment from the time she left the Center 11:24:21
9 for Sight to the time she's seen by another provider at 11:24:25
10 Dr. Loo's office? 11:24:29
11 A. The patient, in all likelihood, had a posterior 11:24:30
12 vitreous detachment prior to when the retinal tear 11:24:37
13 occurred. 11:24:40
14 Q. Okay. And so the notes that we've gone through 11:24:41
15 for the past hour or so before this, no one documents a 11:24:43
16 posterior vitreous detachment. True? 11:24:48
17 A. Correct. 11:24:52
18 Q. So that was missed, in your opinion? 11:24:52
19 A. It was not documented. 11:24:54
20 Q. Hmm. Can you turn to Bates stamped Page NSBME 81 11:24:55
21 and let me know when you're there? 11:25:15
22 A. Okay. 11:25:17
23 Q. This is Dr. Pezda's operative report for the 11:25:18
24 repair procedure. Correct? 11:25:28
25 A. Correct. 11:25:29

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1 Q. Under the second paragraph, under the "Technique" 11:25:30
2 section, about halfway through it says, "Endodiathermy 11:25:33
3 was then used to mark the retinal breaks." 11:25:41
4 Do you see that? 11:25:45
5 A. Yes. 11:25:46
6 Q. It goes on to say, "The peripheral retina was 11:26:23
7 then examined 360 degrees using scleral depression. No 11:26:28
8 further retinal breaks were found." 11:26:33
9 Did I read that correctly? 11:26:37
10 A. Yes. 11:26:38
11 Q. Is a retinal break the same as a retinal tear? 11:26:39
12 A. Yes. 11:26:42
13 Q. And he uses breaks, plural. Do you see that? 11:26:42
14 A. Yes. 11:26:46
15 Q. Does that indicate to you that he found more than 11:26:47
16 one tear? 11:26:53
17 A. You'd have to ask him that. 11:26:54
18 Q. You don't have an opinion one way or the other 11:27:01
19 whether the use of retinal breaks, plural, refers to 11:27:04
20 more than one retinal tear? 11:27:08
21 A. Often there will be a tiny little break next to 11:27:10
22 the causative break and that might be dictated as 11:27:16
23 retinal breaks. 11:27:20
24 Q. And in that situation -- 11:27:22
25 A. In repairing a retinal detachment, it doesn't 11:27:24

1 really matter. 11:27:27
2 Q. Sure. I appreciate that, but when you say there 11:27:28
3 could be a retinal break when you're repairing it -- I'm 11:27:31
4 sorry. I didn't catch what you said. 11:27:35
5 A. Well, you had stated previously that sometimes we 11:27:38
6 find retinal breaks at the time of surgery that weren't 11:27:44
7 seen in the office. 11:27:47
8 Q. Yeah. That's not uncommon. Right? 11:27:49
9 A. I agreed with you. That could be what he's 11:27:53
10 discussing here. Again, I don't know. I wasn't the 11:27:57
11 surgeon. 11:27:59
12 Q. It could be the situation that he finds more 11:27:59
13 breaks or tears in the OR than what he saw in the 11:28:03
14 office. True? 11:28:07
15 A. Correct. 11:28:07
16 Q. That's not malpractice, is it? 11:28:07
17 A. It's not malpractice. He's there repairing the 11:28:09
18 eye. 11:28:13
19 Q. Was it your testimony earlier that a patient's 11:28:13
20 report of flashes can be suggestive of a retinal tear? 11:28:27
21 A. Flashes and floaters are often symptoms patients 11:28:34
22 have when they develop posterior vitreous detachment 11:28:39
23 and/or retinal tear. 11:28:45
24 Q. Turning back to Exhibit 5 -- wait. No. Same 11:28:47
25 exhibit. If you can turn to NSBME 21 and let me know 11:28:56

1 when you're there. 11:29:02
2 A. Okay. 11:29:10
3 Q. This is a visit note from September 21, 2018. 11:29:12
4 Correct? 11:29:23
5 A. Yes. 11:29:23
6 Q. So about six months after the repair procedure? 11:29:25
7 A. Yes. 11:29:31
8 Q. And do you see where it's documented "OCC" -- 11:29:31
9 which I believe stands for occasional -- "flashes in 11:29:38
10 OU." 11:29:42
11 Do you see that? 11:29:43
12 A. Yes. 11:29:43
13 Q. And OU means both eyes? 11:29:44
14 A. Correct. 11:29:46
15 Q. Okay. And so six months after the repair 11:29:47
16 procedure the patient is reporting of flashes in both 11:29:52
17 eyes. Correct? 11:29:56
18 A. Yes. 11:29:57
19 Q. Do you think that's indicative of retinal tears 11:29:58
20 in both eyes at this point? 11:30:02
21 A. Unlikely. 11:30:03
22 Q. If you can turn to Bates stamped Page NSBME 11:30:05
23 0035 -- 11:30:20
24 A. Okay. 11:30:20
25 Q. -- the visit note from March 13, 2018, "Patient 11:30:22

1 complains of flashes when eyes move." 11:30:27

2 Do you see that? 11:30:30

3 A. Yes. 11:30:31

4 Q. Eyes being plural in that sentence. Correct? 11:30:31

5 A. Umm, yes. 11:30:40

6 Q. Sorry to keep switching exhibits on you, but if 11:30:43

7 you can turn back to Bates stamped Page NSBME 0021 and 11:30:51

8 let me know when you're there. 11:30:55

9 A. Okay. 11:30:58

10 Q. Okay. This is that September 21, 2018 visit note 11:30:59

11 that we were briefly discussing. Would you agree that 11:31:11

12 according to the September 21, 2018 visit note, the 11:31:14

13 patient did not complain of constant black and white 11:31:18

14 spots in her center vision? 11:31:21

15 A. I'm sorry. One more time. The note from 11:31:23

16 September 21? 11:31:29

17 Q. Yes. On Page NSBME 0021 as well as 0020. 11:31:31

18 A. And the question is about spots in the vision? 11:31:42

19 Q. At least according to the note, the patient did 11:31:46

20 not complain of constant black and white spots in center 11:31:49

21 vision? 11:31:53

22 A. No. I don't see that as a complaint. 11:31:54

23 Q. Based upon your review of the exhibits, did you 11:32:07

24 see any further visits at Retina Consultants of Nevada 11:32:12

25 after September 21st, 2018? 11:32:16

1 A. No. That's the last one that's in the record. I 11:32:36
2 believe that's the last one I reviewed. 11:32:39
3 Q. And then now if we go back to the Investigative 11:32:41
4 Committee Exhibit 5, I have the next time that there's a 11:32:45
5 visit for this patient being July 19, 2019. Does that 11:32:55
6 sound accurate to you? 11:32:58
7 A. Sorry. What page are you on? 11:33:00
8 Q. NSBME 99. 11:33:02
9 A. This is an OCT I'm looking at? 11:33:20
10 Q. Do you see the exam date as July 19, 2019? 11:33:25
11 A. I'm going to -- I'm going to need new glasses. 11:33:28
12 On the OCT you're referring to. Yes? 11:33:36
13 Q. It's easier -- 11:33:40
14 A. I'll take your word for it. It's hard to read. 11:33:42
15 Q. I was going to say I feel your pain, but if you 11:33:46
16 turn to Page 102, for example, you see the refraction 11:33:49
17 July 19, 2019. 11:33:53
18 A. Yes. Okay. 11:33:55
19 Q. Okay. So from September 21, 2018 until July 19, 11:33:55
20 2019, we have no records of any ophthalmic care that the 11:34:04
21 patient received in the interim? 11:34:08
22 A. Apparently not. 11:34:11
23 Q. If you can turn back to Page 2 -- 101? 11:34:25
24 A. Okay. 11:34:30
25 Q. The second paragraph states, "Patient refuses 11:34:30

1 dilation OU today, agrees to DFE OS only." 11:34:34
2 Did I read that correctly? 11:34:40
3 A. Yes. 11:34:41
4 Q. DFE stands for what? 11:34:42
5 A. Dilated fundus examination. 11:34:46
6 Q. Okay. So she's agreeing to a dilated fundus exam 11:34:49
7 of the left eye only at this visit. Correct? 11:34:53
8 A. Correct. 11:34:56
9 Q. If you can turn to Page 103, and what does it say 11:34:57
10 about the fundus exam? 11:35:09
11 A. This one says the fundi were not examined. 11:35:10
12 Q. Turning to Page 104 -- 11:35:20
13 A. Uh-huh. 11:35:36
14 Q. -- at the top says the "Patient ran out of 11:35:37
15 Timolol. Sample of Combigan b.i.d. OS" -- so twice a 11:35:40
16 day in the left eye? 11:35:46
17 A. Yes. 11:35:47
18 Q. -- "provided in office. RV four to six weeks for 11:35:48
19 IOP check." 11:35:52
20 Does that mean return visit? 11:35:53
21 A. I think so. 11:35:55
22 Q. Okay. So according to this note, the optometrist 11:35:55
23 is asking the patient to return in four to six weeks for 11:35:58
24 an IOP check. True? 11:36:04
25 A. Yes. 11:36:06

1 Q. In chronological order, what is the next visit 11:36:06
2 note that you have in that exhibit? 11:36:11
3 A. So this one again is July 19th is the one we were 11:36:14
4 looking at? 11:36:54
5 Q. The one we were just talking about? 11:36:54
6 A. Yeah. 11:37:00
7 Q. Yeah. 11:37:03
8 A. So the next one appears to be December 27th. 11:37:04
9 Q. And when she returns five months later, not four 11:37:10
10 to six weeks later, was the fundus examined? 11:37:18
11 A. Can you tell me what page you're referring to? 11:37:22
12 Q. Oh. Of course. Page 95. 11:37:45
13 A. Thank you. Again, it says the fundi were not 11:37:50
14 examined in the middle of the page. 11:37:55
15 Q. Have you heard the term, Doctor, the standard of 11:37:57
16 care? 11:38:01
17 A. Yes. 11:38:01
18 Q. Just in general, what is the standard of care? 11:38:01
19 A. It's the expectation of the care that one would 11:38:03
20 receive in the community for a certain condition and in 11:38:13
21 accepted medical practices. 11:38:23
22 Q. Have you ever heard it described as what a 11:38:25
23 reasonable provider would do under similar 11:38:28
24 circumstances? 11:38:30
25 A. Sure. 11:38:30

1 Q. Okay. And you mentioned what a provider would do 11:38:32
2 in the community. Would you agree that the standard of 11:38:38
3 care is not decided by one provider's personal 11:38:40
4 practices, subjective practice, but the standard of care 11:38:47
5 is an objective measure? 11:38:50
6 A. I'm sorry. You'll have to give me perhaps an 11:38:52
7 example there to -- to understand what you're saying. 11:38:59
8 Q. Sure. So earlier you testified that if a patient 11:39:02
9 is difficult to examine, that in general that's 11:39:05
10 something you'd make note of. Do you recall that 11:39:08
11 testimony? 11:39:11
12 A. Yes. 11:39:12
13 Q. You're not trying to suggest that what your 11:39:12
14 personal practices define the standard of care, are you? 11:39:15
15 A. No. 11:39:19
16 MS. HUETH: Doctor, thank you for your time and 11:39:28
17 patience with me. Those are all the questions that I 11:39:30
18 have for now. 11:39:33
19 THE WITNESS: Okay. 11:39:34
20 HEARING OFFICER HALSTEAD: So just for purposes 11:39:35
21 of planning, Mr. Cumings, because we're coming up on 11:39:39
22 lunch. I don't want to rush you, so I don't know how 11:39:42
23 much time you needed. I'm just trying to determine for 11:39:46
24 purposes of a good time to take a break for lunch. 11:39:49
25 MR. CUMINGS: I think I can get through my 11:39:53

1 Redirect here in about 20, 30 minutes. I was wondering 11:39:55
2 how long Ms. Hueth thinks her Direct of her expert is 11:39:59
3 going to take. I'm wondering what our timeline is for 11:40:03
4 the rest of the day here. I didn't think the Cross was 11:40:08
5 going to be over an hour. 11:40:11
6 Do you have an estimate, Ms. Hueth? 11:40:13
7 MS. HUETH: I have asked my expert to join the 11:40:15
8 Zoom at 2 o'clock. I figured that would give more than 11:40:20
9 enough time for us to conclude with him by the end of 11:40:22
10 the day. Just kind of -- that was my rough estimate for 11:40:23
11 planning purposes. 11:40:28
12 MR. CUMINGS: Okay. Do you plan on calling 11:40:29
13 Dr. Loo before that? 11:40:32
14 MS. HUETH: I hadn't decided. I was going to see 11:40:34
15 how our time kind of shook out and how to effectively 11:40:38
16 use all of our time today. 11:40:41
17 MR. CUMINGS: Okay. Because I believe I'll be 11:40:42
18 done with Dr. Friedlander in about half an hour, and I 11:40:44
19 don't want to hold him the entire day. I would like to 11:40:48
20 be able to draw him back as a rebuttal witness if I need 11:40:52
21 to. So logistically, I'm just trying to figure out is 11:40:55
22 it possible for your expert to testify at 1? How long 11:41:00
23 do we plan on breaking for lunch? About an hour? 11:41:04
24 HEARING OFFICER HALSTEAD: I'll leave that up to 11:41:08
25 you guys. I'm good with whatever. 11:41:10

1 MR. CUMINGS: I think we can get through the rest 11:41:12
2 of this case today if that's at all possible. 11:41:14
3 MS. HUETH: Ambitious. It's possible, but 11:41:18
4 whether it's probable, I don't know. 11:41:24
5 MR. CUMINGS: I'll continue with my Direct and 11:41:25
6 we'll break for lunch and determine then what happens. 11:41:28
7 HEARING OFFICER HALSTEAD: Go ahead, Mr. Cumings. 11:41:31
8 REDIRECT EXAMINATION 11:41:31
9 BY MR. CUMINGS: 11:41:31
10 Q. Dr. Friedlander, thank you so much for your 11:41:34
11 patience here. I'd like to sort of clear up the 11:41:37
12 timeline a little bit. 11:41:40
13 Are you still on Page 94 of the IC's exhibits? 11:41:42
14 A. Yes. 11:41:45
15 Q. Counsel made a large issue of the fact that there 11:41:45
16 was no intervening exams between 6/6/2018 and 3/13/2018. 11:41:50
17 Do you recall that? 11:41:56
18 A. Yes. 11:41:56
19 Q. Is it likely that Patient A presented back to 11:41:57
20 Dr. Keel's office on 3/13 because she was experiencing 11:42:00
21 new symptomology? 11:42:05
22 A. Yes. 11:42:06
23 Q. And was that symptomology floaters in the eyes, 11:42:06
24 from your review of the records, and a change in vision? 11:42:10
25 A. Yes. 11:42:14

1 Q. And it was Dr. Keel then who diagnosed a retinal 11:42:14
2 tear? 11:42:19
3 A. Correct. 11:42:19
4 Q. I'd like to look a little bit as far as what does 11:42:20
5 an optometrist do. Is an optometrist the expert in 11:42:23
6 retina? 11:42:28
7 A. No. 11:42:29
8 Q. What is an optometrist typically doing when they 11:42:29
9 see a patient? 11:42:35
10 A. That's a difficult question to answer. 11:42:36
11 Q. Let me rephrase, Doctor. 11:42:42
12 Would a patient typically present off the street 11:42:46
13 to an ophthalmologist such as yourself without a 11:42:50
14 referral? 11:42:54
15 A. No. 11:42:55
16 Q. And why is that? 11:42:55
17 A. Umm, well, we're a specialty practice, and most 11:42:57
18 patients will go to who they think is their primary eye 11:43:07
19 care, which is often an optometrist and sometimes a 11:43:12
20 general ophthalmologist. 11:43:16
21 Q. Anecdotally, when you meet patients, do they know 11:43:19
22 exactly what you do? 11:43:21
23 A. Not really when I first meet them, no. 11:43:22
24 Q. So typically when they're referred to you, they 11:43:27
25 aren't experts in eye anatomy or their conditions. They 11:43:31

1 go to the optometrist first. Correct? 11:43:36
2 A. Typically. 11:43:39
3 Q. So is a patient always the best historian of 11:43:39
4 what's going on in a case where there's a sudden change 11:43:43
5 in their sight? 11:43:46
6 A. The patient is the best historian to tell us what 11:43:48
7 symptoms they're having, what's going on with their eye. 11:43:52
8 Q. But a patient can self-diagnose a retinal tear? 11:43:55
9 A. No. 11:43:59
10 Q. Turning back to the care in this case, we had a 11:43:59
11 patient present on 3/13/2018 at roughly around 2:30, 11:44:03
12 judging from that note on Page 94, with new floaters in 11:44:08
13 her vision and worsening vision. They were then STAT 11:44:13
14 referred to Dr. Loo. Dr. Loo performed an examination 11:44:16
15 and then released the patient back. The patient 11:44:21
16 presented next day at 3/14 with further degradation of 11:44:25
17 their sight. Correct? 11:44:30
18 A. Correct. 11:44:30
19 Q. Okay. I'd like to go back to one of the pages in 11:44:31
20 the record here. I think it was Page 109 -- 111. Yes. 11:44:35
21 111. So whoever the provider was here, I know that 11:44:47
22 Dr. Pezda's letter on 3/14 was addressed to Dr. Keel. 11:44:52
23 So if it was indeed Dr. Keel, they diagnosed, again, a 11:44:57
24 worsening condition and then a complete retinal 11:45:01
25 detachment with what they thought was the macula still 11:45:04

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1 on? 11:45:08

2 MS. HUETH: Let me just object to the extent that 11:45:09

3 assumes facts that are not in evidence with respect to 11:45:11

4 who examined the patient on this day. 11:45:14

5 MR. CUMINGS: Say it doesn't have to be Dr. Keel. 11:45:18

6 That's why I said hypothetically. It could be Dr. Keel, 11:45:18

7 but somebody at that office examined the patient and 11:45:20

8 diagnosed a detached retina. Do you disagree with that? 11:45:24

9 THE WITNESS: You're asking me? 11:45:28

10 MR. CUMINGS: I'm asking Ms. Hueth. 11:45:30

11 HEARING OFFICER HALSTEAD: She's not answering 11:45:33

12 questions, so you can ask your expert. You can't ask 11:45:35

13 her. 11:45:40

14 MR. CUMINGS: Would you like to rule on the 11:45:41

15 objection? 11:45:43

16 HEARING OFFICER HALSTEAD: You just clarified the 11:45:43

17 question, so I don't know that I need to rule on it. 11:45:45

18 BY MR. CUMINGS: 11:45:49

19 Q. Dr. Friedlander, do you understand my question? 11:45:50

20 HEARING OFFICER HALSTEAD: You said it didn't 11:45:51

21 matter who did it. So you can either state your 11:45:53

22 question as a hypothetical who did it or say it doesn't 11:45:55

23 matter who did it and stick with that question. 11:45:58

24 BY MR. CUMINGS: 11:45:49

25 Q. Does it matter who examined the eye if they 11:46:00

1 diagnosed a detached retina at this visit? 11:46:04
2 A. No. I don't see how that would matter. 11:46:08
3 Q. Because at this point we have a detached retina. 11:46:11
4 Correct? 11:46:16
5 A. Correct. 11:46:16
6 Q. Is there any question in the record that the 11:46:17
7 patient's retina was detached? 11:46:19
8 A. Was there any question that it wasn't detached? 11:46:21
9 Everything points to it being detached. 11:46:25
10 Q. Does Dr. Pezda on Page 79, does he disagree that 11:46:28
11 the retina is detached? 11:46:38
12 A. Well, he states pretty clearly there's a retinal 11:46:40
13 detachment in the left eye. 11:46:49
14 Q. Okay. I'd like to boil down a little bit to what 11:46:51
15 exactly the Center For Eyesight was diagnosing here, so 11:47:07
16 if we stay back on Page 111, with the macula-on retinal 11:47:14
17 detachment, and you said it's unlikely that a macula 11:47:22
18 could detach in that amount of time. Do you recall that 11:47:27
19 testimony? 11:47:30
20 A. Yes. 11:47:30
21 Q. Is it likely that they were unable to 11:47:31
22 affirmatively diagnose one way or the other if the 11:47:34
23 macula was on? 11:47:37
24 A. Well, first of all, when they say retinal 11:47:38
25 detachment total old and put an ICD-10 or 9 code, that 11:47:43

1 doesn't really jibe with macula-on RD. 11:47:53
2 Q. How is that? 11:47:59
3 A. By definition, a total retinal detachment is 11:48:00
4 going to involve the macula. It's going to be a 11:48:04
5 macula-off RD. 11:48:08
6 Q. So is it likely they were just mistaken? 11:48:09
7 A. I think so. 11:48:11
8 Q. Who is the expert in retina? Would that be 11:48:12
9 Dr. Pezda or whoever authored this note? 11:48:16
10 A. Dr. Pezda is a retinal specialist. 11:48:19
11 Q. I'd like to look a little bit as well as to what 11:48:23
12 happened after that initial visit with Dr. Loo. Could 11:48:46
13 you turn to Page 54? So the Center for Sight document 11:48:50
14 that they had called and spoken with Dr. Hollander. 11:49:01
15 Correct? 11:49:05
16 A. Hollifield. 11:49:06
17 Q. Hollifield. And they referred them back to this 11:49:08
18 center. Do you see this -- this document here? What 11:49:11
19 does this document appear to be? 11:49:15
20 A. This is a note written by a front office or a 11:49:16
21 tech, I believe. 11:49:21
22 Q. Can you just summarize what this note states? 11:49:22
23 A. Umm, that the patient arrived at 5:24 p.m. and 11:49:25
24 she asks which doctor she'd be seeing. She was informed 11:49:34
25 it would be Dr. Loo, and the patient stated she will not 11:49:39

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1 see him and was told she was supposed to see any doctor. 11:49:42
2 I informed her that Dr. Loo was the doctor here. She 11:49:48
3 then asked us to call Dr. Liang because she was not 11:49:51
4 seeing this doctor. And then the patient walked out 11:49:54
5 when she asked again what doctor was she seeing. 11:50:01
6 Q. Does this indicate that her examination with 11:50:04
7 Dr. Loo the previous day didn't go well? 11:50:07
8 MS. HUETH: Objection. Calls for speculation. 11:50:09
9 It's argumentative and irrelevant. 11:50:12
10 HEARING OFFICER HALSTEAD: I'll sustain it on 11:50:14
11 speculation because I don't -- you haven't established 11:50:18
12 that this witness would have any knowledge of how to 11:50:22
13 interpret this note. It wasn't his note. 11:50:23
14 MR. CUMINGS: I understand that. 11:50:27
15 BY MR. CUMINGS: 11:50:28
16 Q. Let me rephrase the question then. 11:50:28
17 Does a note like this typically -- would a note 11:50:30
18 like this typically be entered into the record? Why is 11:50:34
19 this note here? 11:50:38
20 A. The note's there because the patient is refusing 11:50:39
21 to see Dr. Loo and that's documentation of that. 11:50:44
22 Q. Is it typical that a patient would refuse to see 11:50:48
23 a physician? 11:50:51
24 A. Umm, it is highly inferred here that the 11:50:52
25 interaction on the day before was probably suboptimal. 11:50:59

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1 Q. And Dr. Loo in his response in 2021 but not in 11:51:03
2 his note documents that this was a difficult visit. Do 11:51:08
3 you recall that testimony? 11:51:11
4 A. Yes. Difficult examination I think is what he 11:51:12
5 said. 11:51:17
6 Q. Difficult examination. Okay. 11:51:18
7 A. Yes. 11:51:21
8 Q. Turn back to Page 111 now. 11:51:21
9 A. Okay. 11:51:28
10 Q. Now, looking at Note 7 there, the retinal 11:51:29
11 detachment, could you read that out loud again for us? 11:51:33
12 A. "Retinal detachment, Total (Old)." There's a 11:51:36
13 code. 11:51:42
14 "Condition is worsening. I called and spoke to 11:51:42
15 Dr. Hollifield and explained the situation appears to be 11:51:46
16 a macula-on RD. Will get to RCN at Green Valley (Pezda) 11:51:50
17 office right now. Patient has not eaten since 11:30, 11:51:56
18 will stay NPO until evaluated." 11:52:02
19 Q. Looking at that previous note and then looking at 11:52:05
20 this note, it appears that that previous note occurred 11:52:09
21 prior to this phone call being made. Correct? 11:52:10
22 MS. HUETH: Objection. Calls for speculation. 11:52:16
23 MR. CUMINGS: Let's lay some foundation here. 11:52:18
24 BY MR. CUMINGS: 11:45:49
25 Q. Go back to Page 35, please. 11:52:19

1 HEARING OFFICER HALSTEAD: Actually, I get to 11:52:19
2 rule on these things, and I was going to let you 11:52:21
3 continue with the question because the document -- to 11:52:24
4 the extent the documents indicate that, he can answer. 11:52:26
5 BY MR. CUMINGS: 11:52:31
6 Q. Dr. Friedlander, would you like me to repeat the 11:52:31
7 question? 11:52:35
8 A. Please. 11:52:35
9 Q. This note here when compared to the previous 11:52:36
10 telephone log -- 11:52:40
11 HEARING OFFICER HALSTEAD: What number was the 11:52:41
12 previous telephone log, please? 11:52:44
13 MR. CUMINGS: Ms. Halstead, I believe it was Page 11:52:47
14 35. No, I'm sorry. 54. 11:52:51
15 HEARING OFFICER HALSTEAD: 54. 11:52:57
16 MS. HUETH: 54. 11:52:58
17 BY MR. CUMINGS: 11:53:00
18 Q. Yes. That's -- what time was that note taken? 11:53:00
19 A. On Page 54? 11:53:09
20 Q. Correct, Doctor? 11:53:12
21 A. 5:25 p.m. 11:53:14
22 Q. 5:25. And back on Page 111, now it refers to a 11:53:17
23 conversation with Dr. Hollifield and the patient 11:53:25
24 presenting to Dr. Pezda. Is it likely that this note 11:53:29
25 was authored after 5:24? 11:53:32

1 A. I don't know how I could know that. 11:53:35
2 Q. Do you see that the patient is now going to see 11:53:44
3 Dr. Pezda -- 11:53:47
4 A. Yes. 11:53:48
5 Q. -- after they went to see Dr. Loo? 11:53:48
6 A. I -- I see that they are going to see Dr. Pezda. 11:53:51
7 But it doesn't -- doesn't say anything about not seeing 11:54:01
8 Dr. Loo on this optometrist's note. 11:54:07
9 Q. I agree, Doctor. On Page 54, that telephone log, 11:54:09
10 that was Patient A speaking to their office and refusing 11:54:13
11 to see Dr. Loo. Do you agree with that? 11:54:18
12 A. Patient was in the office, correct. 11:54:21
13 Q. And they refused to see Dr. Loo? 11:54:23
14 A. Yes. 11:54:26
15 Q. And now on Page 111 this record states they're 11:54:26
16 going to RCN and see Dr. Pezda now after a phone call 11:54:30
17 with Dr. Hollifield? 11:54:35
18 A. That's what it says. 11:54:36
19 Q. Okay. So it's likely inferring from that note 11:54:42
20 and the patient's refusal to see Dr. Loo, Dr. Loo's 11:54:50
21 response to the Board in 2021 about a difficult 11:54:57
22 examination, that that examination didn't go well enough 11:55:00
23 that the patient absolutely refused to see Dr. Loo and 11:55:05
24 instead saw Dr. Pezda. Would you agree with that? 11:55:11
25 MS. HUETH: I'm going to object. It calls for 11:55:12

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1 speculation and is argumentative. Lacks foundation. 11:55:13
2 HEARING OFFICER HALSTEAD: Well, here's why I'm 11:55:15
3 sustaining that. Correct me if I'm wrong, but my 11:55:20
4 understanding is the next day she had the retinal 11:55:22
5 detachment and the day before it wasn't spotted by 11:55:25
6 Dr. Loo, so she might not want to go to Dr. Loo because 11:55:29
7 now her retina is detached and he didn't note a tear. 11:55:35
8 So in that sense -- I mean, I don't know one way or the 11:55:38
9 other. The question is speculation. 11:55:39
10 MR. CUMINGS: I'll withdraw the question. 11:55:42
11 BY MR. CUMINGS: 11:55:44
12 Q. I'd like to look a little bit at the 11:55:45
13 postoperative course of Patient A for a moment. Can we 11:55:48
14 look at the records Pages 21 through 24, Doctor? 11:55:53
15 A. Okay. 11:56:00
16 Q. Could you examine these records and let me know 11:56:06
17 when you're done? 11:56:09
18 A. Okay. 11:56:10
19 Q. How would you characterize Patient A's 11:56:34
20 postoperative course? 11:56:38
21 A. Well, it was -- the surgery was successful in 11:56:39
22 that the retina remained attached. There was some 11:56:44
23 postoperative macular edema which was treated for at 11:56:49
24 least several months. And the patient complained of 11:56:57
25 some distortion presumably from that. 11:57:03

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1 Q. So her vision was less than perfect then? 11:57:08
2 A. Umm, she's measured at 20/60 with a pinhole. I 11:57:11
3 don't know what her refraction was there, but it wasn't 11:57:17
4 20/20. 11:57:24
5 Q. And on Page 21, September, it was noted she was 11:57:25
6 still seeing floaters in her vision? 11:57:33
7 A. Yes. 11:57:35
8 Q. Is that unexpected given her age and the vitreous 11:57:36
9 liquification? 11:57:41
10 A. Well, the vitreous has been removed from the left 11:57:43
11 eye. But the -- when a vitrectomy is done, there's 11:57:47
12 always -- there's always more vitreous, and occasionally 11:57:54
13 patients will see floaters following surgery. It's not 11:57:59
14 that unusual. 11:58:03
15 Q. I'd like to speak about the referrals that we 11:58:05
16 were speaking of. You testified that it's not 11:58:07
17 malpractice to miss a tear. Can you extrapolate a 11:58:09
18 little bit on that? 11:58:13
19 A. I think the problem with this -- with this case 11:58:14
20 is that a tear was seen. Patient was sent to the 11:58:18
21 specialist for treatment and then the tear was missed. 11:58:23
22 And then the patient detached, presumably, from the same 11:58:26
23 tear. 11:58:30
24 So, you know, I -- I don't know -- you could ask 11:58:31
25 the question: Do retina specialists miss tears? The 11:58:38

1 answer is probably yes. But unless we get direct 11:58:43
2 feedback from that patient or from another doctor, we're 11:58:48
3 not going to know when that happens. Does that answer 11:58:51
4 your question? 11:58:55
5 Q. I believe so. We had said that optometrists are 11:58:56
6 typically the first-line provider for a patient with an 11:59:00
7 eye issue. Correct? 11:59:07
8 A. They like to be, yes. 11:59:07
9 Q. Typically, when you see a patient, it's because 11:59:08
10 it was a STAT referral from an optometrist? 11:59:11
11 A. Or an ophthalmologist usually, yes. 11:59:14
12 Q. So is this a common presentation in a retina 11:59:18
13 practice? 11:59:21
14 A. Yes. 11:59:23
15 Q. And in a patient with flashes and floaters who is 11:59:23
16 aging, is this uncommon that they would present with 11:59:28
17 possible vitreous detachment? 11:59:32
18 A. It's very common that they would have a vitreous 11:59:36
19 detachment. 11:59:39
20 Q. In the situation like this where there was a STAT 11:59:40
21 referral same day from an optometrist, would you believe 11:59:43
22 that it's reasonable to contact the referring physician 11:59:46
23 if you do not understand why the patient is being 11:59:50
24 transferred? 11:59:52
25 A. Yes. 11:59:53

1 Q. Is there anywhere in the record that shows that 11:59:53
2 Dr. Loo contacted Dr. Keel? 11:59:57
3 A. No. 11:59:58
4 Q. Is there anywhere in the record that shows 11:59:59
5 Dr. Loo was confused -- in the medical records, not the 12:00:02
6 response -- that Dr. Loo was confused why the patient 12:00:06
7 had presented? 12:00:11
8 A. I'm -- I'm sorry. What do you mean "confused"? 12:00:12
9 Q. Unclear why the patient was there. 12:00:24
10 A. Umm, well, I think in his response it could be 12:00:26
11 inferred that. 12:00:30
12 Q. In his response three years later? 12:00:31
13 A. Yes. 12:00:35
14 Q. Please turn to Page 76. 12:00:36
15 A. Okay. 12:00:45
16 Q. This is Dr. Loo's response on 3/14 -- 12:00:45
17 A. Okay. 12:00:50
18 Q. -- regarding his March 13th visit. Do you 12:00:50
19 remember this record? 12:00:53
20 A. Yes. 12:00:54
21 Q. All right. And in here what was -- does it say 12:00:54
22 anything about Dr. Loo being confused as to why the 12:01:02
23 patient had presented? 12:01:05
24 A. No. 12:01:07
25 Q. All right. And did Dr. Loo examine the patient 12:01:11

1 for retinal detachment? 12:01:15
2 A. Again, I would assume Dr. Loo did an examination 12:01:17
3 on the patient and would have seen a retinal detachment 12:01:24
4 had there been one. 12:01:29
5 Q. So you can fairly characterize it as Dr. Loo 12:01:31
6 missed the retinal detachment and, therefore, that's 12:01:34
7 what malpractice is coming from this case? 12:01:38
8 A. No. There was no retinal detachment. 12:01:40
9 Q. Retinal tear. He missed the retinal tear and 12:01:43
10 that's why you're saying that there's malpractice? 12:01:48
11 A. Yes. 12:01:51
12 MR. CUMINGS: No further questions at this time. 12:01:51
13 Thank you, Dr. Friedlander. 12:01:53
14 MS. HUETH: I just have a few follow-up, Doctor. 12:01:56
15 RECROSS-EXAMINATION 12:01:56
16 BY MS. HUETH: 12:01:56
17 Q. You were asked some questions about that 12:01:59
18 telephone encounter note, the handwritten note. Do you 12:02:01
19 recall that? 12:02:05
20 A. Yes. Can you give me the page number again? 12:02:06
21 Q. Sure. It's Page 54. 12:02:09
22 A. Okay. 12:02:17
23 Q. But my question isn't about that page 12:02:18
24 specifically. My question is about if you could turn to 12:02:21
25 Page 107. 12:02:24

1 A. Okay. 12:02:30

2 Q. This is that 3/14 exam. We know the OCT is at 12:02:30

3 4:31, according to this note. Right? 12:02:38

4 A. Yes. 12:02:41

5 Q. And under the chief complaint the last sentence 12:02:42

6 starts with, "Very frustrated with the questions" -- 12:02:45

7 going on to the next page -- "because she being asked 12:02:48

8 the same questions." 12:02:51

9 Did I read that correctly? 12:02:53

10 A. Yes. 12:02:54

11 Q. Where was the Center for Sight located? Like 12:03:00

12 where was this patient's visit? Which location? 12:03:09

13 A. Well, I don't know how many locations they have 12:03:12

14 or where they're at, and I'm not sure where that 12:03:31

15 information is, so if you can point to it, I can show 12:03:40

16 you. 12:03:44

17 Q. Let me just ask a different question. You would 12:03:44

18 agree that you don't know how long it would take the 12:03:47

19 patient to get from the Center for Sight to Dr. Loo's 12:03:50

20 office, do you? 12:03:54

21 A. No, I don't know. Probably depends on traffic 12:03:55

22 and some other variables. 12:04:04

23 MS. HUETH: Those are all my questions, Doctor. 12:04:22

24 Thank you. 12:04:24

25 HEARING OFFICER HALSTEAD: Mr. Cumings, you get 12:04:25

1 the last opportunity. 12:04:28

2 MR. CUMINGS: Thank you. 12:04:30

3 FURTHER REDIRECT EXAMINATION 12:04:31

4 BY MR. CUMINGS: 12:04:31

5 Q. Dr. Friedlander, does distance from a 12:04:32

6 practitioner's office matter in a case like this if 12:04:37

7 there was a missed retinal tear or the patient was 12:04:41

8 frustrated or not? 12:04:45

9 A. I don't see how it could. 12:04:46

10 Q. Do you think that a patient would likely be 12:04:48

11 frustrated if they'd been asked the same questions two 12:04:51

12 days in a row and they've having new and worsening 12:04:55

13 symptoms of vision loss? 12:04:58

14 A. Yes. That happens often. 12:04:59

15 Q. Typically, do patients you deal with that have a 12:04:59

16 STAT referral, are they typically in the best of moods? 12:05:02

17 A. Depends. Usually, though, patients, there's a 12:05:05

18 certain level of anxiety when you're going to see a 12:05:10

19 specialist probably of any kind, especially on a STAT 12:05:13

20 referral. 12:05:16

21 MR. CUMINGS: Dr. Friedlander, I have no more 12:05:18

22 questions for you at this time. I thank you for your 12:05:22

23 participation in today's hearing. 12:05:24

24 HEARING OFFICER HALSTEAD: Thank you, 12:05:26

25 Mr. Cumings. 12:05:26

1 And I understood you earlier to say that you're 12:05:26
2 retaining Dr. Friedlander for potential rebuttal. Is 12:05:29
3 that correct? 12:05:34
4 MR. CUMINGS: Dr. Friedlander, I'll release you 12:05:34
5 at this time. I don't think that there's anything else 12:05:37
6 that you're going to testify that hasn't been covered, 12:05:39
7 and I think your position has been well documented and 12:05:42
8 well founded, so thank you for your time. 12:05:42
9 THE WITNESS: Okay. Thank you. 12:05:44
10 HEARING OFFICER HALSTEAD: Thank you, 12:05:45
11 Dr. Friedlander. 12:05:47
12 Mr. Cumings, are you going to have any other 12:05:49
13 witnesses? 12:05:52
14 MR. CUMINGS: No. 12:05:53
15 HEARING OFFICER HALSTEAD: Do you want to rest 12:05:53
16 your case at this time? 12:05:54
17 MR. CUMINGS: Yes. 12:05:55
18 HEARING OFFICER HALSTEAD: So the IC's resting. 12:05:55
19 What time do you guys want to come back? 12:05:58
20 MR. CUMINGS: Can we do 1? 12:06:00
21 HEARING OFFICER HALSTEAD: Ms. Hueth? 12:06:03
22 MS. HUETH: That's fine with me. 12:06:03
23 HEARING OFFICER HALSTEAD: Okay. We'll see you 12:06:06
24 all back here at 1 o'clock. 12:06:08
25 /// 12:06:11

1 *** 12:06:11

2 (RECESS TAKEN FROM 12:06 P.M. TO 1:01 P.M.) 12:06:11

3 *** 13:01:28

4 HEARING OFFICER HALSTEAD: Ms. Hueth, it's your 13:01:28

5 case. Do you want to announce who your next witness is 13:02:07

6 going to be? 13:02:12

7 MS. HUETH: We'd like to call Dr. Kirk Hou. 13:02:13

8 HEARING OFFICER HALSTEAD: Okay. Thank you, 13:02:17

9 Dr. Hou. I'm the hearing officer. Thank you for 13:02:17

10 appearing today. 13:02:20

11 Whereupon,

12 KIRK K. HOU, MD,

13 having first been called as a witness, was duly sworn

14 and testified as follows:

15

16 HEARING OFFICER HALSTEAD: Can you please state 13:02:27

17 your name and spell your name for the record. 13:02:29

18 THE WITNESS: First name Kirk, K-I-R-K, last name 13:02:32

19 Hou, H-O-U. 13:02:35

20 MS. HUETH: I'm sorry, Doctor. I mispronounced 13:02:37

21 your name. 13:02:40

22 HEARING OFFICER HALSTEAD: Ms. Hueth, your 13:02:41

23 witness. 13:02:44

24 MS. HUETH: Thank you. 13:02:45

25 /// 13:02:45

1 DIRECT EXAMINATION 13:02:45

2 BY MS. HUETH: 13:02:45

3 Q. Doctor, what is your medical specialty? 13:02:45

4 A. Vitreoretinal surgery. 13:02:47

5 Q. Where and when did you go to medical school? 13:02:50

6 A. Washington University in St. Louis. I was there 13:02:53

7 from 2007 to 2015. 13:02:56

8 Q. Was that the medical scientist training program? 13:02:59

9 A. Yeah. So it's a joint MD/Ph.D. program, so both 13:03:05

10 medical doctor and then a doctorate in biophysics. 13:03:11

11 Q. After the medical scientist training program, 13:03:17

12 what did you do next as far as your education? 13:03:21

13 A. I did a medicine intern year at Barnes-Jewish 13:03:24

14 Hospital in St. Louis, and then I matriculated into an 13:03:31

15 ophthalmology residency at UCLA for three years. 13:03:36

16 Q. When did you finish your residency? 13:03:42

17 A. Let's see here. I forget now. 2019. June 2019. 13:03:44

18 Q. We all have the benefit of having your written 13:03:49

19 CV, but it's good to put your memory to the test. 13:03:52

20 A. I have to look it up. 13:03:55

21 Q. After your residency, what did you do next, as 13:03:57

22 far as anything medical? 13:04:00

23 A. I went straight into vitreoretinal fellowship at 13:04:03

24 UCLA. Finished in 2021. 13:04:09

25 Q. How long was the fellowship? 13:04:09

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1 A. Two years. 13:04:12

2 Q. Two years. Do you do any teaching? 13:04:13

3 A. I do. I teach at our county hospital affiliated 13:04:18

4 with the residency program. So I attend the resident 13:04:23

5 clinic there; I attend resident surgeries; and then I 13:04:26

6 also attend our vitreoretinal fellows at the county 13:04:30

7 hospital as well as at UCLA itself. 13:04:34

8 Q. Are you a member of any professional medical 13:04:37

9 organizations? 13:04:40

10 A. I am. So I'm a member of the American Academy of 13:04:40

11 Ophthalmology and also the American Society of Retina 13:04:45

12 Specialists. 13:04:50

13 Q. What is the American Society of Retina 13:04:50

14 Specialists? It sort sounds self-explanatory. 13:04:52

15 A. Yeah. It's a professional organization for 13:04:57

16 vitreoretinal specialists focused on research, outreach, 13:05:03

17 sort of provider training. It's just a pretty standard 13:05:04

18 professional organization for -- focused on 13:05:09

19 vitreoretinal surgeons. 13:05:13

20 Q. Are you board certified? 13:05:15

21 A. I am in ophthalmology, yeah. 13:05:16

22 Q. Based upon your education, training, and 13:05:20

23 experience, do you believe that you're qualified to 13:05:22

24 offer opinions as to whether or not Dr. Loo's care was 13:05:26

25 reasonable? 13:05:30

1 A. I do. 13:05:30

2 Q. And as part of your review of this matter, have 13:05:31

3 you been sent various records or materials? 13:05:37

4 A. I have. So I have in front of me the Board's 13:05:40

5 complaint letter. I have Dr. Loo's response to the 13:05:44

6 Board, as well as records from Dr. Loo's office and from 13:05:47

7 the Center for Sight or Center for Vision. 13:05:51

8 MS. HUETH: At this point, Ms. Halstead, I would 13:06:00

9 move to qualify Dr. Hou as an expert witness. 13:06:03

10 HEARING OFFICER HALSTEAD: Mr. Cumings? 13:06:09

11 MR. CUMINGS: I have no objection to that at this 13:06:11

12 time. 13:06:13

13 HEARING OFFICER HALSTEAD: Thank you. He'll be 13:06:13

14 so designated. 13:06:15

15 BY MS. HUETH: 13:06:15

16 Q. And did you have an opportunity to review those 13:06:21

17 materials that you just listed prior to today? 13:06:24

18 A. Yes. 13:06:27

19 Q. Based upon your education, training, and 13:06:28

20 background, as well as your review of those various 13:06:31

21 materials, do you have an opinion as to whether or not 13:06:34

22 Dr. Loo used reasonable care in his treatment of the 13:06:38

23 patient in this matter? 13:06:41

24 A. Yes. 13:06:42

25 Q. And what is that opinion? 13:06:44

1 A. I believe that he did, yes. 13:06:46

2 Q. And, Doctor, we've had a crash course in retina, 13:06:48

3 all things retina today, so I'll try not to belabor 13:06:56

4 those points, but can you tell, based upon physical exam 13:07:01

5 of a patient, how long a posterior vitreous detachment 13:07:05

6 has been present? 13:07:12

7 A. No. 13:07:12

8 Q. And same question. Can you tell, based upon exam 13:07:13

9 of a patient, for how long a retinal tear has been 13:07:17

10 present? 13:07:21

11 A. You can, but you really wouldn't know that it's a 13:07:21

12 tear until maybe after weeks or months. You can see 13:07:29

13 degenerative changes to the tear, but that wouldn't be 13:07:34

14 obvious right away. 13:07:37

15 Q. Do all posterior vitreous detachment progress to 13:07:38

16 a retinal tear? 13:07:44

17 A. No. I do know that retinal tears happen in 13:07:47

18 probably 8 to 16 percent of posterior vitreous 13:07:50

19 detachments, so the majority do not have retinal tears. 13:07:55

20 Q. The majority of patients with a posterior 13:08:00

21 vitreous detachment? 13:08:02

22 A. Yes. 13:08:05

23 Q. How is a retinal tear diagnosed? 13:08:05

24 A. The gold standard for diagnosing retinal tears 13:08:08

25 indirect -- binocular indirect ophthalmoscopy is 13:08:14

1 typically with scleral depression. In patients who 13:08:19
2 you're not sure or the exam is challenging, there are 13:08:22
3 supplementary methods to diagnose a tear. One would be 13:08:25
4 an ultra wide-field fundus photography. And then 13:08:30
5 secondarily, sometimes you can pick it up on a B-scan 13:08:34
6 ultrasound as well. 13:08:36
7 Q. Are you aware of whether or not in March of 2018 13:08:38
8 Dr. Loo had ultra wide fundus photography available in 13:08:44
9 his office? 13:08:50
10 A. I'm not aware. I don't see any of those types of 13:08:51
11 pictures in the records available to me. 13:08:55
12 Q. In your opinion and in your experience, are 13:08:58
13 retinal tears always visible on exam? 13:09:00
14 A. So they're not always visible on exam. They're 13:09:03
15 not always visible on ultra wide-field fundus 13:09:08
16 photography, and they're not always visible on 13:09:13
17 ultrasound. 13:09:15
18 Q. Are there some tears that are only seen under a 13:09:16
19 surgical microscope? 13:09:19
20 A. That is definitely true. There are sometimes 13:09:21
21 small tears which can be very difficult to find in the 13:09:24
22 clinic that we'd only be able to find in the operating 13:09:29
23 room under surgical microscope. 13:09:32
24 Q. We've heard a little bit about how scleral 13:09:35
25 depression is performed. Would you mind just to briefly 13:09:41

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1 remind us how a provider such as yourself would perform 13:09:44
2 that exam? 13:09:48
3 A. So typically a patient's in the exam chair and 13:09:49
4 they're reclined. You as the provider are wearing some 13:09:52
5 method of endograft ophthalmoscope, which is a light 13:09:56
6 source and sort of binoculars for both eyes, and then in 13:09:59
7 one hand you hold an indirect condensing lens; in the 13:10:01
8 other hand you have a scleral depressor. 13:10:06
9 Depending on where you're looking in the eye, the 13:10:09
10 patient looks in that direction, and then you basically 13:10:09
11 have to push and depress the eye, either on the eye 13:10:11
12 itself or through the eyelids to bring the peripheral 13:10:15
13 portion of the retina into view so that you can actually 13:10:19
14 see it. 13:10:22
15 Q. Do you do it just in one part of the eye or do 13:10:22
16 you do it in multiple parts of the eye? 13:10:25
17 A. So yeah. You have to do each sort of gaze 13:10:27
18 direction. I typically break it up into about nine 13:10:32
19 directions, but patient is looking up off to the side 13:10:36
20 and all the way around, 360 degrees. They have to be 13:10:39
21 fairly cooperative with an exam like that. 13:10:42
22 Q. The scleral depression exam, can that be 13:10:46
23 uncomfortable for some patients? 13:10:49
24 A. It can be. Especially for patients who are 13:10:51
25 photosensitive and some patients are also sensitive to 13:10:54

1 the pressure. It's an unusual sensation. It's 13:10:56
2 definitely not a thing that is comparable in daily life. 13:10:56
3 I mean, I've had it performed on myself when I had a 13:11:00
4 floater. It's definitely uncomfortable. 13:11:03
5 Q. You said photosensitive. That means sensitivity 13:11:05
6 to light? 13:11:10
7 A. Yeah. This is a little bit variable across 13:11:11
8 patients. Some patients, you can shine a bright light 13:11:13
9 at them and they won't flinch. Other patients can 13:11:16
10 barely tolerate it and they're squirming around the 13:11:20
11 entire time. 13:11:24
12 Q. The ability to perform the scleral depression or 13:11:24
13 to see the retina via scleral depression can in some way 13:11:27
14 depend on the patient's ability to tolerate it? 13:11:32
15 A. Yeah. So the patient's cooperation is sort of 13:11:35
16 paramount to the successful sort of dilated exam with 13:11:37
17 depression. There are also patient factors which can 13:11:40
18 contribute as well. For instance, if they have a 13:11:46
19 cataract or if they have corneal edema, they have a 13:11:48
20 pathology that can make it hard. I think in this 13:11:51
21 patient's case she had cataract surgery already, and 13:11:52
22 then she had a posterior capsular opacification which 13:11:56
23 has been opened with the YAG, so there's probably some 13:11:58
24 residual capsular opacification that could have made 13:12:02
25 that exam challenging as well. 13:12:05

1 Q. Speaking of the patient's prior ocular history, 13:12:06
2 does whether or not a patient has an artificial lens 13:12:15
3 potentially impact your ability to see a retinal tear? 13:12:19
4 A. Sometimes, yes. Even just having the edge of the 13:12:22
5 lens -- the edge of the lens can sometimes obscure your 13:12:24
6 view, so that can sometimes impact the exam as well. 13:12:28
7 Q. Did this patient have an artificial lens in the 13:12:32
8 left eye in March of 2018? 13:12:35
9 A. She did. She actually had a specific type of 13:12:38
10 intraocular implant called a Crystalens. 13:12:40
11 Q. What is the significance of the fact that she had 13:12:45
12 a Crystalens compared to a different type? 13:12:47
13 A. Crystalens has sort of -- it's like a rectangular 13:12:49
14 shape and it has these little sort of feet at the very 13:12:54
15 end. Those feet have like a brown color, and that 13:12:58
16 opacity can also sometimes obscure your peripheral view. 13:13:02
17 Q. We talked a little bit about the wide-field 13:13:07
18 fundus photography and other imaging that might be able 13:13:14
19 to aid in diagnosing a retinal tear. What is a B-scan 13:13:18
20 ultrasound? 13:13:22
21 A. A B-scan ultrasound is essentially a 13:13:23
22 two-dimensional ultrasound slice through the eye. It's 13:13:27
23 an imperfect exam in the sense that the eye is three 13:13:32
24 dimensions but the ultrasound is only two-dimensional. 13:13:37
25 Q. Can a B-scan ultrasound aid in an attempt to 13:13:42

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1 locate or identify a retinal tear? 13:13:45
2 A. It can sometimes. I think it takes an 13:13:48
3 experienced provider to find a small tear. It can be 13:13:51
4 very challenging. It's easy to miss. At UCLA even, we 13:13:54
5 have a dedicated professional ultrasonographer and 13:13:58
6 sometimes he misses tears too. 13:14:02
7 Q. We've heard a little bit about how retinal tears 13:14:06
8 can be repaired. We were told that they can be repaired 13:14:12
9 by a laser or a freeze method. Is that right? 13:14:16
10 A. Yes. Those would be the two sort of most common 13:14:20
11 options. 13:14:23
12 Q. Are those typically done in the office or a 13:14:24
13 surgical setting? 13:14:27
14 A. Those are typically done in the office. To do 13:14:28
15 that repair, you'd have to be able to identify the tear 13:14:33
16 and see it and sort of -- you would have to visualize 13:14:37
17 with the same -- excuse me -- with the same sort of 13:14:40
18 scleral depressed exam that you would do to find it, you 13:14:44
19 would use a similar exam to then perform the treatment. 13:14:48
20 Q. So could you take a patient -- or excuse me -- 13:14:51
21 could you laser a patient or prepare to freeze a patient 13:14:53
22 for a retinal tear based solely on a finding from an 13:14:58
23 optometrist? 13:15:02
24 A. No. I think it's incumbent on the treating 13:15:03
25 provider to ensure that the patient does in fact have 13:15:06

1 the pathology that needs to be treated to make the 13:15:09
2 diagnosis. Secondarily, if you can't see it, you can't 13:15:12
3 treat it. So you have to be able to see it to treat it. 13:15:15
4 Q. In your experience, are there occasions in which 13:15:18
5 someone such as an optometrist can think that they see a 13:15:24
6 retinal tear but it's actually not a tear? 13:15:27
7 A. There are times, for instance, that I've been 13:15:30
8 referred patients for retinal tears and the optometrist 13:15:33
9 has actually just been looking at either vitreoretinal 13:15:40
10 traction or just where the vitreous gel is pulling on 13:15:40
11 the retina, or lattice degeneration. Sometimes there's 13:15:44
12 no pathology at all. 13:15:47
13 Q. So the lattice degeneration, and then what was 13:15:48
14 the other thing you described? 13:15:53
15 A. Vitreoretinal traction or a cystic retinal tuft. 13:15:56
16 Something like that. 13:15:59
17 Q. Can that sometimes give the appearance of a tear? 13:15:59
18 A. They can sometimes. It's elevated. It looks a 13:16:02
19 little bit white, and so sometimes it can look like a 13:16:07
20 tear even though it's not a tear. 13:16:11
21 Q. Doctor, you should have a set of exhibits, and if 13:16:13
22 you could turn to Exhibit 5 from the Investigative 13:16:27
23 Committee's exhibit, and Exhibit 5 is the Center for 13:16:33
24 Sight records, and turn to Page 115. 13:16:36
25 A. Yes. 13:16:52

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1 Q. And do you see at the top of the page where it 13:16:52
2 says the exam date? 13:16:56
3 A. I just want to confirm with you that this is a 13:17:01
4 picture of an OCT on the left eye? Are we looking at 13:17:05
5 the same picture? 13:17:09
6 Q. Yeah. 13:17:10
7 A. Yes. On the copy of the OCT picture, the exam 13:17:10
8 date is 3/13/2018. 13:17:14
9 Q. At the bottom of the page where it says CC/HPI, 13:17:19
10 what is this section just in general in an exam note? 13:17:25
11 A. So CC/HPI is short for chief complaint and 13:17:28
12 history of present illness. This is sort of where one 13:17:33
13 would document the patient's complaints, what they're 13:17:37
14 coming in for, and then sort of based on the questions 13:17:39
15 you asked and the story they tell you. 13:17:43
16 Q. And what complaints did the patient report, 13:17:47
17 according to this note, on March 13, 2018? 13:17:50
18 A. So it sounds like she was walking and then she 13:17:52
19 had a sudden episode where her left eye vision went 13:17:55
20 cloudy and then subsequently felt like she was seeing 13:18:00
21 floaters and strings of gray. She additionally did have 13:18:03
22 a ring, like a flash ring of light in her vision. It 13:18:06
23 happened once the previous day. 13:18:10
24 Q. And then the last sentence on that page starts 13:18:11
25 with "OD vision." That's the right eye? 13:18:14

1 A. Yeah. OD is the right eye, yes. 13:18:17
2 Q. It says, "OD vision is clear and is seeing a 13:18:19
3 flutter in the upper right corner that is constantly 13:18:22
4 there." 13:18:25
5 Do you see that? 13:18:25
6 A. Yes. 13:18:26
7 Q. And do you understand that to be referring to the 13:18:27
8 right eye? 13:18:30
9 A. That's what it sounds like to me, yes. 13:18:30
10 Q. If you can turn to Page 0117 in that same 13:18:34
11 exhibit -- 13:18:47
12 A. Okay. 13:18:47
13 Q. -- do you see the section regarding intraocular 13:18:48
14 pressure? 13:18:51
15 A. I do, yes. 13:18:51
16 Q. And can you tell from this when her intraocular 13:18:52
17 pressure was measured on March 13, 2018? 13:18:57
18 A. They checked twice. They checked once at 2:03 13:19:00
19 and then a second time was at 2:31. 13:19:05
20 Q. Doctor, have you had an opportunity to review any 13:19:12
21 notes for this patient prior to March 13, 2018? 13:19:15
22 A. No, this is the first exam note that I have 13:19:22
23 available. 13:19:25
24 Q. If you can turn to the next page, 0118 -- 13:19:25
25 A. Okay. 13:19:33

1 Q. -- under the fundus exam for the left eye, 13:19:34
2 there's a reference, a plus sign in Shafer's. Do you 13:19:37
3 see that? 13:19:41
4 A. I do, yes. 13:19:41
5 Q. What is that? 13:19:42
6 A. Umm, so Shafer's sign is just a term used to 13:19:44
7 refer to seeing pigmented cells within the anterior 13:19:50
8 vitreous using the slit lamp microscope. So the 13:19:55
9 pigment -- sorry. Go ahead. 13:20:01
10 Q. Sorry. Didn't mean to interrupt you. 13:20:02
11 A. I was going to say that pigmented cell is just 13:20:04
12 pigmented cell. That can be from iris chafing, from 13:20:08
13 iris procedures, from cataract surgery. You can also 13:20:12
14 sometimes see it in the context of a retinal tear. 13:20:17
15 Q. Did this patient have any prior surgeries that 13:20:19
16 could lead to pigment noted as Shafer's? 13:20:22
17 A. It's possible. I mean, she did have a peripheral 13:20:28
18 iridectomy or iridotomy. It's not clear based off of 13:20:32
19 the records here, but she had essentially a hole induced 13:20:35
20 in her iris and that can release pigment. 13:20:37
21 She's also had the explantation of an implantable 13:20:41
22 contact lens. Even the placement of an implantable 13:20:44
23 contact lens, it's basically a lens that's sitting right 13:20:48
24 behind the iris. It often causes iris chafing, iris 13:20:51
25 rubbing, which can release pigment, and it certainly -- 13:20:53

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1 when you explant a lens, that also induces iris trauma. 13:20:56
2 And then having regular, run-of-the-mill cataract 13:21:00
3 surgery can sometimes also release iris pigment to cause 13:21:03
4 a Shafer's sign like this. 13:21:05
5 So she's had at least a few procedures which 13:21:08
6 could result in the release of iris pigment and then 13:21:12
7 pigment into the anterior vitreous. 13:21:13
8 Q. Since we don't have any records that predate 13:21:16
9 March 13, 2018, is there any way for you to say with any 13:21:19
10 degree of certainty whether this notation of positive 13:21:23
11 Shafer's is a new finding? 13:21:24
12 A. No, it's not possible. 13:21:25
13 Q. Still on this same page, did the optometrist 13:21:27
14 document a tear in the left eye? 13:21:41
15 A. Yes. This document, optometrist documented a 13:21:42
16 superotemporal horseshoe tear in the left eye. 13:21:47
17 Q. We've heard a little bit today about where the 13:21:49
18 superotemporal would be, and that would be away from the 13:21:53
19 nose. Is that right? 13:21:58
20 A. Yes. It would be away from the nose in the left 13:21:59
21 eye. 13:22:03
22 Q. Can you tell from looking at this March 13, 2018 13:22:03
23 note when the assessment or plan was documented? 13:22:13
24 A. Yeah. I was looking at that. I don't see it. I 13:22:17
25 mean, a lot of times electronic medical records do have 13:22:21

1 a timestamp when you sign them, but I don't see them. 13:22:24
2 It may have been cut off at the very bottom here where 13:22:29
3 the scan is cut off, but I don't see an obvious notation 13:22:31
4 of the time. 13:22:35
5 Q. Were you able to see any obvious notation of the 13:22:35
6 time when the note was signed? 13:22:38
7 A. No. 13:22:40
8 Q. Did you see anything in your review of the 13:22:46
9 materials to indicate that this note or any other 13:22:49
10 written documentation was sent from the Center for Sight 13:22:52
11 to Dr. Loo's office on March 13, 2018? 13:22:56
12 A. I just see that it was documented that they were 13:22:59
13 going to refer her to a retinal provider, but it doesn't 13:23:06
14 say that they transmitted these notes or made any phone 13:23:10
15 calls. 13:23:13
16 Q. And if you can turn -- so it's the Investigative 13:23:14
17 Committee's Exhibit 4, and this is the records from 13:23:25
18 Retina Consultants of Nevada. And turn to NSBME Page 34 13:23:27
19 and let me know when you're there. 13:23:34
20 A. I'm there. 13:23:36
21 Q. Excuse me. Page 35. 13:23:37
22 A. 35. Okay. 13:23:44
23 Q. Do you see any documentation of the patient's 13:23:48
24 chief complaint for this visit? 13:23:51
25 A. Here it states at the top of the page that 13:23:53

1 patient is complaining of flashes when the eyes move, 13:23:57
2 and it sounds like it's been going on for two days. 13:24:01
3 Q. And the chief complaint, that's essentially the 13:24:04
4 reason why the patient's there? 13:24:09
5 A. Yes. So this -- the chief complaint is typically 13:24:11
6 reserved for the patient's statement of why they are 13:24:14
7 there in the office that day. Sorry. I'm a little bit 13:24:17
8 incomplete there. I see that it's split onto two lines. 13:24:20
9 It says the visual acuity got cloudy, floaters, and veil 13:24:23
10 over eye. 13:24:30
11 Q. Did you see in your review of the records that 13:24:30
12 Dr. Loo obtained OCTs at this visit? 13:24:33
13 A. Yes. There was an OCT picture from this visit. 13:24:38
14 Q. Was that appropriate for him to do? 13:24:44
15 A. Yes. I think so. It's reasonable for evaluating 13:24:46
16 anyone coming into a retina clinic with an OCT. Gives 13:24:51
17 you sort of a microscopic little analysis of the retinal 13:24:56
18 anatomy, helps explain any drop in vision, and can help 13:25:00
19 with any sort of analysis of what's going on with the 13:25:04
20 patient that day. 13:25:06
21 Q. Sorry. Let me take a step back. The patient's 13:25:07
22 complaint of flashes and floaters, are those in and of 13:25:16
23 themselves indicative of a retinal tear? 13:25:21
24 A. No. I mean, flashes are indicative of vitreal 13:25:24
25 traction that can also be common in the setting of, say, 13:25:30

1 intraocular inflammation or retinal degeneration for 13:25:33
2 other reasons, so it's not specific to a retinal tear. 13:25:36
3 And floaters as well can just happen in any 13:25:40
4 normal person who has vitreous syneresis or early 13:25:43
5 degeneration of the vitreous gel. It can also be a sign 13:25:48
6 of bleeding or inflammation or infection inside the eye. 13:25:53
7 So again, not specific to a retinal tear. 13:25:54
8 Q. I'm sorry I skipped this. When we were looking 13:25:56
9 at the optometrist's note from March 13, 2018, did you 13:25:59
10 see any documentation of a posterior vitreous 13:26:04
11 detachment? 13:26:09
12 A. No, I did not. That was not documented. 13:26:09
13 Q. Based upon your review of the records, 13:26:13
14 specifically NSBME 0034, do you see where the 13:26:22
15 intraocular pressure is measured? 13:26:30
16 A. I do. Here it's measured, I think, 3:53, so 13:26:32
17 almost 4 o'clock. 13:26:39
18 Q. Was it appropriate to measure the patient's 13:26:40
19 intraocular pressure? 13:26:43
20 A. It's always important to sort of complete a full 13:26:44
21 exam, especially when seeing a new patient. It's 13:26:47
22 important to keep in mind this patient has been dilated 13:26:50
23 already, so any drop in her pressure could be 13:26:54
24 artificially elevated just by that process. It's 13:26:56
25 important to make sure you're doing a complete, thorough 13:27:00

1 exam for every patient, and that includes intraocular 13:27:03
2 pressure. 13:27:07
3 Q. Doctor, if I can ask you to assume hypothetically 13:27:07
4 that the patient was given additional dilating drops at 13:27:10
5 Dr. Loo's office, would that have been reasonable? 13:27:14
6 A. Yes. I mean, it's been potentially a couple 13:27:17
7 hours since they were seen in the previous provider's 13:27:21
8 office and just to make sure that you get good dilation, 13:27:25
9 to do the best you can at a dilating exam of the retinal 13:27:29
10 periphery, then it's reasonable to dilate the patient 13:27:30
11 again, yes. 13:27:33
12 Q. And did Dr. Loo perform a dilated exam? 13:27:34
13 A. So here it's documented that dilation eye drops 13:27:38
14 were placed, and then based on the exam and fundus 13:27:43
15 drawing, it sounds like a dilated exam was performed. 13:27:47
16 Q. Did you see indication in the record that Dr. Loo 13:27:50
17 obtained a B-scan ultrasound? 13:27:59
18 A. Yes. Umm, it sounds like it's documented here in 13:28:01
19 the bottom right corner on this Page 34. Shorthand says 13:28:07
20 ultrasound left eye, no RD. 13:28:12
21 Q. Was it appropriate for him to obtain that 13:28:15
22 ultrasound? 13:28:20
23 A. I think it's important for a couple reasons. Any 13:28:20
24 time someone comes in with vitreous opacities, 13:28:24
25 ultrasound can help you identify those vitreous 13:28:29

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1 opacities, can help you understand whether or not a 13:28:29
2 patient has a posterior vitreous detachment or not. It 13:28:33
3 can sometimes find a retinal tear. In this case, I 13:28:35
4 think the most important thing is to rule out retinal 13:28:38
5 detachment, which in this case was done. 13:28:39
6 Q. Other than the physical exam, the OCT, the B-scan 13:28:41
7 ultrasound, in your opinion, was there anything else 13:28:49
8 that Dr. Loo could have done to try and find a retinal 13:28:53
9 tear? 13:28:57
10 A. I don't think so. I mean, the most important 13:29:00
11 thing -- I think the gold standard is the dilated 13:29:02
12 indirect ophthalmoscopy with scleral depression. And 13:29:08
13 then everything else is sort of supplemental to 13:29:09
14 ultrasound or even ultra wide-field fundus photography 13:29:13
15 because all of the imaging modalities can have 13:29:14
16 artifacts, can be obscured by sort of -- imaging can be 13:29:17
17 often obscured by, like, the eyelids, per se. 13:29:20
18 So I think the gold standard is always going to 13:29:22
19 be an exam, and Dr. Loo did a peripheral dilated exam. 13:29:24
20 He did it with scleral depression and even went so far 13:29:29
21 as to get an ultrasound as well to supplement his 13:29:34
22 initial exam. I can't think of anything else that one 13:29:37
23 could do in this situation. 13:29:44
24 Q. If after like in this case you do an exam, you 13:29:46
25 obtain the ultrasound, do an OCT, but you're not seeing 13:29:48

1 a retinal tear, if it turns out that a retinal tear was 13:29:53
2 present but you didn't see it, do you have an opinion as 13:29:57
3 to whether that's malpractice? 13:30:01
4 A. I really don't feel like that's malpractice. I 13:30:02
5 mean, it's possible to miss tears. I think for any 13:30:07
6 retinal provider it's incumbent on them to do their best 13:30:11
7 to make sure that the exam is complete and thorough and 13:30:17
8 done to the best of their ability given the constraints 13:30:17
9 of the situation, whether it's patient compliance or 13:30:19
10 other ocular comorbidities. 13:30:22
11 So I think having done sort of this exam, 13:30:24
12 especially with scleral depression, I can't think of 13:30:28
13 anything else that one could do to sort of find or 13:30:32
14 diagnose a tear. So I do not think that Dr. Loo 13:30:36
15 exhibited malpractice in this situation. 13:30:39
16 Q. There's been suggestion today that one thing that 13:30:42
17 could have been done is Dr. Loo could have called the 13:30:45
18 optometrist. Do you have an opinion as to whether by 13:30:48
19 the time Dr. Loo has finished his exam, if he called the 13:30:53
20 optometrist and he would have been able to get ahold of 13:30:57
21 her? 13:31:01
22 A. It's difficult to say. I think sort of 13:31:02
23 correspondence between providers is a two-way street. 13:31:05
24 Certainly as a referring provider, I try and provide the 13:31:09
25 person I'm referring to complete documentation. And 13:31:12

1 then when I'm being referred to, I try and have my staff 13:31:16
2 try and obtain complete documentation, whether that's 13:31:19
3 through the patient or directly from the clinic. For 13:31:22
4 instance, here in our office, the office staff will call 13:31:26
5 the referring provider and ask them to send over any 13:31:28
6 notes available. 13:31:32
7 It's difficult to say. Sounds like this might 13:31:32
8 have been an end-of-the-day kind of situation. This 13:31:35
9 patient's not arriving in Dr. Loo's office for 13:31:37
10 evaluation until almost 4 o'clock. So it can be hard 13:31:43
11 sometimes in the flow of a regular clinic day which is 13:31:45
12 very busy to get those records obtained in real time. 13:31:47
13 We often have to rely on our office staff to help with 13:31:50
14 that. It can be very challenging. 13:31:54
15 Q. If your office staff requests that the referring 13:31:54
16 provider send over records but you don't receive them, 13:31:57
17 would you then refuse to see the patient? 13:32:01
18 A. No. I think that the patient's coming to you 13:32:03
19 with a very specific complaint, and regardless of the 13:32:07
20 records coming to you, you're going to be doing your own 13:32:10
21 exam to try and confirm or find additional pathology. 13:32:13
22 And so the other outside records are helpful, I think, 13:32:16
23 but in this case you're always responsible for 13:32:20
24 reevaluating the patient and sort of determining your 13:32:23
25 own assessment and plan. 13:32:26

1 Q. Even if Dr. Loo had the optometrist's note 13:32:28
2 indicating that she thought she saw a horseshoe tear, 13:32:32
3 would Dr. Loo still have to do his own exam? 13:32:36
4 A. He'd have to do his own exam. I don't think his 13:32:39
5 exam would have been any different. The methodologies 13:32:42
6 that he would have used for his exam would not have been 13:32:45
7 any different with or without the other provider's 13:32:48
8 documentation. 13:32:52
9 Q. Doctor, if you can go back to Exhibit 5 and turn 13:32:56
10 to Page NSBME 109 and let me know when you're there. 13:33:01
11 A. Okay. Yes. 109. 13:33:08
12 Q. Do you see in the intraocular pressure 13:33:21
13 measurements the entry No. 11 for the intraocular 13:33:26
14 pressure measurement, what time it was done on 3/14? 13:33:30
15 A. Sounds like -- this looks like it was done at 13:33:36
16 4:25. 13:33:40
17 Q. If you can turn to the next page, which is 110 -- 13:33:44
18 A. Okay. 13:33:51
19 Q. -- do you see any reference on this page or any 13:33:52
20 of the pages from this visit note on March 14th that a 13:33:57
21 posterior vitreous detachment was seen? 13:34:03
22 A. No, that is not documented here. 13:34:07
23 Q. How rare is it, if at all, to have a retinal tear 13:34:09
24 or detachment without a posterior vitreous detachment? 13:34:14
25 A. It is possible. The exact numbers or percentages 13:34:19

1 for that are not really well reported. It's possible. 13:34:22
2 It's relatively uncommon. 13:34:25
3 Q. Do you see any reference on this visit note we've 13:34:27
4 been looking at from March 14, 2018 that any hemorrhage 13:34:33
5 was seen? 13:34:37
6 A. No. There's no documentation of any hemorrhage 13:34:37
7 on this note. 13:34:45
8 Q. If you can turn back two pages to Page 108 -- 13:34:46
9 A. Okay. 13:35:00
10 Q. -- the visual acuity in the left eye on March 14, 13:35:01
11 2018 was what? 13:35:06
12 A. Here it's documented as being without correction 13:35:07
13 20/150 and (indiscernible) to 20/80. There's a column 13:35:13
14 next to it. The column heading is "Int w/o Rx." I 13:35:18
15 don't know exactly what that stands for shorthand, but 13:35:24
16 based on that recording, that measured vision, 13:35:28
17 potentially 20/20. But I am not sure what that stands 13:35:31
18 for. 13:35:38
19 Q. In the notes for that same entry, it states, 13:35:38
20 "Needs to look around the black spot to see the letters 13:35:41
21 down and to the out." 13:35:45
22 Do you see that? 13:35:46
23 A. I do, yes. 13:35:47
24 Q. Did you see anything written like that from the 13:35:47
25 day before? 13:35:51

1 A. No. Nothing like that was documented the day 13:35:51
2 before. 13:35:56
3 Q. Does that appear to be a change in the patient's 13:35:56
4 condition? 13:36:00
5 A. It does, yes. 13:36:00
6 Q. And the assessment by the provider who saw the 13:36:02
7 patient at Center for Sight on March 14th -- and this is 13:36:10
8 on Page 110. Sorry to jump around on you. 13:36:14
9 A. That's okay. 13:36:19
10 Q. -- is that there's a superior RD. Is that 13:36:20
11 retinal detachment? 13:36:24
12 A. Yes. 13:36:25
13 Q. With horseshoe tear. Macula appears to be on. 13:36:26
14 Do you see that? 13:36:31
15 A. Yes, I do. 13:36:32
16 Q. When Dr. Pezda sees the patient later that day, 13:36:33
17 what is his finding with respect to whether or not the 13:36:39
18 macula is on or off? 13:36:41
19 A. So when this patient saw Dr. Pezda later that 13:36:43
20 day, he documented a macula-off detachment. Actually, 13:36:48
21 you can see if you look at NSBME 0107, OCT is not 13:36:52
22 particularly good quality. It's a copy of a printout. 13:36:59
23 From this scan you can see that there's some retinal 13:37:01
24 fluid under the fovea that constitutes a macula-off 13:37:04
25 detachment, based on this photo. 13:37:09

1 Q. So perhaps -- 13:37:11
2 A. So that would be in line with Dr. Pezda's 13:37:15
3 assessment. 13:37:18
4 Q. Okay. And then Dr. Pezda's assessment, did he 13:37:18
5 see any evidence of vitreous hemorrhage? 13:37:33
6 A. He did. He did document inferior vitreous 13:37:36
7 hemorrhage on his exam. 13:37:41
8 Q. That was not documented by the provider who saw 13:37:42
9 the patient a few hours earlier at Center for Sight? 13:37:47
10 A. Yes. 13:37:50
11 Q. How does he describe the vitreous hemorrhage? 13:37:51
12 A. He described it as primarily here in the fundus 13:37:54
13 drawing on NSBME 0032. He just shades in a little bit 13:37:59
14 at the very bottom of the picture and then draws a line 13:38:05
15 to it, and then it's shorthand abbreviated VH. That's 13:38:11
16 typically vitreous hemorrhage. He does say in his 13:38:14
17 impression there's mild vitreous hemorrhage left eye. 13:38:18
18 Q. Would you turn to NSBME Page 81, please? 13:38:22
19 A. Page 81. This is the operative report for the 13:38:31
20 patient's surgery? 13:38:42
21 Q. Yes. 13:38:43
22 A. Okay. Yeah. I'm here. 13:38:44
23 Q. Okay. And so under the paragraph at the bottom 13:38:48
24 of the page -- it's about five lines -- it states 13:38:51
25 hemorrhage was -- excuse me. A couple lines down it 13:38:56

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1 says, "Endodiathermy was then used to mark the retinal 13:39:03
2 breaks." 13:39:09
3 Do you see that? 13:39:10
4 A. I do, yes. 13:39:11
5 Q. "The peripheral retina was then examined 13:39:11
6 360 degrees using scleral depression. No further 13:39:15
7 retinal breaks were found." 13:39:19
8 Do you see that? 13:39:21
9 A. I do, yes. 13:39:22
10 Q. Is a retinal break sometimes used synonymously 13:39:23
11 with retinal tear? 13:39:27
12 A. Yes. 13:39:29
13 Q. When Dr. Pezda refers to breaks, does that 13:39:29
14 indicate to you that it's more than one? 13:39:33
15 A. Yes. Yeah. Sounds like there may have been more 13:39:36
16 than one. 13:39:43
17 Q. And there may have been additional breaks or 13:39:44
18 tears that he didn't see in the office earlier that day? 13:39:47
19 A. Yes. I think based on his exam, he only 13:39:50
20 documented one. One tear. 13:39:53
21 Q. And is that unusual that you might find 13:39:55
22 additional tears under the surgical microscope that you 13:39:58
23 couldn't see in the office? 13:40:03
24 A. No, it's not unusual. Sometimes these tears can 13:40:05
25 be very small, especially in a patient who is 13:40:08

1 pseudophakic or has had cataract surgery. Those 13:40:12
2 patients are prone to having very small, hard-to-find 13:40:16
3 tears. 13:40:20
4 Q. Is there additional equipment or tools that you 13:40:20
5 have in the operating room to visualize those small 13:40:25
6 tears that are not available in the clinic setting? 13:40:29
7 A. You have a couple. Primarily the central 13:40:31
8 microscope has an ability to provide a lot of 13:40:37
9 magnification and, therefore, you can see small tears 13:40:39
10 more easily. Additionally, the patient is under 13:40:42
11 anesthesia and has some measure of sort of 13:40:44
12 immobilization of the eye so the eye is not moving so 13:40:48
13 you can control the eye and the direction of the eye. 13:40:49
14 That helps you sort of get good visualization of the 13:40:52
15 retinal periphery. Those are all factors that can help 13:40:56
16 identify retinal tears in surgery that are hard to find 13:41:00
17 in clinic. 13:41:04
18 Q. Doctor, based upon your review of the materials, 13:41:04
19 as well as your education, training, and background, do 13:41:08
20 you think that Dr. Loo used reasonable care when he 13:41:11
21 examined the patient? 13:41:16
22 A. I do, yes. 13:41:17
23 Q. Do you think Dr. Loo fell below the standard of 13:41:19
24 care by not diagnosing a retinal tear when he saw the 13:41:24
25 patient? 13:41:28

1 A. I do not. 13:41:28
2 Q. And why not? 13:41:29
3 A. I think -- I think in this situation, regardless 13:41:31
4 of what other people see, you have to do your own exam 13:41:35
5 and you can only go -- you can only make an assessment 13:41:39
6 and plan based off what you see that day. 13:41:43
7 So Dr. Loo did a full, thorough examination. He 13:41:46
8 additionally supplemented that with an ultrasound just 13:41:50
9 to make sure and double check. Sounds like this patient 13:41:54
10 may have been very difficult to examine and have other 13:41:57
11 ocular comorbidities which also made the exam 13:41:59
12 challenging, and so I think he did his due diligence in 13:42:02
13 trying to make sure he did the best he could to find out 13:42:05
14 if this patient had a retinal tear in front of him that 13:42:07
15 day. 13:42:11
16 I think he did a good exam and I think he 13:42:11
17 supplemented that with additional methodologies to try 13:42:14
18 and just double check everything. So I believe that he 13:42:17
19 went in line with the standard of care for a situation 13:42:20
20 like this. 13:42:23
21 MS. HUETH: Thank you, Doctor. Those are all my 13:42:25
22 questions for now. Mr. Cumings might have some 13:42:27
23 questions for you. 13:42:30
24 THE WITNESS: Sure. 13:42:32
25 MR. CUMINGS: Thank you, Ms. Hueth. 13:42:34

1 Ms. Halstead, may I proceed? 13:42:37
2 HEARING OFFICER HALSTEAD: (Moved head.) 13:42:40
3 CROSS-EXAMINATION 13:42:40
4 BY MR. CUMINGS: 13:42:40
5 Q. Doctor, how are you doing today, sir? 13:42:42
6 A. Well. Thank you. 13:42:44
7 Q. Good. I'd like to thank you for being here 13:42:46
8 today. I'm going to try to make this brief for you. 13:42:47
9 I see that you were working your fellowship until 13:42:49
10 2021. Is that correct? 13:42:52
11 A. Yes. 13:42:53
12 Q. Have you been seeing your own patients now? 13:42:54
13 A. Yes. 13:42:57
14 Q. For the last, what, two to three years? 13:42:58
15 A. Two to three years, yes. 13:43:01
16 Q. Have you performed any surgeries in that time? 13:43:03
17 A. Yes. 13:43:06
18 Q. How often are you in surgery? 13:43:06
19 A. I'm in surgery two days a week. I attend 13:43:09
20 surgeries at the county hospital and then I do my own 13:43:12
21 surgeries as well from my private clinic, so about two 13:43:16
22 days a week. 13:43:19
23 Q. Have you ever practiced in Nevada? 13:43:20
24 A. I have not. 13:43:22
25 Q. Where are you licensed at currently? 13:43:23

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1 A. California. 13:43:25
2 Q. Just California? 13:43:25
3 A. Yes. 13:43:26
4 Q. Okay. Have you ever read the Nevada Revised 13:43:27
5 Statutes Chapter 629 or 630? 13:43:32
6 A. I have not. 13:43:35
7 Q. Have you ever been charged with malpractice 13:43:36
8 previously? 13:43:41
9 A. No. 13:43:41
10 Q. Do you do a lot of expert witness work? 13:43:42
11 A. No. 13:43:46
12 Q. Have you ever done any expert witness work 13:43:47
13 testifying in cases such as these before? 13:43:50
14 A. I've done case reviews but I have not testified 13:43:53
15 yet. 13:43:57
16 Q. Have you ever met Dr. Loo in person? 13:43:57
17 A. No. 13:43:59
18 Q. Have you ever worked with him professionally in 13:43:59
19 any capacity? 13:44:02
20 A. No. 13:44:04
21 Q. Are you being paid to testify today? 13:44:04
22 A. Yes. 13:44:06
23 Q. I'd like to quickly touch on a few points 13:44:12
24 medically. I think you and our expert are in alignment 13:44:16
25 on a lot of these issues here. 13:44:20

1 Based upon a diagnosis on how long a tear is 13:44:23
2 present, do these things progress typically rapidly or 13:44:26
3 slowly? 13:44:31
4 A. So a tear happens, and once a tear happens, it 13:44:31
5 happens. Is that what you're asking? 13:44:38
6 Q. I think you had testified that you cannot tell 13:44:40
7 from looking at a tear how long that tear has been 13:44:44
8 present. Do you recall that? 13:44:47
9 A. Yes. Yes. I do, yeah. 13:44:49
10 Q. But once a tear happens, is it a rapid 13:44:50
11 progression to detachment or is it something that occurs 13:44:52
12 more slowly? 13:44:56
13 A. It can be either/or. We know that there's a 13:44:57
14 delayed rate of progression to retinal detachment. It 13:45:01
15 can be right away, but it can also be months or years 13:45:05
16 later. 13:45:09
17 Q. It's on the more rare side. Correct? 13:45:09
18 A. Yes. That is more rare. 13:45:11
19 Q. You said it was 8 to 16 percent of cases with a 13:45:13
20 tear result in a full detachment? 13:45:15
21 A. 8 to 16 percent of cases patients who have a 13:45:17
22 posterior vitreous detachment will develop a retinal 13:45:21
23 tear. If untreated, an untreated retinal tear has a 30 13:45:26
24 to 50 percent chance of progression to a retinal 13:45:28
25 detachment. 13:45:31

1 Q. You said the best ways to really diagnose a 13:45:32
2 retinal tear is with a scleral depression examination or 13:45:35
3 ultra wide-field fundus photography? 13:45:35
4 A. Typically I would say more in line with the exam, 13:45:39
5 because the ultra wide-field fundus picture, oftentimes 13:45:41
6 the patient's eyelid and eyelashes are in the way and 13:45:45
7 you don't see around the periphery as well as you'd like 13:45:46
8 anyways, but it can help as a supplement. 13:45:50
9 Q. So it's difficult doing a scleral depression 13:45:51
10 really to catch it affirmatively. Would you equate that 13:45:53
11 to luck? 13:45:57
12 A. No. Well, my -- I guess I would take a step back 13:45:57
13 and say that I think my statement was with regard to the 13:46:01
14 ultra wide-field fundus photography. Scleral depression 13:46:03
15 is not just luck but provider skill as well. 13:46:07
16 Q. Was ultra wide-field fundus photography widely 13:46:12
17 available in 2018? 13:46:16
18 A. Yes. It's an expensive machine, but it was 13:46:17
19 available at that time. 13:46:20
20 Q. And then you said you can also use OCT and a 13:46:20
21 B-scan. Correct? 13:46:24
22 A. OCT probably won't tell you if a patient has a 13:46:24
23 retinal tear, but a B-scan might. 13:46:28
24 Q. But it might. Right? 13:46:29
25 A. Might. 13:46:31

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1 Q. So you also said that your -- your office employs 13:46:32
2 a full-time ultrasonographer. Is that correct? 13:46:36
3 A. Yes. 13:46:40
4 Q. If a patient's been evaluated previously, say 13:46:42
5 in -- hypothetically, previously in the day, can that 13:46:46
6 make a subsequent exam that day less tolerable? 13:46:50
7 A. That's a good question. It should not change the 13:46:54
8 patient's ability to tolerate an exam. However, I will 13:46:58
9 say being anxious can. So this is a patient who has 13:47:01
10 anxiety and she has also just subsequently received news 13:47:06
11 that she has a tear in her retina. 13:47:12
12 Patient's comfort is not just sort of their 13:47:15
13 ability to tolerate the scleral depression or light, but 13:47:18
14 they have to be invested in the procedure to sort of 13:47:19
15 cooperate with you. For someone who's anxious and sort 13:47:20
16 of potentially emotional at that time, it can be very 13:47:24
17 challenging to work with the patient under the 13:47:26
18 circumstances. 13:47:27
19 Q. How do you receive them -- the bulk of your 13:47:27
20 patients? 13:47:31
21 A. I have referrals internally from other doctors at 13:47:31
22 UCLA. Also referred patients that are complex patients 13:47:34
23 from other retinal providers in the community for a 13:47:37
24 second opinion. And then we also have sort of -- sort 13:47:40
25 of screening-type exams that we do. We see patients 13:47:44

1 referred from internal medicine or endocrinology with 13:47:48
2 the UCLA system as well. 13:47:52
3 Q. Do you receive a lot of patients from 13:47:54
4 optometrists in the community? 13:47:56
5 A. A small portion, yes. 13:47:57
6 Q. A small portion but not a large amount of your 13:47:59
7 patients? 13:48:01
8 A. No, not the majority. 13:48:01
9 Q. Okay. Can floaters indicate a tear? 13:48:02
10 A. Floaters typically are not symptomatic for a 13:48:06
11 tear, but they can certainly happen in the context of a 13:48:11
12 posterior vitreous detachment or a vitreous syneresis. 13:48:18
13 Q. What about a complicated clinical presentation? 13:48:18
14 Say previous cataract surgery, nearsightedness, surgery 13:48:21
15 with a YAG laser? Can that be indicative of a possible 13:48:26
16 tear? Is that a risk factor? 13:48:32
17 A. So this patient is -- 13:48:35
18 Q. Just hypothetically, Doctor. 13:48:37
19 A. Hypothetically, a young myopic patient who has 13:48:40
20 had cataract surgery and a YAG laser, that's someone who 13:48:43
21 is at high risk for a posterior vitreous detachment at a 13:48:46
22 younger age. And then again, posterior vitreous 13:48:54
23 detachment comes with 8 to 16 percent risk of developing 13:48:54
24 a retinal tear. 13:48:56
25 Q. So if you had a complex presentation from a 13:48:56

1 patient that had a Crystalens previous surgery with a 13:48:58
2 YAG laser, floaters, and cataract surgery, then would 13:49:01
3 you characterize that patient as a complex presentation? 13:49:07
4 A. Sure. Yeah. It's not a standard presentation. 13:49:12
5 That's for sure. 13:49:14
6 Q. You said that B-scans, they're hard to diagnose a 13:49:15
7 torn retina. Correct? 13:49:22
8 A. Yes. It's doable, but it can be challenging. 13:49:24
9 Q. Even your expert sonographer misses them, you 13:49:28
10 said. Correct? 13:49:32
11 A. Correct. 13:49:33
12 Q. If you had a STAT referral from an optometrist 13:49:33
13 that had a diagnosed horseshoe tear from a patient, if 13:49:37
14 you were unable to find the tear yourself, would you 13:49:42
15 contact that provider? 13:49:45
16 A. That's the hard part. I don't know if Dr. Loo 13:49:47
17 knew this patient had a retinal tear when he saw her, 13:49:50
18 but certainly I would do everything in my power to make 13:49:52
19 sure that I could confirm that retinal tear. That's 13:49:56
20 exam, ultrasound, imaging otherwise. 13:49:58
21 I would, again, have my staff do the best they 13:50:00
22 could to sort of get those records as well. It's always 13:50:03
23 difficult. If at the very end of the day if we haven't 13:50:08
24 gotten the records, I might try calling myself sometimes 13:50:11
25 too, but at the very end of the day, if they're not 13:50:13

1 there and not available, it can be very challenging to 13:50:14
2 coordinate these complex patients, as you said. 13:50:18
3 Q. I agree. Would you look at a quick record for 13:50:21
4 me. I think we've already looked at it, but it was on 13:50:23
5 Page -- forgive me if I have to flip for a second. I 13:50:23
6 believe it was on Page 34, 35. 13:50:30
7 A. Yes. 13:50:39
8 Q. Looking at the OS side, do you see the fundus 13:50:39
9 diagram there? 13:50:43
10 A. I do, yes. 13:50:44
11 Q. You see below there, there's a handwritten box 13:50:45
12 with some handwriting scribbled in there? 13:50:52
13 A. Yes. In the very bottom right. 13:50:52
14 Q. What does that say? 13:50:53
15 A. Basically it says "U/S: OS no RD," which I would 13:50:54
16 interpret to mean ultrasound left eye no retinal 13:50:54
17 detachment. 13:51:01
18 Q. So a B-scan would be useful in determining if 13:51:01
19 there was retinal detachment but not necessarily 13:51:04
20 dispositive if there's a retinal tear? 13:51:07
21 A. Yes. 13:51:10
22 Q. Do you think that the presence of this note here 13:51:10
23 would indicate that he was looking for a detachment in 13:51:13
24 the left eye? 13:51:16
25 A. I mean, it's -- it's -- it's -- he performed an 13:51:17

1 ultrasound, which is a thorough analysis of the vitreous 13:51:21
2 situation, the vitreous anatomy with the retina looking 13:51:26
3 for tears and retinal detachments and such. 13:51:27
4 Q. Would you characterize an optometrist as a 13:51:30
5 retinal professional, an expert? 13:51:35
6 A. Based on training, they have training to do a 13:51:41
7 full, complete eye exam. They also have additional 13:51:44
8 training in sort of glasses and contacts. So they have 13:51:47
9 the ability to do a full exam, yes. 13:51:49
10 Q. But are they an expert in diagnosing them such as 13:51:52
11 somebody like yourself? 13:51:56
12 A. That's a good question, because there are 13:52:00
13 certainly very skilled optometrists out there. I think 13:52:01
14 it depends on the optometrists and their particular 13:52:04
15 experience. Because there are optometrists who do 13:52:08
16 specific specialized training in retina and retinal 13:52:09
17 exams as well, so it depends on the person's level of 13:52:11
18 training. 13:52:15
19 Q. Hypothetically, your C-level student of an 13:52:15
20 optometrist? 13:52:18
21 A. An average optometrist, I would say they are able 13:52:19
22 to do a full exam. I would always want to reconfirm any 13:52:21
23 findings that they suggest a patient might have. 13:52:27
24 Q. Certainly. So you said you have had cases where 13:52:29
25 they said there's a tear here but you weren't able to 13:52:32

1 find that tear. Correct? 13:52:36

2 A. Yes, that would be true. So based on the best of 13:52:37

3 my ability, imaging, etcetera, to make sure that I did 13:52:40

4 not find a tear. That is true. 13:52:43

5 Q. In such a case, would you schedule a follow-up 13:52:45

6 with that patient to ensure that you weren't missing 13:52:47

7 anything, that there was no change? 13:52:50

8 A. Yeah. So there's two things I would say. First, 13:52:53

9 I would tell that patient "You have to come back if you 13:52:56

10 have any changes in your symptoms. If you have new 13:52:59

11 flashing lights, new floaters, blind spots in your 13:53:01

12 vision, doesn't matter, we're available for you 24/7." 13:53:04

13 And then subsequent to that, I would say, "We should see 13:53:06

14 you in the next week or the week after, even three to 13:53:09

15 four weeks out," depending on my level of concern for 13:53:11

16 that patient. 13:53:14

17 Q. I agree. I think that's a wise thing to do. 13:53:14

18 In this case, you're aware that the patient did 13:53:19

19 have a retinal detachment. Correct? 13:53:21

20 A. Ultimately, yes. 13:53:23

21 Q. That occurred when? 13:53:24

22 A. It sounds like it happened the next day. 13:53:26

23 Q. Next day. Is it common that you'll have maybe a 13:53:29

24 vitreous detachment, no retinal tear, progress 13:53:33

25 immediately to a retinal detachment in that short period 13:53:37

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1 of time? 13:53:39
2 A. It can happen, yes. It's not common, but it can 13:53:39
3 happen. 13:53:43
4 Q. How rare would that be? 13:53:43
5 A. I don't think there are specific numbers to give 13:53:46
6 you for data-wise. In my personal experience, I've seen 13:53:48
7 it definitely happen more than just once or twice, but 13:53:51
8 the majority of cases, it -- typically they detach right 13:53:53
9 away or they detach later. But it can happen even a few 13:53:58
10 days afterwards if that was going to happen. 13:54:01
11 MR. CUMINGS: Doctor, I really appreciate your 13:54:04
12 time. I have no more questions for you at this moment. 13:54:05
13 Thank you for testifying today. I appreciate it. 13:54:08
14 THE WITNESS: You're welcome. 13:54:10
15 MS. HUETH: I just have a few follow-up, if 13:54:10
16 that's okay. 13:54:12
17 HEARING OFFICER HALSTEAD: Go ahead, Ms. Hueth. 13:54:13
18 REDIRECT EXAMINATION 13:54:13
19 BY MS. HUETH: 13:54:13
20 Q. Doctor, when in your education and training did 13:54:16
21 you first learn how to diagnose retinal tears? 13:54:21
22 A. That's something that we start from the very 13:54:24
23 beginning of residency, the first day we step into 13:54:25
24 residency, because we're seeing patients typically in 13:54:28
25 the emergency room. We get a lot of patients coming in 13:54:29

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1 for flashing lights and floaters, and so it's something 13:54:32
2 we start with right away. 13:54:35
3 Q. Since that time in your residency when you 13:54:37
4 learned to diagnose retinal tears, you're seeing 13:54:39
5 patients in the emergency room up until today, could you 13:54:42
6 give us an estimate of how much patients you've 13:54:46
7 diagnosed with a retinal tear? 13:54:48
8 A. Probably a few hundred. 13:54:50
9 Q. Just lastly, are you -- do you still have in 13:54:51
10 front of you NSBME 34? 13:55:02
11 A. I do. I'm on that page now. 13:55:04
12 Q. Do you see at the bottom of the page on the 13:55:06
13 left-hand side there is in all caps "REPORT"? 13:55:09
14 A. Yes. 13:55:13
15 Q. Then to the right it's circled "loss of vision"? 13:55:20
16 A. I do. I do see that, yes. 13:55:23
17 Q. If I represented to you that Dr. Loo will testify 13:55:25
18 that he told the patient to return if she had any 13:55:28
19 worsening vision, would you have any reason to dispute 13:55:33
20 that? 13:55:37
21 A. No, I would not. 13:55:37
22 MS. HUETH: Those are all my questions. Thank 13:55:44
23 you. 13:55:47
24 HEARING OFFICER HALSTEAD: Mr. Cumings, did you 13:55:49
25 have anything further? 13:55:52

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1 MR. CUMINGS: I have no Recross at this time. 13:55:52
2 Thank you, Doctor. 13:55:54
3 HEARING OFFICER HALSTEAD: Thank you for your 13:55:56
4 time, Doctor. 13:55:57
5 THE WITNESS: You're welcome. 13:55:59
6 HEARING OFFICER HALSTEAD: Ms. Hueth, are you 13:56:01
7 going to retain Dr. Hou for any reason? 13:56:02
8 MS. HUETH: No. 13:56:06
9 Thank you, Doctor. 13:56:07
10 THE WITNESS: You're welcome. 13:56:08
11 MR. CUMINGS: Have a great day, sir. 13:56:10
12 THE WITNESS: You too. Thank you. 13:56:13
13 Is it okay if I log off now? 13:56:13
14 MS. HUETH: Yes. Thank you. 13:56:15
15 HEARING OFFICER HALSTEAD: Do you have any 13:56:17
16 further witnesses, Ms. Hueth? 13:56:23
17 MS. HUETH: Yes. If no one needs a break, I will 13:56:26
18 call Dr. Loo. 13:56:29
19 HEARING OFFICER HALSTEAD: I actually would like 13:56:31
20 a little bit of a break. Let's come back at 2:10. 13:56:32
21 MS. HUETH: Okay. Thank you. 13:56:38
22 *** 13:56:39
23 (RECESS TAKEN FROM 1:56 P.M. TO 2:09 P.M.) 13:56:39
24 *** 14:09:56
25 HEARING OFFICER HALSTEAD: We'll go back on the 14:09:56

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1 record. Ms. Hueth, I note that you were going to call 14:09:59
2 Dr. Loo. Is that correct? 14:10:03
3 MS. HUETH: Yes. 14:10:06
4 HEARING OFFICER HALSTEAD: Dr. Loo, can I have
5 you raise your right hand, please.
6 Whereupon,
7 ROY HAN-HUI LOO, MD,
8 having first been called as a witness, was duly sworn
9 and testified as follows:
10 14:10:15
11 HEARING OFFICER HALSTEAD: Go ahead, Ms. Hueth. 14:10:15
12 MS. HUETH: Thank you. 14:10:15
13 DIRECT EXAMINATION 14:10:15
14 BY MS. HUETH: 14:10:15
15 Q. Dr. Loo, how long have you been practicing in 14:10:22
16 Nevada? 14:10:24
17 A. I came here in 2002, so I'm working in my 22nd 14:10:25
18 year here. 14:10:31
19 Q. And what is your specialty? 14:10:31
20 A. Vitreoretinal surgery. 14:10:34
21 Q. Where did you go to medical school? 14:10:36
22 A. Jefferson Medical College in Philadelphia. 14:10:37
23 Q. When did you graduate? 14:10:40
24 A. 1995. 14:10:42
25 Q. What made you want to go to medical school? 14:10:43

1 A. Just the thought of helping people and just 14:10:45
2 empathy. Just help people as much as I can. 14:10:57
3 Q. After graduating medical school, what did you do 14:11:00
4 next as far as medical education or training? 14:11:03
5 A. I served an internship at the Good Samaritan 14:11:05
6 Regional Medical Center in Phoenix. 14:11:09
7 Q. Did you have any particular area of focus during 14:11:12
8 that year? 14:11:16
9 A. No. It was general internal medicine. So 14:11:16
10 basically running around the hospital, taking care of 14:11:23
11 folks with stroke or heart attack or pneumonia, general 14:11:26
12 medical issues. 14:11:31
13 Q. After your internship, what did you do next? 14:11:33
14 A. I started an ophthalmology residency at the 14:11:39
15 Greater Baltimore Medical Center. 14:11:42
16 Q. And how long was your residency? 14:11:44
17 A. It was three years. 14:11:47
18 Q. When did you complete that? 14:11:48
19 A. That was in 1999. 1996 to 1999. 14:11:49
20 Q. The internship -- or excuse me, the residency in 14:11:56
21 ophthalmology, is that general ophthalmology, or did you 14:12:00
22 have a particular specialty in residency? 14:12:04
23 A. It was a general ophthalmology. 14:12:07
24 Q. After completing your residency, what did you do 14:12:10
25 next? 14:12:14

1 A. I served a retina fellowship in the vitreous of 14:12:14
2 the retina at the Bascom Palmer Eye Institute at the 14:12:23
3 University of Miami. 14:12:24
4 Q. What is the reputation of the Bascom Palmer Eye 14:12:25
5 Institute? 14:12:29
6 A. I think it's among the top rated programs in the 14:12:30
7 world, according to not just myself but I would say U.S. 14:12:36
8 News and World Report ranks it as No. 1. 14:12:41
9 Q. How long was your fellowship? 14:12:46
10 A. My particular fellowship was three years. The 14:12:48
11 first year was focused on medical retina. The second 14:12:51
12 year was more focused on vitreoretinal surgery. And the 14:12:58
13 third year I served as the chief to all the residents. 14:13:04
14 So I attended their surgeries and was part of their 14:13:08
15 mentorship, and I was pretty much their instructor to 14:13:14
16 them as well as the director of ocular trauma services 14:13:21
17 at the Bascom Palmer Eye Institute. 14:13:27
18 Q. How long were you the chief? 14:13:30
19 A. That was one year. 14:13:32
20 Q. When did you complete your fellowship? 14:13:33
21 A. I finished my fellowship in 2002. 14:13:35
22 Q. What made you decide to specialize in the retina? 14:13:39
23 A. Well, I think it's something you fall into. In 14:13:42
24 my opinion, it is -- it was some of the most satisfying 14:13:46
25 things that you can do to help a patient. It's very 14:13:54

1 challenging. Oftentimes the retina is thought of as the 14:13:58
2 last step between the patient and a pathologist, and it 14:14:03
3 is really some of the most beautiful views in all of 14:14:10
4 medicine that one can ever gaze upon. 14:14:14
5 Q. At what point in your education or training did 14:14:17
6 you first learn how to diagnose a retinal tear? 14:14:20
7 A. Again, as Dr. Hou mentioned, we first really 14:14:23
8 start to look at the retina in residency and to see 14:14:29
9 retinal tears then. 14:14:32
10 Q. Since your residency up until today, could you 14:14:34
11 give us an estimate of how many retinal tears you've 14:14:39
12 diagnosed? 14:14:43
13 A. There's so many, we're sure to have lost count. 14:14:44
14 There can be, you know, eyes with multiple, multiple 14:14:51
15 tears, so it's going to go into the tens of thousands of 14:14:56
16 retinal tears that I have seen. 14:15:00
17 Q. Could you estimate in a given week or month how 14:15:02
18 many times you're diagnosing a retinal tear? 14:15:05
19 A. Anywhere from, you know, the 10s to 100. 14:15:09
20 Somewhere in that range. 14:15:16
21 Q. Are you a member of any professional societies? 14:15:17
22 A. I am. The American Academy of Ophthalmology and 14:15:22
23 the American Society of Retinal Specialists. 14:15:26
24 Q. Is Dr. Friedlander a member of those societies as 14:15:30
25 well? 14:15:33

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1 A. I believe he mentioned he was. 14:15:33
2 Q. How about Dr. Hou? 14:15:35
3 A. Yes. I remember that. 14:15:37
4 Q. What did you do after you finished your 14:15:38
5 fellowship? 14:15:40
6 A. It was time to apply for -- for a job, for a 14:15:41
7 permanent place to spend my career, so I chose private 14:15:48
8 practice and that's how I ended up here in Las Vegas. 14:15:53
9 Q. How did you choose Las Vegas? 14:15:58
10 A. It was one of the more rapidly growing cities in 14:16:00
11 the United States. Henderson, at the time. So lots of 14:16:04
12 opportunity. Opportunity to serve. 14:16:09
13 Q. You said you came to Las Vegas when? 14:16:15
14 A. 2002. 14:16:17
15 Q. Have you been practicing here ever since? 14:16:19
16 A. Yes. 14:16:23
17 Q. Have you ever testified or defended your care and 14:16:23
18 treatment in a formal hearing like this before? 14:16:30
19 A. Never. 14:16:33
20 Q. Have you had a chance to review the formal 14:16:34
21 complaint that was filed in this matter? 14:16:37
22 A. Yes. 14:16:40
23 Q. Are you aware that the first count alleges 14:16:40
24 malpractice? 14:16:57
25 A. Yes. 14:16:58

1 Q. I believe you should have a copy of that 14:16:58
2 Complaint. It's the Board's Exhibit 3 as well as the 14:17:05
3 Respondent's exhibit -- the number is Exhibit 2, so 14:17:14
4 probably the second tab in your binder of materials. If 14:17:27
5 you could turn to Paragraph 10, do you see that it 14:17:34
6 defines malpractice as "the failure of a physician, in 14:17:47
7 treating a patient, to use the reasonable care, skill, 14:17:51
8 or knowledge ordinarily used under similar 14:17:54
9 circumstances"? 14:17:57
10 A. Yes. 14:17:57
11 Q. The Complaint alleges that you committed 14:17:58
12 malpractice by failing to diagnose and treat the 14:18:01
13 patient's retinal tear, leading to detachment of the 14:18:04
14 retina in the patient's left eye. Do you see that? 14:18:08
15 A. Yes. 14:18:12
16 Q. In your opinion, Doctor, did you commit 14:18:12
17 malpractice? 14:18:15
18 A. No. 14:18:16
19 Q. Do all -- let me take a step back. 14:18:16
20 What is the relationship, if any, between the 14:18:27
21 posterior vitreous and the retina? 14:18:30
22 A. Well, again, as mentioned previously, the 14:18:32
23 vitreous is the jelly-like substance that fills the 14:18:36
24 center of the eye. It has a consistency and clarity of 14:18:40
25 about raw egg white. As we go through life though, it 14:18:45

1 does liquefy and contract. The retina is the tissue 14:18:49
2 that lines the back of the eye that acts very much like 14:18:53
3 the film of a camera. 14:18:57
4 Q. Can the posterior vitreous detach? 14:18:58
5 A. Yes. 14:19:02
6 Q. And when that happens, does it always lead to a 14:19:02
7 retinal tear? 14:19:05
8 A. Not always. 14:19:06
9 Q. What is a retinal tear? 14:19:07
10 A. A retinal tear is where the vitreous may have an 14:19:14
11 abnormal attachment, and as that vitreous contracts, it 14:19:21
12 can pull on the retina and cause a tear, basically a 14:19:26
13 discontinuity of the retina. 14:19:31
14 Q. And how is it diagnosed in the clinic or office 14:19:32
15 setting? 14:19:35
16 A. I would agree with the other experts so far that 14:19:36
17 usually the best way to observe a tear is to look 14:19:39
18 physically with the headlamp, the indirect 14:19:44
19 ophthalmoscope, in combination with depression of the 14:19:49
20 eye to bring the very most peripheral retina into view. 14:19:54
21 Q. And we've heard quite a bit about how scleral 14:19:59
22 depression is performed. Just very briefly, can you 14:20:04
23 describe for us how you typically perform it? 14:20:07
24 A. Again, it's with the indirect ophthalmoscope, 14:20:10
25 placing that, basically, headlamp in front of our eyes, 14:20:15

1 and then with one hand we -- we focus that light with 14:20:18
2 the condensing lens onto the inside of a patient's eye. 14:20:23
3 We would have the patient look in a direction that we 14:20:27
4 would want to observe a retinal tear in that particular 14:20:30
5 area, while at the same time using a scleral depressor, 14:20:34
6 which is basically a metal instrument, kind of a 14:20:40
7 rod-shaped stick, if you will, to as gently as possible 14:20:44
8 but still requires some amount of decent force to deform 14:20:49
9 the eye to -- the anterior part of the eye to bring that 14:20:54
10 retina into view that would otherwise not be visible 14:21:00
11 just with indirect ophthalmoscopy alone. 14:21:05
12 Q. Why does it require that pressure? 14:21:08
13 A. It's -- has to do with the geometry of the eye. 14:21:10
14 The iris, even though if it's fully dilated, still 14:21:15
15 prevents a view to the very, very far periphery without 14:21:21
16 a little assistance from the scleral depressor. 14:21:25
17 Q. In your experience can patients find that scleral 14:21:30
18 depression uncomfortable? 14:21:39
19 A. As we've heard from the other experts also, the 14:21:42
20 answer is yes. It is oftentimes uncomfortable. We try 14:21:45
21 to be gentle about it; we try to be compassionate about 14:21:49
22 it, but it is the most ideal way to -- I wish we could 14:21:52
23 have a more comfortable way every single time, but 14:21:57
24 that's the gold standard. 14:22:00
25 Q. Do retinal tears typically cause pain? 14:22:02

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1 A. Typically, not. 14:22:08
2 Q. Based upon examination of a patient, can you tell 14:22:10
3 how long a retinal tear has been present? 14:22:15
4 A. In general, no. Unless the retinal tear 14:22:18
5 sometimes has been there chronically over months, years, 14:22:22
6 something like that. Sometimes we might see a little 14:22:26
7 bit of pigment around the tear, but we can never say for 14:22:30
8 certain exactly when that tear occurred. 14:22:33
9 Q. How are retinal tears treated? 14:22:35
10 A. As mentioned before, oftentimes in the clinic if 14:22:37
11 it's just a retinal tear alone, we can apply laser 14:22:43
12 phototherapy around that retinal tear. Basically kind 14:22:49
13 of a welding process with light. But other times -- an 14:22:52
14 older -- older method of treatment was to use the 14:22:58
15 freezing -- freezing-type treatment. 14:23:01
16 Q. Does the laser treatment or the freezing-type 14:23:06
17 treatment of a retinal tear guarantee that the patient 14:23:09
18 won't go on to develop a retinal detachment? 14:23:12
19 A. Unfortunately, in medicine there's not too many 14:23:16
20 guarantees, so the answer to that is no. It does not 14:23:20
21 guarantee. 14:23:23
22 Q. In your experience, are there sometimes findings 14:23:23
23 that can look like a retinal tear but aren't? 14:23:28
24 A. Absolutely. So a lot of times, you know, just 14:23:31
25 like patients will have pigmentation, alterations on 14:23:37

1 their skin, turns out you can have pigmentary 14:23:42
2 alterations on the inside of the eye as well. So 14:23:46
3 something that -- pigment configuration that looks like 14:23:48
4 a horseshoe or otherwise a retinal break or tear can 14:23:53
5 occur. 14:23:57
6 Other items, as mentioned, lattice alterations or 14:23:58
7 cystic retinal tufts or transitional alterations on the 14:24:03
8 retina can look like a retinal tear that aren't really 14:24:07
9 tears. 14:24:10
10 Q. Moving on specifically to this patient, when did 14:24:10
11 you first see her? 14:24:15
12 A. I saw her on 3/13/2018 is when I saw her. 14:24:16
13 Q. Did she have a regularly scheduled appointment to 14:24:31
14 see you? 14:24:35
15 A. No. She was added onto my schedule late in the 14:24:36
16 day. 14:24:44
17 Q. When you saw the patient, did you have an 14:24:44
18 understanding as to who referred her? 14:24:45
19 A. We get a kind of preprinted blank exam sheet, and 14:24:48
20 the referring doctor's name looked like it was printed 14:24:59
21 on there was Dr. Keel, optometrist. Local optometrist. 14:25:05
22 Q. Are you referring to your 3/13/18 note -- 14:25:09
23 A. Yes. 14:25:15
24 Q. -- which, for the record, is Bates stamped NSBME 14:25:19
25 35? 14:25:22

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1 A. Correct. 14:25:22
2 Q. Typically when an optometrist wants to send a 14:25:26
3 patient to you, will the optometrist contact you 14:25:29
4 directly? 14:25:33
5 A. Most of the times not, but sometimes, yes. 14:25:33
6 Q. If they don't contact you directly, would they 14:25:36
7 sometimes call your office? 14:25:40
8 A. Yes. 14:25:42
9 Q. And in March of 2018, did you have an expectation 14:25:43
10 as to what information your office staff would request 14:25:48
11 from a referring provider? 14:25:51
12 A. Usually it's the demographics like name, age, 14:25:52
13 identity information, as well as the purpose of the 14:25:58
14 visit and any clinic notes that may come with. A 14:26:04
15 written referral is often sent. 14:26:11
16 Q. Do you have any reason to believe that on 14:26:12
17 March 13, 2018 if a call was received by a staff member 14:26:15
18 from Center for Sight, that they would not have asked 14:26:19
19 for that same information? 14:26:22
20 A. I expect that they would have asked for it. 14:26:23
21 Q. In March of 2018, did you have independent access 14:26:25
22 to the Center for Sight chart? 14:26:30
23 A. No. 14:26:32
24 Q. By the time you saw the patient on March 13th, 14:26:33
25 2018, had you received any documents from the referring 14:26:42

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1 provider? 14:26:45
2 A. I did not. 14:26:45
3 Q. If we can take a look, do you have your visit 14:26:46
4 note in front of you? 14:26:52
5 A. Yes. 14:26:55
6 Q. I want to start with the exam sheet that the tech 14:26:56
7 completes, and that's Bates stamped NSBME 35. 14:27:00
8 A. Yes. 14:27:06
9 Q. First of all, what is the tech's role in the kind 14:27:07
10 of visit with the patient? 14:27:11
11 A. It's basically to gather initial information: 14:27:12
12 the patient's medical history, their associated 14:27:19
13 symptoms, their chief complaint, surgical history, 14:27:26
14 review of systems, and initial vision information and 14:27:32
15 intraocular pressure. 14:27:41
16 Q. The chief complaint, is that akin to -- from the 14:27:43
17 patient's perspective or in the patient's words, why 14:27:49
18 they're there to see you? 14:27:52
19 A. Yes. 14:27:53
20 Q. Did this patient tell you on March 13, 2018 that 14:27:54
21 her optometrist had diagnosed a horseshoe retinal tear? 14:27:57
22 A. No. 14:28:02
23 Q. According to the note, what did the patient 14:28:03
24 report as the reason for her visit? 14:28:06
25 A. According to our notes, as she noted, floaters 14:28:08

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1 and flashes and some cloudiness to the vision. 14:28:16
2 Q. The chief complaint in the note, is that the 14:28:22
3 documentation of why basically the patient's there? 14:28:25
4 A. Yes. 14:28:28
5 Q. Did the patient report any loss of peripheral 14:28:28
6 vision? 14:28:35
7 A. No. 14:28:36
8 Q. Did the patient report any pain or distortion? 14:28:37
9 A. No. 14:28:40
10 Q. Did the patient report to you that there was a 14:28:42
11 black spot that she had to look around in order to see? 14:28:44
12 A. No. 14:28:48
13 Q. Did the patient report, at least based on the 14:28:54
14 notes, headaches? 14:28:57
15 A. No. 14:28:58
16 Q. According to the note, were the patient's 14:29:08
17 intraocular pressures measured? 14:29:12
18 A. Yes. 14:29:14
19 Q. And can you tell at what time that was done? 14:29:14
20 A. Appears 3:53 in the afternoon. 14:29:17
21 Q. That's, just for the record, NSBME 34. 14:29:21
22 Were the patient's eyes dilated? 14:29:25
23 A. Yes. 14:29:29
24 Q. And typically, would that be done before or after 14:29:30
25 obtaining the intraocular pressure? 14:29:34

1 A. Typically after. 14:29:36
2 Q. Is there in general a period of time after 14:29:39
3 dilating drops are administered that you'll wait for 14:29:41
4 them kind of to take effect before you see the patient? 14:29:45
5 A. Typically about 45 minutes or so for optimum 14:29:47
6 dilation. Sometimes longer. 14:29:52
7 Q. So based upon the timeline of when the 14:29:54
8 intraocular pressure was measured, do you have an 14:29:57
9 estimate as to when you would have seen the patient? 14:30:01
10 A. I would say at the earliest, 4:30ish, if not 4:45 14:30:03
11 for the initial exam. 14:30:20
12 Q. Even though, as we just discussed, the tech might 14:30:21
13 get from the patient some history and the chief 14:30:24
14 complaint, would you still also ask the patient 14:30:27
15 questions? 14:30:30
16 A. Absolutely. 14:30:30
17 Q. And what is your custom and practice as far as 14:30:31
18 when you meet a new patient? You introduce yourself, 14:30:34
19 and what sorts of questions do you ask? 14:30:39
20 A. Indeed, I do introduce myself. I try to start 14:30:41
21 with general questions, such as "What brings you here 14:30:45
22 today," and we kind of refine those questions as the 14:30:49
23 examination proceeds. I might ask more detailed 14:30:52
24 questions back and forth between general and more 14:31:00
25 detailed questions. 14:31:06

1 Q. Did you perform a retina exam of the patient? 14:31:13
2 A. I did. 14:31:16
3 Q. Did that include the scleral compression? 14:31:16
4 A. As much of it as I could accomplish. Indeed, I 14:31:21
5 recall the patient -- it was obvious that I wasn't the 14:31:23
6 first person to examine the patient that day. And they 14:31:28
7 were somewhat anxious, exhausted from the previous 14:31:35
8 visit, and this now being their second or more visit to 14:31:41
9 have someone take a look at their retinas, they were 14:31:46
10 photosensitive to the light as well as the pressure from 14:31:53
11 the scleral depressor. 14:31:55
12 Q. Earlier, Mr. Cumings asked Dr. Friedlander about 14:32:00
13 your response to the allegation letter in which you 14:32:04
14 stated that your examination was limited as the patient 14:32:07
15 reported she could not tolerate keeping her eye open, 14:32:10
16 light sensitivity, and discomfort. 14:32:14
17 Do you remember Dr. Friedlander being asked those 14:32:17
18 questions? 14:32:20
19 A. I do. 14:32:21
20 Q. Now, Doctor, did you document in your note any 14:32:21
21 difficulty or limitations in the exam because of the 14:32:24
22 patient's discomfort? 14:32:28
23 A. I did not. 14:32:29
24 Q. And why not? 14:32:30
25 A. I don't know that it would have made the record 14:32:32

1 more complete. At the same time, I proceeded to 14:32:36
2 thoroughly investigate further by ordering additional 14:32:45
3 exams and testing. 14:32:50
4 Q. Do you have an understanding that sometimes 14:32:57
5 copies of your notes will be sent back to a referring 14:32:58
6 provider? 14:33:03
7 A. Sure. 14:33:03
8 Q. In your opinion, if your note reflected that the 14:33:04
9 patient's had difficulty tolerating the exam, would that 14:33:07
10 have impacted subsequent providers? 14:33:12
11 A. I don't know that it would have. 14:33:14
12 Q. Why do you say that? 14:33:15
13 A. Any given day a patient can be more or less 14:33:17
14 cooperative. There's so many things that influence the 14:33:21
15 quality of the exam, but we always try to provide the 14:33:31
16 best possible exam at the given time. 14:33:34
17 Q. Did you also obtain any imaging on March 13, 2018 14:33:36
18 of the patient? 14:33:46
19 A. I did. As mentioned, we obtained an OCT, an 14:33:46
20 optical coherence tomogram, as well as a B-scan 14:33:50
21 ultrasound. 14:33:56
22 Q. What is the OCT? 14:33:57
23 A. The OCT simply is simplified as a laser scan of 14:33:58
24 the -- of the most posterior portion of the retina. 14:34:05
25 Q. Why did you obtain OCT for this patient on 14:34:14

1 March 13th? 14:34:18

2 A. It's always a good idea for the obtaining of an 14:34:19

3 OCT for a retina patient. It lets you know about a lot 14:34:25

4 of things as far as the health of the retina in general. 14:34:28

5 It can reveal a lot of pathology just on its own or 14:34:41

6 explain why a patient may not be seeing as well as you 14:34:46

7 might want. 14:34:50

8 Q. Did you obtain a B-scan ultrasound for this 14:34:51

9 patient? 14:34:54

10 A. Yes. 14:34:55

11 Q. In the sequence or timeline of events of your 14:34:55

12 encounter with the patient, at what point are you 14:34:58

13 getting the B-scan ultrasound? 14:35:01

14 A. This would be near the end after -- after a 14:35:03

15 history and physical, first of all, after the 14:35:14

16 examination of the anterior portion of the eye with the 14:35:16

17 slit lamp, after a dilated fundus exam, after the OCT, a 14:35:21

18 B-scan ultrasound would be next. 14:35:33

19 Q. Based on your custom and practice as well as what 14:35:35

20 is documented in the note, can you give an estimate as 14:35:38

21 to what time of day it was when you obtained the B-scan 14:35:41

22 ultrasound? 14:35:45

23 A. It was easily after 5 o'clock. 14:35:46

24 Q. Did you have optometrist Dr. Keel's cell phone 14:35:47

25 number -- 14:35:53

1 A. I did not. 14:35:54

2 Q. -- at that time? 14:35:57

3 Do you obtain that B-scan ultrasound on every 14:35:57

4 patient? 14:36:00

5 A. I don't. 14:36:00

6 Q. And why did you obtain it in this case? 14:36:01

7 A. Basically, it was the patient's complaints. I 14:36:07

8 didn't want to be dismissive of her issues. I wanted to 14:36:10

9 be as absolutely thorough as possible. If anything 14:36:19

10 could pick up any amount of pathology, I wanted to 14:36:24

11 explore that avenue. 14:36:28

12 Q. And I'm sorry. Did you say, did you perform a 14:36:31

13 dilated fundus exam? 14:36:34

14 A. I did. 14:36:36

15 Q. What is a fundus exam? 14:36:37

16 A. A fundus exam is taking a look at the posterior 14:36:38

17 aspect of the eye. It doesn't just include the retina, 14:36:42

18 but it includes the retinal vasculature, the macula, 14:36:45

19 which is the portion of the retina that is responsible 14:36:51

20 for the very center of the vision; the optic nerve, as 14:36:54

21 well as looking at the vitreous. 14:36:58

22 Q. Based upon your dilated fundus exam, did you see 14:37:00

23 any evidence of hemorrhage in the eye? 14:37:09

24 A. I did not. 14:37:12

25 Q. Hemorrhage, is that just another word for 14:37:13

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1 bleeding? 14:37:16

2 A. I did not. 14:37:16

3 Q. Based upon your dilated fundus exam and the 14:37:18

4 ultrasound, just kind of the totality of your encounter 14:37:21

5 with the patient, did you see any indication of a 14:37:25

6 posterior vitreous detachment? 14:37:27

7 A. I did not. 14:37:30

8 Q. Did you see any indication on exam or imaging 14:37:31

9 that the patient had a retinal tear? 14:37:34

10 A. No. 14:37:37

11 Q. Earlier today we've been discussing Shafer's 14:37:48

12 sign? 14:37:52

13 A. Yes. 14:37:52

14 Q. When you examined the patient, did you see any 14:37:53

15 indication of Shafer's sign that you felt was indicative 14:37:56

16 of a retinal tear? 14:38:00

17 A. No. 14:38:02

18 Q. Did you see any evidence of a retinal detachment? 14:38:02

19 A. No. 14:38:11

20 Q. You talk a little bit about the limitations of 14:38:12

21 the B-scan ultrasound in detecting a tear. Are those 14:38:15

22 same limitations present if you're looking for a 14:38:20

23 detachment? 14:38:24

24 A. If a detachment is small enough, yes, it's 14:38:24

25 possible to miss it on an ultrasound as well, but it 14:38:28

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1 would be a little bit harder to miss. 14:38:32
2 Q. To miss the detachment? 14:38:33
3 A. Yes. 14:38:36
4 Q. With the ultrasound? 14:38:36
5 A. It's a little bit more obvious. A detachment is 14:38:37
6 a little bit more obvious, a little easier to see on a 14:38:41
7 B-scan than a retinal tear. Might be. Sometimes if a 14:38:46
8 retinal tear is large enough, you can actually see that 14:38:49
9 on an ultrasound as well. 14:38:52
10 Q. Based upon your examination of the patient, as 14:38:55
11 well as the imaging, what was your impression? 14:38:57
12 A. As far as I could tell, what I saw in the patient 14:38:59
13 was the floaters that she noted. I did agree with her 14:39:05
14 that she was seeing some floaters. I did confirm I see 14:39:11
15 those floaters as well. I didn't see any other 14:39:15
16 significant pathology. 14:39:19
17 Q. Floaters in which eye? 14:39:21
18 A. Both eyes, actually. 14:39:23
19 Q. Floaters, is that indicative of a retinal tear? 14:39:26
20 A. No. 14:39:30
21 Q. Are floaters normal? 14:39:30
22 A. Indeed. If more of an adult were to be taught 14:39:34
23 how to find their own floaters, they would be visible to 14:39:45
24 an observant adult. So yes, they're pretty typical, 14:39:51
25 pretty common. 14:39:56

1 Q. Did you have any recommendations for follow-up 14:39:56
2 for the patient? 14:40:01
3 A. My admonition to her was, you know, "Hey, listen, 14:40:02
4 this is what I see. This is what I find. I think, you 14:40:07
5 know, I don't see any horrific pathology, but I'm 14:40:10
6 concerned," and I mentioned to her -- I admonished her 14:40:17
7 that "You're allowed to stay the same. You're allowed 14:40:23
8 to improve in your vision symptoms, but certainly you're 14:40:26
9 not allowed to get any worse. Any worsening, we want 14:40:30
10 you to let us know about it and to return to get 14:40:34
11 reevaluated." 14:40:37
12 Q. There's reference in your note to -- it says 14:40:38
13 neuro ophth? 14:40:43
14 A. Yeah. Again, I didn't want to be dismissive of 14:40:43
15 her complaints, and I wanted to see if there were any 14:40:48
16 other further issues as far as her having some 14:40:56
17 cloudiness in the -- in her vision that I recommended 14:41:00
18 referral to a neuro ophthalmologist. 14:41:07
19 Q. You mentioned that you would have explained to 14:41:12
20 the patient that you didn't see any horrific pathology, 14:41:21
21 but would you have also explained that you didn't see 14:41:24
22 anything that required immediate treatment? 14:41:27
23 A. Yes. 14:41:29
24 Q. On March 13th, 2018, did you call Dr. Keel's 14:41:30
25 office to get more information? 14:41:41

1 A. I didn't. 14:41:43
2 Q. If, let's assume hypothetically, you called 14:41:45
3 Dr. Keel's office and you were told, "Oh, the patient's 14:41:53
4 being sent for a horseshoe tear" -- 14:41:56
5 A. Yes. 14:41:56
6 Q. -- would that have changed your exam in any way? 14:41:59
7 A. Not at all. I would have looked for something 14:42:02
8 like that regardless of the -- what -- whether or not 14:42:05
9 she saw a retinal tear. 14:42:12
10 Q. In your opinion, can you treat a retinal tear 14:42:16
11 based solely on what another provider sees? 14:42:29
12 A. Absolutely not. Umm, that would be akin to 14:42:33
13 taking a laser and just firing it randomly inside 14:42:37
14 somebody's eye. You can't treat something that you 14:42:41
15 can't see. 14:42:44
16 Q. Well, in this case, we've seen that Dr. Keel 14:42:45
17 documented a superotemporal horseshoe tear. Where is 14:42:50
18 that? 14:42:55
19 A. It's in the upper, outer quadrant of someone's 14:42:56
20 eye. 14:43:00
21 Q. Okay. Well, you wouldn't necessarily be firing 14:43:00
22 randomly. Why couldn't you just laser where Dr. Keel 14:43:06
23 said it was? 14:43:10
24 A. You might be treating nothing. That would be 14:43:11
25 inappropriate. 14:43:13

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1 Q. Are there risks associated with lasering the 14:43:14
2 retina? 14:43:18
3 A. Sure. Including the blind spot in the place that 14:43:18
4 you laser. 14:43:23
5 Q. It could create a blind spot? 14:43:23
6 A. It would create a blind spot. 14:43:26
7 Q. When you saw the patient, were you specifically 14:43:29
8 looking for a retinal tear? 14:43:31
9 A. Not specifically, but it's among the things that 14:43:33
10 we would typically look for. 14:43:36
11 Q. Because you weren't specifically looking for it; 14:43:38
12 you didn't know Dr. Keel thought she found one, do you 14:43:41
13 think that made your exam any less thorough? 14:43:45
14 A. Not at all. 14:43:48
15 Q. Are you aware that the patient returned to the 14:43:50
16 Center for Sight the next day, on March 14th, 2018? 14:43:58
17 A. Yes. 14:44:01
18 Q. Doctor, do you have a copy of the Center for 14:44:02
19 Sight records? I think they might be in your 14:44:12
20 (indiscernible) there. Can you turn to page Bates stamp 14:44:25
21 NSBME 107? 14:44:28
22 A. Yes. 14:44:33
23 Q. Under the chief complaint, the second sentence 14:44:33
24 says, "Patient was seen yesterday and was sent to RCN." 14:44:40
25 What is RCN? 14:44:46

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1 A. Retina Consultants of Nevada. 14:44:47
2 Q. Is that your office? 14:44:49
3 A. Yes. 14:44:51
4 Q. "For a horseshoe tear in the OS towards the 14:44:51
5 nose." Do you see that? 14:44:55
6 A. Yes. 14:44:55
7 Q. When Dr. Keel documented what she thought was the 14:44:56
8 horseshoe tear, did she say it was towards the nose? 14:45:01
9 A. No, she did not. 14:45:04
10 Q. If you can turn to Page 110 of those records -- 14:45:06
11 A. Yes. 14:45:15
12 Q. -- it notes the macula appears to be on. Do you 14:45:16
13 see that? Under the fundus exam of the left eye? On 14:45:24
14 Page 110? 14:45:41
15 A. 110. I don't see where it says the -- 14:45:41
16 Q. Right there. 14:45:49
17 A. Ah. Yes. I see that. 14:45:50
18 Q. In this note, did you see any indication that 14:45:56
19 hemorrhage was seen? 14:46:02
20 A. No. 14:46:03
21 Q. Did you see any indication in this note from 14:46:09
22 March 14, 2018 that a posterior vitreous detachment was 14:46:12
23 seen? 14:46:15
24 A. No. 14:46:15
25 Q. Do you have an understanding as to whether the 14:46:16

1 patient returned to your office on March 14th, 2018? 14:46:20

2 A. Yes. 14:46:25

3 Q. And do you recall Mr. Cumings asking the witness 14:46:25

4 about that telephone encounter handwritten note? 14:46:31

5 A. I believe, yes. 14:46:35

6 Q. And were you at the office around that time on 14:46:36

7 March 14, 2018? 14:46:40

8 A. Yes, I was. 14:46:41

9 Q. And were you willing to see the patient? 14:46:43

10 A. Absolutely. I offered to. 14:46:45

11 Q. And the patient ultimately indicated -- and I'm 14:46:48

12 paraphrasing -- that she wasn't comfortable to see you. 14:46:53

13 Do you recall that being in the message? 14:46:56

14 A. Yes. 14:46:58

15 Q. Do you take offense with that? 14:46:58

16 A. Not at all. 14:47:00

17 Q. Does that happen time to time that patients feel 14:47:02

18 more comfortable with one provider over another? 14:47:10

19 A. Yes. 100 percent. 14:47:13

20 Q. Was there any indication to you, based upon your 14:47:15

21 involvement with the patient on March 13th, that she 14:47:15

22 wasn't comfortable with you? 14:47:22

23 A. No. She was uncomfortable with the exam but not 14:47:22

24 with me, that I felt. 14:47:25

25 Q. If you can turn to the note from your office on 14:47:27

1 March 14th, and can you tell us who ultimately saw the 14:47:36
2 patient that day from your office? 14:48:00
3 A. Dr. Pezda. 14:48:03
4 Q. Is Dr. Pezda a retina specialist as well? 14:48:05
5 A. He is. 14:48:08
6 Q. Just for the record, that's Bates stamped 14:48:09
7 NSBME 32 and NSBME 33. 14:48:14
8 And according to Dr. Pezda's note, was the 14:48:18
9 patient's macula on or off? 14:48:21
10 A. Off. 14:48:23
11 Q. And did you hear the testimony earlier today that 14:48:24
12 the OCT from the Center for Sight seemed to indicate 14:48:27
13 that the macula was actually off earlier? 14:48:31
14 A. Yes. 14:48:35
15 Q. Based upon your education, training, and 14:48:35
16 experience, can a patient develop a retinal detachment 14:48:54
17 within a matter of hours? 14:48:59
18 A. I've seen it happen, yes. 14:49:00
19 Q. In your experience, is it common for a patient to 14:49:02
20 develop a retinal tear without a posterior vitreous 14:49:07
21 detachment? 14:49:13
22 A. It's possible, yes. 14:49:14
23 Q. Is it common? 14:49:15
24 A. Less common than developing one with a posterior 14:49:16
25 vitreous separation. 14:49:22

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1 Q. Assume hypothetically that when you saw the 14:49:24
2 patient on March 13th, 2018 that you saw a retinal tear 14:49:28
3 and decided to laser it, would that guarantee that the 14:49:32
4 patient would not go on to develop a retinal detachment? 14:49:35
5 A. No. 14:49:40
6 Q. And along those same lines, if you had seen a 14:49:40
7 tear, lasered it, and the patient still developed a 14:49:51
8 detachment, do you have an opinion as to whether the 14:49:56
9 surgical repair would have been the same? 14:49:58
10 A. It would have been the same. 14:50:01
11 Q. Can you take a look at Dr. Pezda's typed 14:50:03
12 operative report, which for the record is NSBME 81 and 14:50:09
13 then -- 14:50:16
14 A. The operative report? 14:50:17
15 Q. Dr. Pezda's operative report. 14:50:20
16 A. Yes. 14:50:20
17 Q. Earlier I've been asking about the line that 14:50:24
18 references retinal breaks, plural? 14:50:27
19 A. Yes. 14:50:30
20 Q. Do you see that? 14:50:30
21 A. I do. 14:50:31
22 Q. For how long did you work with Dr. Pezda? 14:50:32
23 A. Oh, let's see. Seven years. 14:50:34
24 Q. In your experience, when a surgeon documents 14:50:41
25 retinal breaks, plural, is it fair to infer that there 14:50:44

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1 was more than one? 14:50:48

2 A. Yes. 14:50:49

3 Q. Is "retinal break" sometimes used interchangeably 14:50:49

4 with a retinal tear? 14:50:53

5 A. Yes. 14:50:55

6 Q. Based upon your review of Dr. Pezda's operative 14:50:55

7 report, does it appear that he found more than one tear 14:50:59

8 or break? 14:51:02

9 A. That's the implication, yeah. 14:51:03

10 Q. And in his clinic note from earlier in the day, 14:51:05

11 does he document more than one tear? 14:51:08

12 A. He does not. He documents the one. 14:51:10

13 Q. In his clinic note from earlier that day, did 14:51:12

14 Dr. Pezda document a posterior vitreous detachment? 14:51:17

15 A. Yes. 14:51:21

16 Q. We've gone through today the note from the 14:51:22

17 optometrist from the day before, as well as the note 14:51:26

18 from the unknown provider on the 14th? 14:51:29

19 A. Yes. 14:51:31

20 Q. Did you see anywhere in there that it was 14:51:32

21 documented that the patient had a posterior vitreous 14:51:34

22 detachment? 14:51:39

23 A. No. 14:51:40

24 Q. How is it that in the OR a retinal tear can be 14:51:41

25 identified that wasn't seen in the clinic setting? 14:51:50

1 A. Conditions are certainly more ideal in the 14:51:53
2 operating room to detect pathology that is not as 14:51:56
3 visible in the clinic. The patient, indeed, is usually 14:52:03
4 under anesthesia, a numbing injection similar to 14:52:09
5 Novocain is sometimes placed around the eye to provide 14:52:17
6 comfort if the patient is awake or if they're not 14:52:21
7 completely under general anesthesia. The issue of a 14:52:24
8 patient's discomfort is removed from a more ideal 14:52:33
9 examination. 14:52:39
10 Furthermore, during surgery, you have the 14:52:41
11 assistance of a high-powered operating room scope that 14:52:43
12 is not available in the clinic. In addition, the light 14:52:49
13 source to illuminate the patient's retina is actually a 14:52:56
14 fiberoptic cable that is inserted actually onto the 14:53:01
15 inside of the patient's eye during surgery, and in 14:53:05
16 combination with that operating room microscope, as 14:53:10
17 we've heard earlier, it's oftentimes apparent that more 14:53:13
18 tears are present than were noted by anybody in the 14:53:18
19 clinic. 14:53:22
20 Q. In March of 2018, did your office have a 14:53:23
21 wide-field fundus photography equipment? 14:53:27
22 A. We did not. 14:53:31
23 Q. Is that sometimes referred to as an Optos camera? 14:53:32
24 A. Yes. 14:53:36
25 Q. In your opinion, in March of 2018, did the 14:53:37

1 standard of care require retina specialists to use 14:53:40
2 wide-field fundus photography? 14:53:45
3 A. No. And I don't believe it does today. Again, 14:53:47
4 the more gold standard is actually visualization of the 14:53:50
5 retina, and that's, you know, more typically done with 14:53:55
6 the scleral depression and indirect ophthalmoscopy. 14:54:01
7 Q. Are you familiar with the wide-field fundus 14:54:04
8 photography? 14:54:07
9 A. Yeah. We have one now. 14:54:07
10 Q. And can it replace the exam when looking for a 14:54:09
11 retinal tear? 14:54:12
12 A. Never. Never. 14:54:13
13 Q. Why not? 14:54:14
14 A. Again, the problem with a picture is that it is 14:54:15
15 two-dimensional, and a lot of pathology that can look 14:54:18
16 like a retinal tear on a picture is not a retinal tear, 14:54:25
17 such as a pigmentary alteration in the shape of a 14:54:28
18 horseshoe that looks like a tear on the picture, on the 14:54:33
19 wide field, but when you actually put the indirect on, 14:54:37
20 the headset, and press on the peripheral retina -- and 14:54:40
21 it's a dynamic exam. It's not just press and look. 14:54:48
22 It's movement of that scleral depressor over the surface 14:54:53
23 of the -- over the surface of the retinal break to get 14:54:58
24 that flap to move. That's really how you ideally 14:55:03
25 diagnose a retinal tear. 14:55:06

1 Q. This patient was added onto your schedule at the 14:55:09
2 end of the day? 14:55:14
3 A. Yes. 14:55:15
4 Q. Were you rushing? 14:55:15
5 A. No. It was just the end of the day. 14:55:16
6 Q. Were you tired? Could that have impacted your 14:55:18
7 exam? 14:55:22
8 A. Yes, but I wasn't tired. 14:55:23
9 Q. Dr. Loo, can you be absolutely certain that when 14:55:26
10 you saw the patient on March 13, 2018 that you did not 14:55:30
11 miss a retinal tear? 14:55:34
12 A. You know, it's impossible to say in medicine that 14:55:36
13 you're 100 percent certain of anything. I'd like to 14:55:39
14 think I didn't miss a retinal tear, but can I be 14:55:45
15 100 percent certain? No. 14:55:49
16 Q. Are there situations that you've experienced 14:55:52
17 where you are referred a patient who's got a retinal 14:55:55
18 tear and you find more tears? 14:56:01
19 A. Absolutely, yeah. 14:56:03
20 Q. And in that situation, do you feel like it's 14:56:05
21 malpractice of the other provider for not finding all of 14:56:09
22 the tears? 14:56:13
23 A. I do not. 14:56:13
24 Q. In this case, in your opinion, was there anything 14:56:14
25 else that you could do on March 13, 2018 to try and find 14:56:21

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1 a retinal tear? 14:56:25
2 A. I still rack my brain thinking if there's 14:56:26
3 anything else I could have done, and I honestly cannot 14:56:30
4 think of one. I spoke with the patient. I examined the 14:56:33
5 front part of the eye, dilated them again even though 14:56:37
6 they arrived somewhat dilated, waited until when I 14:56:41
7 thought they would be completely dilated, took a look in 14:56:46
8 the back of the eye, did the dilated fundus examination, 14:56:51
9 scleral depression to the best of her tolerance. 14:56:57
10 On top of that, we obtained two supplemental 14:57:00
11 tests, both the OCT and the B-scan ultrasound, which did 14:57:04
12 not show a retinal break/tear detaching. 14:57:11
13 Q. If you assume for purposes of this question that 14:57:18
14 there was a retinal tear present on the day you saw the 14:57:28
15 patient but you didn't see it, do you have an opinion as 14:57:31
16 to whether or not that is malpractice? 14:57:34
17 A. I don't feel that it is. 14:57:36
18 Q. And why not? 14:57:39
19 A. I think it would be arrogant to say that all 14:57:40
20 retinal tears are visible at any given moment. They 14:57:46
21 aren't. There's so many factors that come into play. 14:57:52
22 Even retinal tears that aren't visible in the clinic, 14:57:59
23 oftentimes we find them in the operating room 14:58:04
24 subsequently, so no. 14:58:07
25 Q. Do you believe that your care of this patient was 14:58:11

1 reasonable? 14:58:17

2 A. I do. 14:58:18

3 MS. HUETH: Those are all the questions I have 14:58:27

4 for now. Thank you, Doctor. 14:58:28

5 THE WITNESS: Thank you. 14:58:32

6 HEARING OFFICER HALSTEAD: You can go ahead and 14:58:33

7 cross, Mr. Cumings. 14:58:34

8 MR. CUMINGS: Thank you, Ms. Halstead. I 14:58:40

9 appreciate that. 14:58:40

10 CROSS-EXAMINATION 14:58:40

11 BY MR. CUMINGS: 14:58:40

12 Q. Dr. Loo, is Dr. Pezda a good doctor? 14:58:43

13 A. I believe so. 14:58:46

14 Q. You said you practiced with him for seven years? 14:58:47

15 A. That's approximate. I can't be certain of the 14:58:49

16 exact number, but it's more than a few. 14:58:52

17 Q. He's a pretty thorough guy? 14:58:55

18 A. Yes. 14:58:58

19 Q. Do you still have Page 32 handy in Exhibit 4? 14:58:58

20 A. Is that going to be his exam? 14:59:05

21 Q. It's just going to be his diagram there. 14:59:07

22 A. I believe it's his handwritten notes from 3/14. 14:59:11

23 Q. Yeah. I just wanted to ask you a couple 14:59:16

24 questions about that real fast. OS is left eye. Right? 14:59:18

25 A. Correct. 14:59:24

1 Q. Left eye. So when you're looking at that 14:59:25
2 diagram, the right side of that circle -- right? You're 14:59:29
3 with me? That's the temporal side. Correct? 14:59:34
4 A. Yes. 14:59:37
5 Q. So that's where the tear was originally found by 14:59:38
6 Dr. Keel. Correct? In that original note? 14:59:41
7 A. I believe that she says in her note that she saw 14:59:45
8 it there. 14:59:48
9 Q. But you said you didn't have that note? 14:59:49
10 A. I did not. 14:59:51
11 Q. You also said that if you had that note, it 14:59:52
12 wouldn't have changed your examination. Correct? 14:59:56
13 A. Correct. 14:59:58
14 Q. And you also said that you weren't aware why the 14:59:58
15 patient was there that day. Correct? 15:00:01
16 A. Other than what she mentioned to me. 15:00:02
17 Q. How many patients a day do you see typically? 15:00:04
18 A. Anywhere from 15 to 50, depending on the day. 15:00:07
19 Q. And how do you get a patient normally? 15:00:16
20 A. Oof. So many different ways. Umm, referrals 15:00:18
21 often. We're more of a specialty discipline, so 15:00:24
22 sometimes a patient will visit with their primary care 15:00:30
23 physician, maybe get seen by an optometrist or 15:00:34
24 ophthalmologist or perhaps then even find their way to 15:00:39
25 me. 15:00:43

1 Q. Uh-huh. 15:00:43

2 A. Sometimes it's even from other retina 15:00:44

3 specialists. 15:00:46

4 Q. Have you ever called a referring practitioner, 15:00:47

5 ever? 15:00:54

6 A. Yes. 15:00:54

7 Q. Why would you do that? 15:00:55

8 A. To either get or receive information. 15:00:57

9 Q. Okay. And you said that a scleral depression is 15:01:01

10 the best way to diagnose a tear. Isn't that correct? 15:01:09

11 A. It's one of the more useful tools, yeah, but you 15:01:13

12 can see one without scleral depression. 15:01:17

13 Q. That's what Dr. Hou had said as well. Correct? 15:01:20

14 A. I believe so, yeah. 15:01:24

15 Q. And that's also what Dr. Friedlander said as 15:01:24

16 well. Right? 15:01:28

17 A. Yes. 15:01:29

18 Q. Did you contact Dr. Keel on March 13th? 15:01:31

19 A. I did not. 15:01:34

20 Q. But you saw her name on the record that was 15:01:35

21 preprinted. Correct? 15:01:38

22 A. Yes. 15:01:38

23 Q. That was on the record that you had taken on 15:01:39

24 March 13th. Is that right? 15:01:42

25 A. Yes. 15:01:43

1 Q. Do you typically write your notes for patients 15:01:43
2 after they've gone or during the examination? 15:01:50
3 A. Typically, during the examination. I try to 15:01:54
4 write as much as I can at the moment. 15:01:56
5 Q. While everything is fresh? 15:01:59
6 A. Yes. 15:02:00
7 Q. Would you turn to Page 34 real fast for me? 15:02:00
8 A. Is that this one? 15:02:05
9 Q. Exhibit 4, Doctor. 15:02:09
10 MS. HUETH: Counsel, the doctor is looking at the 15:02:12
11 version of those records from Respondent's exhibits, 15:02:14
12 which I apologize, are not Bates stamped, so I'm 15:02:18
13 following along with the Bates stamped version and 15:02:21
14 letting him know what we're looking at. 15:02:24
15 BY MR. CUMINGS: 15:02:24
16 Q. Doctor, when I previously referenced Dr. Pezda's 15:02:27
17 exam, were you looking at the correct page? 15:02:30
18 A. I believe so. I think you were referencing his 15:02:32
19 exam from 3/14? 15:02:35
20 Q. Yes. 15:02:36
21 A. Okay. 15:02:37
22 Q. And then the next page I have is your exam from 15:02:38
23 3/13 of handwritten notes. Correct? 15:02:42
24 A. Yes. 15:02:44
25 Q. Below the OS right there, you see you wrote 15:02:44

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1 ultrasound? 15:02:47

2 A. Yes. 15:02:53

3 Q. You had stated that an ultrasound isn't the best 15:02:53

4 way to find a tear. Right? That it's a scleral 15:02:56

5 depression test? 15:03:01

6 A. It's a supplement to everything else that we 15:03:02

7 have. 15:03:05

8 Q. And then over in your Impressions section you 15:03:05

9 said "blind spot OS." That's the blind spot on the left 15:03:08

10 eye. Right? 15:03:13

11 A. Correct. It's kind of a reference to the 15:03:13

12 floaters that the patient was noticing as well. 15:03:16

13 Q. And you were aware of the patient's previous 15:03:19

14 surgeries. Correct? 15:03:23

15 A. Indirectly. In the patient we can see the 15:03:24

16 artificial lenses in place -- 15:03:31

17 Q. I think if you go to the next page, Page 35, you 15:03:34

18 documented, if that's your handwriting -- is this your 15:03:38

19 handwriting, sir? 15:03:41

20 A. No. This is the technician's handwriting. 15:03:42

21 Q. Oh, so you didn't author this note. Your 15:03:44

22 technician did? 15:03:47

23 A. My portion is on the other page. That's my 15:03:48

24 handwriting. 15:03:53

25 Q. Do you review this page when you examine the 15:03:54

1 patient? 15:03:57

2 A. Yes. They're back to back. 15:03:57

3 Q. Did you see the -- it's about halfway down the 15:03:59

4 page there, it says "Previous laser or surgery"? 15:04:03

5 A. Yes. 15:04:05

6 Q. Can you kind of interpret that for us? What do 15:04:06

7 all those things mean? 15:04:12

8 A. It looks like CE with IOL OU. That's 15:04:13

9 basically -- it looks like it's cataract extraction with 15:04:17

10 the placement of an intraocular lens both eyes. Next is 15:04:20

11 comma and then ICL, or intraocular contact lens 15:04:26

12 implants; OU, both eyes basically; and then a comma and 15:04:33

13 then is referencing a YAG laser capsulotomy to the left 15:04:37

14 eye. 15:04:43

15 Q. You had said this patient presented for floaters? 15:04:45

16 A. Yes. 15:04:52

17 Q. Right? 15:04:52

18 And you documented that the patient had a blind 15:04:53

19 spot in the left eye? 15:04:56

20 A. Yes. 15:04:58

21 Q. You saw that there's documentation that there was 15:04:58

22 a lens placed? 15:05:00

23 A. Yes. 15:05:02

24 Q. And you saw that there was documentation of a 15:05:02

25 previous cataract surgery? 15:05:05

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1 A. Yes. 15:05:07
2 Q. And you saw that there was also documentation of 15:05:07
3 a previous laser surgery in the left eye as well. 15:05:10
4 Right? 15:05:13
5 A. Correct. 15:05:13
6 Q. Can any of those things be risk factors for a 15:05:13
7 possible retinal tear? 15:05:19
8 A. Yes. 15:05:20
9 Q. Would you consider that to be a complex 15:05:20
10 presentation for a patient? 15:05:23
11 A. It's subjective, I suppose. Some things may be 15:05:24
12 complex to somebody else, simple to, you know, yet 15:05:33
13 another person. Relative. I don't want to get too 15:05:36
14 bogged down -- 15:05:38
15 Q. I think your expert -- 15:05:41
16 MS. HUETH: Sorry. Can he just be permitted to 15:05:42
17 finish his answer? 15:05:44
18 A. Yeah. I don't know how to judge whether 15:05:46
19 something is complex or simple. 15:05:49
20 BY MR. CUMINGS: 15:05:49
21 Q. Dr. Hou -- 15:05:55
22 A. What might be complex to somebody is simple to 15:05:56
23 somebody else. 15:05:59
24 Q. Do you recall Dr. Hou testifying that this was a 15:05:59
25 relatively complex presentation for such a patient? 15:06:03

1 A. Maybe relative to another patient who hasn't had 15:06:05
2 all this. That, I could understand. 15:06:10
3 Q. Do you recall Dr. Hou testifying that these 15:06:13
4 things can be risk factors for a tear? 15:06:15
5 A. Sure. I agree. 15:06:18
6 Q. And you had said also that you had never done a 15:06:20
7 laser treatment on a patient that didn't have a tear. 15:06:27
8 Right? 15:06:30
9 A. Yes. I think the idea there is that you don't 15:06:30
10 just shoot a laser into a region that someone says "Hey, 15:06:35
11 there's a tear there" but you don't actually see one. 15:06:42
12 Q. And you've also said that if a tear is not 15:06:44
13 visible in the clinic, that you've seen it in the OR. 15:06:46
14 Right? 15:06:49
15 A. Ask the question again. 15:06:49
16 Q. At the end of your testimony with Ms. Hueth, you 15:06:51
17 had stated if a tear is not visible in the clinic, that 15:06:55
18 you can see it in the OR when you're operating. Right? 15:06:59
19 It's easier? 15:07:01
20 A. Often, but not always. 15:07:02
21 Q. How would that happen? Would a patient be 15:07:04
22 sedated typically? 15:07:08
23 A. I want to answer the how would it happen first. 15:07:08
24 Q. Sure. 15:07:12
25 A. Because there's two questions that you asked at 15:07:13

1 the same time. The how is the conditions are certainly 15:07:16
2 more ideal in the operating room, as we've heard from 15:07:24
3 the other physicians as well, to reveal pathology that 15:07:27
4 wouldn't otherwise be seen in the clinic. 15:07:33
5 Q. Okay. But that would be if they had a confirmed 15:07:36
6 tear. Right? 15:07:40
7 A. No. That's not what we're saying at all. We're 15:07:41
8 saying that pathology that is -- that is present in the 15:07:44
9 clinic but not visible is sometimes more visible or 15:07:50
10 easily -- more easily seen in the operating room with 15:07:54
11 kind of the more ideal instrumentation. 15:07:59
12 Q. What kind of -- I'm sorry, Doctor. What kind 15:08:07
13 of -- 15:08:09
14 A. Tears, for example, that may be very, very small 15:08:09
15 that you don't see in the clinic are more easily 15:08:15
16 identifiable in the operating room. 15:08:19
17 Q. Okay. So I understand that you mean it's a tear 15:08:21
18 that you can't really see in the clinic on an 15:08:24
19 examination but is present and needs to be fixed and is 15:08:26
20 more easily visualized in that surgical setting? 15:08:31
21 A. Correct. Sometimes the tears are even suspected 15:08:35
22 to be even smaller than the operating room equipment can 15:08:39
23 identify. 15:08:42
24 Q. And that would probably be a tear that's not 15:08:43
25 going to be picked up on a B-scan. Right? 15:08:47

1 A. Typically, no. 15:08:49
2 Q. You said it's got to be a big tear to pick it up 15:08:50
3 on a B-scan. Right? 15:08:54
4 A. It's a lot easier to see a bigger tear. 15:08:55
5 Q. So a B-scan is more useful for viewing a detached 15:08:56
6 retina, not a torn retina? 15:09:01
7 A. I would agree with that. 15:09:04
8 Q. Okay. Now, you had said the time of the day that 15:09:05
9 you saw the patient, it was later in the day. Correct? 15:09:08
10 A. Yes. 15:09:11
11 Q. You had said that it would have been hard to get 15:09:12
12 ahold of Dr. Keel. Right? 15:09:19
13 A. Yes. 15:09:22
14 Q. Did you attempt to call Dr. Keel? 15:09:22
15 A. No. 15:09:25
16 Q. Did anybody from your office call Dr. Keel? 15:09:25
17 A. It appears that there was a referral at some 15:09:28
18 point. 15:09:32
19 Q. From Dr. Keel? 15:09:32
20 A. Yeah. There has to be some communication with 15:09:34
21 their office and ours, such that we even know that the 15:09:38
22 patient's expected. 15:09:43
23 Q. Exactly. So it's likely that they had sent this 15:09:45
24 patient over and contacted your office, because it was 15:09:49
25 on your schedule. She just didn't walk in off the 15:09:52

1 street. Right? 15:09:56
2 A. Because it was on my schedule but it was added 15:09:56
3 late in the day. So in other words, I'm seeing the 15:09:59
4 patients that are known from me from, say, for example, 15:10:03
5 the day before, that schedule is set. But during the 15:10:07
6 day, you know, for any number of reasons I could have 15:10:11
7 someone added to my schedule. Not necessarily without 15:10:16
8 me knowing. It can happen even late in the day. 15:10:21
9 Q. Certainly. And you said you never do a B-scan on 15:10:25
10 every single patient. Right? 15:10:28
11 A. It's not never. Never is a strong word. We're 15:10:29
12 saying that I don't provide a B-scan on every single 15:10:33
13 patient. 15:10:37
14 Q. So you don't always provide a B-scan? 15:10:37
15 A. Correct. 15:10:40
16 Q. Approximately how many patients do you provide a 15:10:41
17 B-scan to? 15:10:44
18 A. Per day or... 15:10:45
19 Q. Just -- so say there's a patient that's a STAT 15:10:48
20 referral from another practitioner. Do you always 15:10:52
21 provide a B-scan on those? 15:10:55
22 A. No. No, no. 15:10:56
23 Q. Why did you do it in this case? 15:10:57
24 A. I felt it would assist in us just trying to be as 15:10:59
25 thorough as possible. 15:11:05

1 Q. So you were looking for a possible tear or 15:11:06
2 detachment? 15:11:12
3 A. I was looking for anything that might help us 15:11:12
4 find something of substance. 15:11:15
5 Q. You've been sitting here all day listening to the 15:11:16
6 questions back and forth between Dr. Friedlander and 15:11:19
7 Dr. Hou. Right? 15:11:23
8 A. Yes. 15:11:23
9 Q. You've been paying pretty close attention? 15:11:23
10 A. Yes. 15:11:27
11 Q. There's been lots of questions about all the exam 15:11:28
12 notes from the -- let me get it right -- the Center for 15:11:30
13 Sight. Do you recall those sort of questions? 15:11:32
14 A. Sure. 15:11:33
15 Q. Do you remember Ms. Hueth asking extensively of 15:11:34
16 Dr. Friedlander about office notes that said there was a 15:11:39
17 sub temporal horseshoe tear? 15:11:46
18 A. You have to rephrase that one. 15:11:49
19 Q. Let me refresh your memory. Maybe we can do it 15:11:51
20 with the help of the record. Can you turn at Exhibit 5 15:11:56
21 of the IC exhibits, and we're going to look at Page 110. 15:11:59
22 A. Yes. 15:12:04
23 Q. Ms. Hueth questioned extensively both 15:12:04
24 Dr. Friedlander and Dr. Hou about this horseshoe tear. 15:12:10
25 A. Okay. 15:12:13

1 Q. Do you recall that? 15:12:14

2 A. Yes. 15:12:15

3 Q. All right. And then if you look at Page 110, 15:12:15

4 she's saying that the tear has now moved to the nose 15:12:18

5 side. Right? 15:12:22

6 MS. HUETH: Objection. That misstates my 15:12:24

7 question. 15:12:28

8 MR. CUMINGS: Ms. Halstead. 15:12:36

9 HEARING OFFICER HALSTEAD: You want to rephrase 15:12:36

10 the question. 15:12:39

11 BY MR. CUMINGS: 15:12:39

12 Q. If you look at Page 111, sir -- 15:12:45

13 A. 111? 15:12:49

14 Q. Yes. 15:12:51

15 A. 111. 15:12:51

16 Q. 111. Just a little foundation here. It says 15:12:52

17 appears to be a macula-on RD? 15:12:57

18 A. Yes. 15:13:03

19 Q. Retinal detachment? 15:13:04

20 A. Yes. 15:13:06

21 Q. Right? 15:13:07

22 And then on the previous page, OS, it says 15:13:08

23 superior OD with horseshoe tear, macula appears to be 15:13:11

24 on. 15:13:18

25 A. Yes. 15:13:19

1 Q. Right? 15:13:21
2 And a few pages past that, on the 3/13 note, 15:13:22
3 which was the first time that Dr. Keel referred the 15:13:27
4 patient to your office, that's on Page 118. 15:13:29
5 A. 118. Yes. 15:13:32
6 Q. See the OS side there on the fundus -- 15:13:40
7 A. Yes. 15:13:42
8 Q. It says superotemporal horseshoe tear? 15:13:43
9 A. Yes. 15:13:48
10 Q. Now let's turn back to Dr. Pezda's note. This is 15:13:48
11 the hand-drawn one we looked at at the very start. Do 15:13:52
12 you recall that? 15:13:55
13 A. Yes. 15:13:55
14 Q. This is the superotemporal side we had discussed. 15:13:55
15 Right? 15:13:59
16 A. Yes. 15:13:59
17 Q. So that's where the tear occurred? 15:14:00
18 A. It appears so. 15:14:02
19 Q. That's where the detachment occurred here? 15:14:04
20 A. Appears so. 15:14:07
21 Q. Right in that exact spot? 15:14:09
22 A. Approximately. 15:14:10
23 Q. And you said you never saw that record? 15:14:11
24 A. Which record did I not see? 15:14:15
25 Q. Any of the records from the Center For Eyesight 15:14:17

1 is what I recall you saying. 15:14:21
2 A. Correct. 15:14:23
3 Q. There's been a lot of talk about how these 15:14:23
4 records aren't accurate, but you didn't see them. 15:14:26
5 Correct? 15:14:29
6 A. Not until after. 15:14:30
7 Q. Not until after. 15:14:31
8 Then looking at Dr. Pezda's record, it's 15:14:32
9 consistent with that first note from Dr. Keel. Sub 15:14:35
10 temporal tear? 15:14:44
11 A. Superotemporal. 15:14:44
12 Q. Superotemporal. I'm sorry. 15:14:45
13 So that's consistent with that first note, and 15:14:46
14 you also stated that you've called referring providers 15:14:46
15 in some cases but not all cases. Right? 15:14:49
16 A. Yes. 15:14:52
17 Q. You didn't call the provider in this case? 15:14:52
18 A. Yes. 15:14:56
19 Q. You had a STAT referral on 3/13? 15:14:56
20 A. It was -- yes. 15:15:00
21 Q. Same-day referral? 15:15:00
22 A. Yes. Appears so. 15:15:02
23 Q. This patient had previous cataract surgery? 15:15:03
24 A. Yes. 15:15:07
25 Q. And an intraocular lens placement? 15:15:08

1 A. Yes. 15:15:11

2 Q. A YAG laser surgery? 15:15:11

3 A. Yes. 15:15:13

4 Q. What you documented as a blind pot in the left 15:15:13

5 eye? 15:15:17

6 A. Yes. 15:15:17

7 Q. Correct? Right? 15:15:18

8 And new and worsening eye vision with the 15:15:21

9 floaters? 15:15:26

10 A. That -- her complaint was floaters. 15:15:26

11 Q. Correct. So is it likely that you just missed 15:15:29

12 the tear on your sub temporal -- your scleral depression 15:15:32

13 exam? 15:15:37

14 A. I don't feel like I did. 15:15:37

15 Q. You said that you can't be certain that you 15:15:39

16 missed it is how I believe you characterized it. 15:15:44

17 A. Not 100 percent certain, but I don't feel I did. 15:15:46

18 Q. Did this complaint end up in a lawsuit? 15:15:50

19 A. Yes. 15:15:53

20 Q. Did you pay out on that lawsuit? 15:15:53

21 MS. HUETH: I'm going to object to relevance 15:15:55

22 because whether or not a doctor resolved a case or 15:15:59

23 settled a case is not indicative of whether or not he 15:16:02

24 met the standard of care unless it was established in 15:16:05

25 that lawsuit by a preponderance of the evidence that the 15:16:08

1 doctor committed malpractice. 15:16:11

2 HEARING OFFICER HALSTEAD: Sustained. 15:16:14

3 BY MR. CUMINGS: 15:16:16

4 Q. Dr. Loo, you've opined about the standard of care 15:16:18

5 in this case. Isn't that correct? 15:16:21

6 A. Yes. 15:16:22

7 Q. You felt that you met the standard of care? 15:16:23

8 A. Yes. 15:16:25

9 Q. Did you schedule this patient for a follow-up? 15:16:26

10 A. The follow-up was not a definite day. It was 15:16:29

11 under conditions that would highly merit a follow-up. 15:16:36

12 Q. Is it something that you scheduled anything? 15:16:41

13 A. No, nothing scheduled. 15:16:43

14 Q. Nothing scheduled. Okay. 15:16:45

15 And your colleague found a tear that resulted in 15:16:50

16 a detachment the very next day in the same spot that 15:16:51

17 Dr. Keel had seen it? 15:16:54

18 A. Appears so. 15:16:57

19 MR. CUMINGS: No more questions. Thank you, 15:16:58

20 Doctor. 15:17:04

21 MS. HUETH: I just have a few follow-up, if 15:17:04

22 that's okay. 15:17:06

23 HEARING OFFICER HALSTEAD: Go ahead, Ms. Hueth. 15:17:07

24 /// 15:17:07

25 /// 15:17:07

1 REDIRECT EXAMINATION 15:17:07
2 BY MS. HUETH: 15:17:07
3 Q. Doctor, Counsel was asking you about the 15:17:12
4 patient's potential risk factors for a retinal tear. 15:17:14
5 Right? 15:17:18
6 A. Yes. 15:17:18
7 Q. Okay. And you acknowledged that the patient's 15:17:18
8 prior ocular surgery could be a risk factor for 15:17:21
9 developing a retinal tear? 15:17:27
10 A. Sure. 15:17:28
11 Q. Okay. You were aware of those prior ocular 15:17:29
12 surgeries at the time you saw the patient. Is that 15:17:31
13 right? 15:17:34
14 A. Yes. 15:17:34
15 Q. In light of those risk factors, what else could 15:17:35
16 you do to find the retinal tear? 15:17:39
17 A. I'll say that a lot of patients present with a 15:17:41
18 lot of risk factors for anything and everything all the 15:17:44
19 time, but just because someone has a risk factor doesn't 15:17:48
20 change the thoroughness of our exam. Our exams are 15:17:53
21 meant to be as thorough as possible, regardless of any 15:17:58
22 risk factor. Someone could have no risk factors and 15:18:01
23 we're still going to look just as hard and do a 15:18:07
24 thorough -- as thorough an examination as possible 15:18:09
25 whether or not those factors are present. 15:18:12

1 The risk factors are helpful sometimes in 15:18:13
2 suggesting, you know, Hey, maybe, you know, why don't 15:18:17
3 you look out for certain things that may be associated 15:18:20
4 with those risk factors, but it doesn't make a retinal 15:18:23
5 tear appear just because someone has those risk factors. 15:18:28
6 Q. Do those risk factors change the way you do your 15:18:32
7 exam? 15:18:35
8 A. Not at all. It's the same exam. 15:18:36
9 MS. HUETH: Those are all my questions. Thank 15:18:38
10 you. 15:18:40
11 THE WITNESS: Thank you. 15:18:42
12 HEARING OFFICER HALSTEAD: Mr. Cumings, did you 15:18:42
13 have anything further? 15:18:45
14 MR. CUMINGS: Yeah. I just had a couple more 15:18:45
15 questions, Doctor. 15:18:48
16 RECROSS-EXAMINATION 15:18:48
17 BY MR. CUMINGS: 15:18:48
18 Q. You had stated three years later in your response 15:18:50
19 to the Board but nowhere in your previous records or 15:18:52
20 your letter to Dr. Keel on 3/13 that this was a 15:18:55
21 difficult exam. Do you recall that? 15:19:00
22 A. I do. 15:19:02
23 Q. Okay. And you also had stated that in certain 15:19:02
24 cases you haven't directly visualized a tear in the 15:19:04
25 clinic but you knew the tear was there and corrected 15:19:08

1 that tear in a surgical setting. Right? 15:19:11
2 A. No. Rephrase that question because it's -- the 15:19:14
3 inference isn't correct. 15:19:18
4 Q. Certainly, sir. You had said if a tear's not 15:19:20
5 visible in clinic, the best way to look at it is in the 15:19:24
6 OR. Right? 15:19:28
7 A. No. No. That's not the implication. Sometimes 15:19:29
8 a tear that is not visible in the clinic can be visible 15:19:33
9 in the OR. It doesn't mean that a tear is present in 15:19:37
10 the clinic that can only be seen in the operating room. 15:19:41
11 It just means that the OR setting is more ideal, as 15:19:45
12 you've heard from both of the experts here in this case. 15:19:51
13 Q. And this tear was visible in the clinic. Right? 15:19:55
14 A. Not to me. I didn't see it there. 15:19:59
15 MR. CUMINGS: I have no more questions at this 15:20:05
16 time, Doctor. Thank you for your time. 15:20:07
17 HEARING OFFICER HALSTEAD: Ms. Hueth, it's your 15:20:09
18 witness. I'll give you the last question, if you have 15:20:12
19 one. 15:20:12
20 FURTHER REDIRECT EXAMINATION 15:20:12
21 BY MS. HUETH: 15:20:12
22 Q. Is a patient going to get to the OR without you 15:20:15
23 seeing a tear? 15:20:18
24 A. No. 15:20:19
25 MS. HUETH: That's it. 15:20:20

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1 HEARING OFFICER HALSTEAD: Do you guys mind if I 15:20:21
2 ask some clarifying questions? 15:20:23
3 MS. HUETH: Of course not. 15:20:25
4 HEARING OFFICER HALSTEAD: The other two tests 15:20:31
5 that were undertaken, not the visual exam, but the OCT 15:20:33
6 and the B-scan ultrasound, were those records part of 15:20:38
7 the record before me? 15:20:40
8 THE WITNESS: Is she asking me? 15:20:46
9 MS. HUETH: She's asking me. 15:20:50
10 HEARING OFFICER HALSTEAD: No, I'm actually 15:20:50
11 asking Mr. Cumings. I'm sorry. You can't tell who I'm 15:20:52
12 looking at. 15:20:53
13 MR. CUMINGS: If you look at Defendant's Exhibit 15:20:53
14 No. 5, those are the color copies of the OCT on 3/13, 15:20:58
15 and I think that black one below with the line is the 15:21:04
16 B-scan. 15:21:07
17 HEARING OFFICER HALSTEAD: Okay. Correct me if 15:21:09
18 I'm wrong, but I didn't hear anyone ask the experts if 15:21:10
19 they saw a tear on any of those images or any of those 15:21:13
20 other tests. Is that correct? 15:21:16
21 MR. CUMINGS: No. I asked Dr. Friedlander that. 15:21:18
22 HEARING OFFICER HALSTEAD: What was his answer, 15:21:21
23 because I don't recall. I'll get the transcript and 15:21:23
24 I'll look and see, but... 15:21:25
25 MR. CUMINGS: Certainly. Dr. Loo I think can 15:21:28

1 back me up on this. He says that shot in the back, the 15:21:30
2 OCT, is just a picture of the back of the eye. It's not 15:21:32
3 the entire eye, and the B-scan is a slice. It's not a 15:21:35
4 picture of the entire eye. I think there's been a lot 15:21:39
5 of testimony that the B-scan is good for detecting a 15:21:42
6 retinal detachment but not necessarily a retinal tear. 15:21:47
7 If you look actually on Dr. -- 15:21:51
8 MS. HUETH: Why don't you stay with the question. 15:21:54
9 HEARING OFFICER HALSTEAD: Here's what I'm 15:21:58
10 getting at. No one identified a tear on those other two 15:21:59
11 tests. Correct? Neither of the other experts. 15:22:01
12 MS. HUETH: No. 15:22:03
13 MR. CUMINGS: That's incorrect. On the OCT scan 15:22:04
14 on 3/14 from the Center for Sight, it's visible there, 15:22:08
15 and actually, Dr. Loo -- Dr. Hou said that as well. 15:22:14
16 MS. HUETH: That's not what he said. They said 15:22:17
17 that you can tell that there's fluid and that the macula 15:22:18
18 appears to be off. No one said anything about a tear 15:22:21
19 being visible on either -- 15:22:25
20 MR. CUMINGS: No, a detachment. 15:22:25
21 HEARING OFFICER HALSTEAD: Okay. I'll look at 15:22:28
22 the record. I don't want you guys to debate it. I'll 15:22:28
23 just look it up myself. Give me one moment. I want to 15:22:32
24 make sure I don't have any other questions because I 15:22:58
25 wrote them down as we went along. Some of them were 15:23:01

1 covered. I think most of them were. 15:23:05
2 I think Dr. Loo mentioned that there was a 15:23:09
3 referral and there was a referral form. Did I 15:23:12
4 misunderstand that? 15:23:15
5 MS. HUETH: I believe so, because Dr. Loo 15:23:16
6 testified that there was no referral form or any sort of 15:23:18
7 written referral that his office received from the 15:23:22
8 Center for Sight. 15:23:25
9 I'm so sorry. Were you asking me or Dr. Loo? 15:23:31
10 HEARING OFFICER HALSTEAD: Whoever. I mean, this 15:23:33
11 is on the record, so I'll look it up. I was trying to 15:23:35
12 get an understanding. 15:23:38
13 MR. CUMINGS: I believe he testified that 15:23:43
14 somebody in his office spoke to somebody there because 15:23:45
15 the patient was on his schedule. 15:23:48
16 HEARING OFFICER HALSTEAD: Right. So I 15:23:50
17 understand there was -- I didn't know if there was a 15:23:51
18 referral form that had been sent over, but it sounded 15:23:54
19 like there wasn't or it hadn't gotten to Dr. Loo if it 15:23:56
20 happened. Again, I'll double check the record. 15:23:58
21 Do my questions raise any further questions for 15:24:06
22 Dr. Loo by either of you? 15:24:13
23 MR. CUMINGS: Just one brief one real fast. 15:24:22
24 /// 15:24:22
25 /// 15:24:22

1 FURTHER RECROSS-EXAMINATION 15:24:22
2 BY MR. CUMINGS: 15:24:22
3 Q. Dr. Loo, can you see this page? It's the color 15:24:26
4 scans from your office. I just want to confirm, that's 15:24:30
5 an OCT. Right? 15:24:33
6 A. Yes. 15:24:34
7 Q. And that's a B-scan? 15:24:34
8 A. Okay. No, no. Go up. That's more of a 15:24:37
9 black-and-white photograph. The OCT is actually down 15:24:41
10 one and over one. That one. 15:24:45
11 Q. And then that's a B-scan? 15:24:47
12 A. That is -- no. That is a comparison. It's the 15:24:49
13 computer's comparison between two OCTs. The B-scan is 15:24:56
14 nowhere on there. 15:25:02
15 MR. CUMINGS: Oh. Okay. Thank you, Doctor. 15:25:03
16 THE WITNESS: Sure. 15:25:07
17 HEARING OFFICER HALSTEAD: Ms. Hueth, anything 15:25:10
18 further? 15:25:12
19 MS. HUETH: Yes. 15:25:13
20 FURTHER REDIRECT EXAMINATION 15:25:13
21 BY MS. HUETH: 15:25:13
22 Q. Doctor, I'm going to show you what's in the 15:25:14
23 Investigative Committee's Exhibit 4, and it's Bates 15:25:18
24 stamped NSBME 80. Is this the B-scan ultrasound? 15:25:20
25 A. That's the B-scan. 15:25:26

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1 Q. Doctor, based upon everything you've reviewed and 15:25:30
2 heard today, did you ever receive anything in writing 15:25:33
3 from the Center for Sight referring the patient to you? 15:25:36
4 A. No. 15:25:36
5 MR. CUMINGS: Chelsea, I'm sorry. What page was 15:25:39
6 that on? 15:25:40
7 MS. HUETH: 80. 15:25:41
8 MR. CUMINGS: Thank you. 15:25:43
9 HEARING OFFICER HALSTEAD: We're going to move to 15:25:47
10 closings, but I'm going to ask you to both go really 15:25:48
11 slow because you guys have been -- there's a lot of 15:25:52
12 terminology. This is the first time I'm hearing it. 15:25:56
13 You guys have been both working on this for months, not 15:26:01
14 me. So go very slow for me because I'm trying to take 15:26:04
15 copious notes. 15:26:06
16 MS. HUETH: Would it be possible to request a 15:26:07
17 15-minute break? That way I can gather my thoughts and 15:26:10
18 notes and prepare it or give it in a slow, thoughtful 15:26:13
19 manner. 15:26:16
20 HEARING OFFICER HALSTEAD: Absolutely. 15:26:16
21 Mr. Cumings? 15:26:16
22 MR. CUMINGS: I have no objection to that. 15:26:18
23 HEARING OFFICER HALSTEAD: It's 3:26, according 15:26:20
24 to my clock. We'll come back at 3:45. 15:26:23
25 MS. HUETH: Thank you. 15:26:30

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1 *** 15:26:32

2 (RECESS TAKEN FROM 3:26 P.M. TO 3:48 P.M.) 15:26:32

3 *** 15:48:31

4 HEARING OFFICER HALSTEAD: We're back on the 15:48:31

5 record. Go ahead and do your closing, Mr. Cumings. 15:48:32

6 CLOSING STATEMENT 15:48:36

7 MR. CUMINGS: On behalf of the Investigative 15:48:36

8 Committee, I want to thank the hearing officer, 15:48:39

9 Ms. Halstead; Ms. Smith, the court reporter; Dr. Loo's 15:48:40

10 counsel, and Dr. Loo himself for your good work today, 15:48:43

11 and all the witnesses for their time and consideration. 15:48:47

12 As I mentioned in my opening statement, we're 15:48:49

13 here today to present evidence so the Board can 15:48:51

14 determine if Dr. Loo violated the Medical Practice Act. 15:48:55

15 As you heard from Dr. Friedlander, the Board's expert, 15:48:57

16 an ophthalmologist practicing for decades in Nevada, it 15:48:59

17 can be difficult to diagnose a torn retina. However, 15:49:05

18 after a STAT referral, it is the ophthalmologist's 15:49:05

19 responsibility to treat a patient with a torn retina. 15:49:09

20 Dr. Friedlander first testified that Patient A 15:49:12

21 had a confirmed diagnosis of a superotemporal horseshoe 15:49:13

22 tear by Dr. Keel, the optometrist who made the STAT 15:49:18

23 referral to Retina Consultants of Nevada, right where 15:49:20

24 Dr. Pezda, Dr. Loo's partner, found a tear on March 14th 15:49:24

25 after the retina detached. 15:49:26

1 Secondly, Dr. Friedlander testified that Dr. Loo 15:49:27
2 failed to diagnose and treat Patient A's torn retina. 15:49:30
3 Despite Dr. Loo's self-serving response to the IC's 15:49:36
4 allegation letter three years after the events in 15:49:38
5 question, asserting that he was not aware of the 15:49:41
6 situation, Dr. Loo's own records demonstrate that he was 15:49:43
7 looking for a detached retina and simply missed the 15:49:44
8 horseshoe tear as he doesn't always perform a B-scan. 15:49:50
9 He himself stated that he cannot be sure that he didn't 15:49:50
10 miss this torn retina. 15:49:53
11 Third, if what Dr. Loo asserts in his response is 15:49:55
12 true, it does not excuse the fact that he failed to 15:49:58
13 inquire why Patient A was referred -- was referred STAT 15:50:00
14 to Retina Consultants of Nevada on the same day. 15:50:03
15 Dr. Loo has in the past called referring providers for 15:50:07
16 additional information. Despite a large amount of 15:50:10
17 testimony being expelled on the time of day which the 15:50:12
18 referral occurred and whether or not Dr. Keel was 15:50:14
19 available, it appears that when it mattered, Dr. Loo 15:50:16
20 didn't pick up the phone and call. 15:50:21
21 Dr. Hou, the Respondent's own expert, himself 15:50:21
22 recognizes the importance of appropriate management of 15:50:25
23 such a patient. He at least schedules follow-ups for 15:50:26
24 his referrals with torn retinas. 15:50:30
25 Dr. Hou and Dr. Friedlander's testimony was 15:50:31

1 remarkably consistent. The best way to diagnose a torn 15:50:34
2 retina is with a scleral depression examination and not 15:50:38
3 fancy imaging or B-scans, which are unlikely to detect a 15:50:42
4 tear, even by an ultrasound expert, as Dr. Hou 15:50:46
5 testified. 15:50:50
6 Dr. Loo also agrees that when a tear cannot be 15:50:50
7 visualized in the clinic, it can be found and treated in 15:50:54
8 the OR so long as they know it's there. However, this 15:50:57
9 can be difficult, and Dr. Loo stated that he didn't 15:51:01
10 bother to obtain records or contact Dr. Keel and 15:51:02
11 admitted if he did, it wouldn't have changed his mind. 15:51:05
12 If it was not for Dr. Loo's failure to 15:51:08
13 appropriately diagnose and treat the patient and his 15:51:08
14 failure to follow up with Dr. Keel, Patient A's retina 15:51:11
15 would not have detached and necessitated an emergency 15:51:14
16 surgery to reattach the retina. 15:51:16
17 As Dr. Friedlander stated, torn and detached 15:51:19
18 retinas are commonplace for an ophthalmologist and it is 15:51:21
19 their responsibility to follow the patient to ensure 15:51:23
20 that they don't suffer the complications incurred from a 15:51:25
21 detached retina such as Patient A did. 15:51:28
22 The evidence and testimony presented today show 15:51:31
23 clearly that Dr. Loo missed the torn retina. He did not 15:51:33
24 confirm with the referring optometrist what Patient A's 15:51:38
25 STAT referral was, and furthermore, his records 15:51:38

1 demonstrate that he either failed to perform or document 15:51:41
2 the thorough examination of Patient A's left eye, which 15:51:42
3 was billed per his CPT codes. 15:51:47
4 The difficulty of Patient A's examination is only 15:51:50
5 documented in one place and one place only, and that's 15:51:51
6 in his letter to the Board three years later. The 15:51:54
7 exhibits admitted here today, along with the testimony, 15:51:57
8 support the allegations of malpractice and a failure to 15:52:00
9 maintain proper medical records, and on behalf of the 15:52:03
10 Investigative Committee, we ask the Board to consider 15:52:05
11 the record that was presented here today and render the 15:52:06
12 appropriate findings and discipline. Thank you very 15:52:09
13 much. 15:52:12
14 HEARING OFFICER HALSTEAD: Thank you, 15:52:13
15 Mr. Cumings. 15:52:15
16 I'm going to switch panes with Ms. Hueth so I can 15:52:17
17 take my copious notes. 15:52:19
18 MR. CUMINGS: I hope that wasn't too fast. I'm 15:52:22
19 sorry if it was. 15:52:25
20 HEARING OFFICER HALSTEAD: You were a little 15:52:26
21 fast, but we all do that. You weren't too fast that I 15:52:28
22 didn't catch it, and if you were too fast, the court 15:52:31
23 reporter would have told you to slow down, I'm sure. 15:52:32
24 I've been told that many, many times by court reporters. 15:52:34
25 Ms. Hueth, go ahead. 15:52:39

1 MS. HUETH: Thank you. 15:52:41

2 CLOSING STATEMENT 15:52:41

3 MS. HUETH: On behalf of Dr. Loo, it's been my 15:52:42

4 privilege to defend Dr. Loo throughout this process. 15:52:45

5 Dr. Loo takes this matter very seriously and believes 15:52:50

6 very strongly that he met the standard of care and that 15:52:54

7 his care of the patient was reasonable and that his 15:52:57

8 records were appropriate. 15:52:59

9 Malpractice is the failure to use reasonable 15:53:01

10 care, skill, or knowledge ordinarily used under similar 15:53:05

11 circumstances. Simply the claim that Dr. Loo allegedly 15:53:08

12 missed a retinal tear does not automatically constitute 15:53:12

13 malpractice. It is not strict liability. At the end of 15:53:17

14 the day, whether or not Dr. Loo committed malpractice 15:53:21

15 comes down to whether or not his care was reasonable. 15:53:24

16 Dr. Friedlander agrees that anybody can miss a 15:53:29

17 retinal tear and that it is not malpractice. 15:53:32

18 Dr. Friedlander agrees that Dr. Loo is very well trained 15:53:37

19 and very well qualified and a good doctor. In fact, 15:53:41

20 when Dr. Friedlander reviewed Dr. Loo's records, 15:53:45

21 including Dr. Pezda's subsequent note documenting a 15:53:49

22 retinal detachment, he did not think there was 15:53:54

23 malpractice. He found no malpractice. 15:53:57

24 Dr. Friedlander testified over and over again 15:54:01

25 regarding the circumstances in which a retinal tear 15:54:04

1 cannot be seen in clinic and that it may exist at the 15:54:07
2 time, but that is not malpractice. 15:54:11
3 All of the experts agree that unless you can see 15:54:14
4 yourself a retinal tear, you do not treat with laser, 15:54:18
5 freezing, or take the patient to the OR. There's been 15:54:24
6 no expert testimony that Dr. Loo should have taken the 15:54:28
7 patient to the OR without seeing the retinal tear, if it 15:54:32
8 existed at the time, himself. 15:54:36
9 Dr. Loo testified and the records demonstrate 15:54:42
10 that the patient was added onto his schedule at the end 15:54:45
11 of the day. Dr. Loo's office staff, as part of their 15:54:48
12 normal protocol, requested the information from the 15:54:52
13 referring provider, including the patient's name, age, 15:54:54
14 demographics, as well as why is the patient being 15:54:59
15 referred, and requested a referral note or the 15:55:02
16 provider's most recent note. Nothing was sent. There's 15:55:05
17 nothing in the Center for Sight records to indicate that 15:55:09
18 any documents were sent to Dr. Loo. 15:55:14
19 Dr. Loo, nonetheless, as was appropriate, as all 15:55:18
20 experts agree, still saw the patient, asked the patient 15:55:21
21 "What brings you in? What is your chief complaint?" 15:55:25
22 All of the experts agree that the chief complaint is the 15:55:28
23 reason why the patient is there. And although no one 15:55:31
24 expects the patient to diagnose themselves, they do get 15:55:35
25 a history and symptomatology from the patient. 15:55:41

1 The patient provides the reason for her visit, 15:55:44
2 why she's been sent there, and that's documented on 15:55:47
3 Page 35, NSBME 35. 15:55:50
4 Everyone who has testified, all of the experts, 15:55:55
5 agree scleral depression is uncomfortable. 15:55:59
6 Dr. Friedlander agreed it is not surprising -- he's not 15:56:03
7 surprised that the patient would find the scleral 15:56:06
8 depression exam uncomfortable and have difficulty 15:56:09
9 tolerating it. This notion that Dr. Loo somehow made 15:56:13
10 this up three years after the fact is completely 15:56:19
11 dispelled by Dr. Friedlander's own testimony that it's 15:56:23
12 not surprising, given this is the patient's second exam 15:56:27
13 of the day; she's having a bright light flash in her eye 15:56:30
14 and a scleral depressor is pressed upon her eye not just 15:56:33
15 in one spot, but in a 360 around the eye to visualize 15:56:38
16 the retina. The notion that Dr. Loo somehow made up 15:56:42
17 this theory of this patient having difficulty tolerating 15:56:47
18 the exam is further dispelled by the fact that Dr. Loo 15:56:52
19 took the extra step to get the B-scan ultrasound after 15:56:55
20 his exam. 15:56:59
21 Dr. Loo is not here to testify that the B-scan 15:56:59
22 would have picked up a retinal tear, if there was one, 15:57:02
23 but testified, and as the experts agreed, it can be a 15:57:05
24 supplement; it can be an aid to evaluate the retina to 15:57:09
25 look for potential detachment, tear, but not just those 15:57:13

1 specifically, to look for any acute pathology. 15:57:17
2 As Dr. Friedlander testified, he agrees that 15:57:21
3 Dr. Loo performed the appropriate exam and it was 15:57:24
4 appropriate to obtain the B-scan ultrasound to evaluate 15:57:27
5 the patient for anything going on that required 15:57:30
6 treatment at the time. 15:57:33
7 Ultimately, the scleral depressor tool is the 15:57:36
8 best tool that they have to evaluate the eye. No one 15:57:40
9 testified that a tear was seen on OCT or the B-scan 15:57:45
10 ultrasound. However, all of the experts agree it was 15:57:49
11 appropriate and reasonable to obtain both of them. All 15:57:53
12 of the experts who testified here today agree that 15:57:57
13 Dr. Loo's exam was reasonable. All of the experts 15:58:00
14 further agree that you can't treat a tear unless you 15:58:06
15 yourself see it. 15:58:11
16 Dr. Friedlander explained that he also is often 15:58:14
17 referred patients from an optometrist and the 15:58:17
18 optometrist thinks that they saw a retinal tear. 15:58:20
19 Dr. Friedlander, Dr. Loo, and Dr. Hou all explained how 15:58:25
20 sometimes what may appear to be a retinal tear can 15:58:31
21 actually be something else, and that's why it's 15:58:34
22 incumbent upon the provider to examine the patient and 15:58:37
23 decide for themselves whether or not there's a retinal 15:58:40
24 tear. 15:58:43
25 Every expert who has testified here today agrees 15:58:46

1 that even if the tear is seen and lasered, the patient 15:58:49
2 can still develop a retinal detachment. There's been no 15:58:54
3 evidence to -- with the requisite certainty that this 15:58:58
4 patient would not have gone on to develop a retinal 15:59:03
5 detachment even if the tear had been lasered. 15:59:06
6 There has similarly been no evidence -- and it's 15:59:10
7 the Investigative Committee's burden of proof to 15:59:16
8 establish by a preponderance of the evidence -- that 15:59:20
9 Dr. Loo did not use reasonable case. The Investigative 15:59:22
10 Committee has utterly failed to meet their burden. 15:59:25
11 There's been no evidence that the standard of care 15:59:28
12 required Dr. Loo to call Dr. Keel or her office and 15:59:30
13 again ask, "Please, send over a note. Please tell me 15:59:34
14 why you're sending this patient here." There's been no 15:59:38
15 evidence that even if he had done that, he would have 15:59:41
16 gotten any additional information. 15:59:45
17 But the evidence from the only person who was 15:59:46
18 there on March 13th, 2018, Dr. Loo, was that by the time 15:59:48
19 he saw the patient, it's close to if not after 5 p.m. 15:59:53
20 when most optometrists and ophthalmologists' offices 15:59:57
21 close. There's no evidence that even if Dr. Loo had 16:00:02
22 called that he would have gotten any additional 16:00:06
23 information. 16:00:09
24 But what the evidence has established 16:00:10
25 unequivocally is that Dr. Loo performed a thorough and a 16:00:12

1 reasonable exam of the patient. 16:00:17
2 The records have demonstrated and as 16:00:19
3 Dr. Friedlander testified that it's rare for a patient 16:00:23
4 to have a retinal tear without a posterior vitreous 16:00:26
5 detachment, and as records demonstrate, no one -- not 16:00:33
6 Dr. Keel, not the unknown provider who saw patient at 16:00:35
7 the Center for Sight the next day, nor Dr. Loo -- saw 16:00:38
8 evidence of posterior vitreous detachment. It's only 16:00:42
9 Dr. Pezda who notes that once he has the benefit of also 16:00:46
10 seeing that the patient's developed a full retinal 16:00:48
11 detachment with the macula now off. 16:00:52
12 At the end of this hearing, the evidence, the 16:00:56
13 testimony, the documents all establish that Dr. Loo 16:01:02
14 performed a thorough, reasonable exam. The fact that a 16:01:06
15 tear was allegedly missed is not indicative or alone 16:01:10
16 malpractice. Again, this is not strict liability. The 16:01:15
17 case has to be examined through the lens of did he act 16:01:18
18 reasonably, and the evidence overwhelmingly suggests and 16:01:22
19 demonstrates that he did, that his records were complete 16:01:30
20 and accurate and included the pertinent information that 16:01:33
21 was needed for the patient's diagnosis and care. 16:01:35
22 Again, thank you for your time and attention to 16:01:39
23 this serious matter. 16:01:42
24 HEARING OFFICER HALSTEAD: Okay. Thank you, 16:01:45
25 everyone. I will take this under advisement and 16:01:49

1 consider it further once I receive the transcripts. 16:01:52
2 Is there any further matters outside of the 16:01:54
3 merits of the case before we go off the record? 16:02:00
4 MR. CUMINGS: Just a quick point of order. 16:02:03
5 Dr. Friedlander certainly testified that he thought what 16:02:06
6 occurred was malpractice and I think -- 16:02:10
7 MS. HUETH: Hold on. Now you're just making 16:02:11
8 argument -- 16:02:13
9 MR. CUMINGS: I'm just saying your 16:02:14
10 characterization is incorrect. 16:02:15
11 MS. HUETH: Your commentary -- 16:02:16
12 HEARING OFFICER HALSTEAD: Okay. Stop. So we 16:02:18
13 have a record and I will go through it thoroughly and 16:02:19
14 carefully consider this, like I do all matters. There's 16:02:23
15 a few points that you guys don't agree on, which is why 16:02:26
16 it's transcribed and you get me to make the call. 16:02:29
17 So I will -- what you guys don't know is I go 16:02:32
18 through the record and I actually outline every piece of 16:02:36
19 testimony and generally refer to that when I go through 16:02:39
20 my order. So if it's in the record, I will review it 16:02:42
21 and consider it. So that's why I asked if there was 16:02:46
22 anything outside of the merits of the case that we need 16:02:50
23 to discuss. 16:02:52
24 Anything outside of the merits, Mr. Cumings? 16:02:56
25 MR. CUMINGS: No. 16:02:59

1 HEARING OFFICER HALSTEAD: Ms. Hueth? 16:03:00

2 MS. HUETH: No, thank you. 16:03:01

3 HEARING OFFICER HALSTEAD: All right. Thank you, 16:03:03

4 everyone. I appreciate your time. 16:03:03

5 (The proceedings concluded at 4:03 p.m.)

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1 CERTIFICATE OF REPORTER

2 STATE OF NEVADA)
SS:
3 COUNTY OF CLARK)

4 I, KELE R. SMITH, Certified Shorthand Reporter,
5 do hereby certify that I took down in Stenotype all of
6 the proceedings had in the before-entitled matter via
7 videoconference at the time indicated; and that
8 thereafter said shorthand notes were transcribed into
9 typewriting at and under my direction and supervision
10 and the foregoing transcript constitutes a full, true,
11 and accurate record of the proceedings had.
12 IN WITNESS WHEREOF, I have hereunto affixed
13 my hand this 14th day of February, 2024.
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19 KELE R. SMITH, NV CCR #672, CA CSR #13405
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Nevada Rules of Civil Procedure

Part V. Depositions and Discovery

Rule 30

(e) Review by Witness; Changes; Signing. If requested by the deponent or a party before completion of the deposition, the deponent shall have 30 days after being notified by the officer that the transcript or recording is available in which to review the transcript or recording and, if there are changes in form or substance, to sign a statement reciting such changes and the reasons given by the deponent for making them. The officer shall indicate in the certificate prescribed by subdivision (f)(1) whether any review was requested and, if so, shall append any changes made by the deponent during the period allowed.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE STATE RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored

in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

4

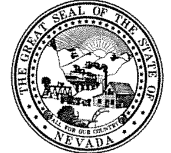
EXHIBIT 1

EXHIBIT 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
325 E. Warm Springs Road, Suite 225
Las Vegas, NV 89119

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director



March 9, 2021

Roy Loo, M.D.
653 N. Town Center Drive #518
Las Vegas NV 89144

RE: BME CASE #: 21-20008
PATIENT: [redacted]

Dear Dr. Loo:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges your care and treatment of the patient may have fallen below the standard of care.

It is alleged:

1. The patient presented to you on or around March 13, 2018, for a horseshoe retinal tear to the retina of her left eye supertemporally with surrounding hemorrhages.

2. You failed to identify and diagnose the patient's tear and released her to home.

It is further alleged:

3. The patient developed complications which included a posterior vitereous detachment in her left eye and underwent immediate surgical repair of the retinal detachment in her left eye.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient**. Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 21 calendar days.**

Please return the health care records with the signed Custodian of Records Affidavit, enclosed herewith. If you are not a custodian of the patient records, please indicate where the health care records can be obtained.

✓ 4-5-21

10-15-2020

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NMPA until a thorough investigation is completed. As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(4), NAC 630.040 & NRS 630.306(1)(b)(2).

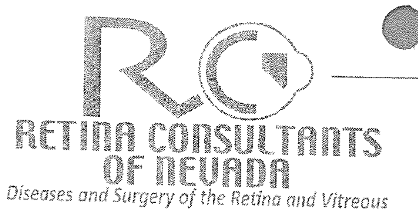
Respectfully,

Don Andreas
Sr. Investigator
Las Vegas Office

10-15-2020

EXHIBIT 2

EXHIBIT 2



Roger M. Simon, M.D.
R. Jeffrey Parker, M.D.
Rodney D. Hollifield, M.D.
Roy H. Loo, M.D.
Allen B. Thach, M.D.
Meher Yepremyan, M.D.
Jason C. Wickens, M.D.
Matthew S. Pezda, M.D.
Judy C. Liu, M.D.
Charles M. Calvo, M.D.

March 30, 2021

VIA ELECTRONIC MAIL
(dandreas@medboard.nv.gov)

Nevada State Board of Medical Examiners
Don Andreas, Senior Investigator
325 E. Warm Springs Road, Suite 225
Las Vegas, NV 89119

RE: BME CASE #: 21-20008
PATIENT: [redacted]

Dear Mr. Andreas:

Thank you for the opportunity to respond to the Board's March 9, 2021 correspondence regarding patient, [redacted]. Attached is a copy of the patient's records. However, the custodian of records is Retina Consultants of Nevada.

The patient first presented to me on March 13, 2018 with complaints of floaters in the left eye. The patient indicated she was referred to my office by her optometrist, but I did not receive any referral paperwork indicating a specific reason for the visit. The patient's past history was significant for high myopia, intraocular lens placement (IOP) in both eyes, and a YAG laser capsulotomy to the left eye. The patient's visual acuity was 20/25 in the right eye and 20/80 in the left. I performed a slip lamp evaluation which revealed white and quiet conjunctiva, clear cornea, deep and quiet anterior chamber, normal iris, and posterior chamber intraocular lens in each eye. In the right eye, I noticed 1+ posterior opacification and the left posterior capsule was open in the left eye. A dilated fundus examination was also performed and demonstrated vitreous syneresis, 0.25 cup to disc optic nerve, normal vasculature, and attached periphery on 360°. Unfortunately, my examination was limited as the patient reported she could not tolerate keeping her eye open, light sensitivity, and discomfort. I tried to minimize discomfort as much as possible, but the patient was difficult to examine resulting in a limited examination.

We also performed a B-scan ultrasound of the left eye and there was no retinal detachment seen. Based on the imaging and limited examination I was able to perform, it was my impression that the patient had floaters in each eye. I discussed my findings with the patient and instructed her to return for further evaluation if she noticed any changes in her vision. I also discussed with the patient referring her for a neuro-ophthalmology evaluation to

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(702) 369-0200
(800) 228-5810

determine if there was another explanation for the patient's complaints. I did not have any further involvement in the patient's care or treatment.

It is my understanding that the patient returned to the office the next day reporting she had significantly decreased vision in the left eye since that morning. The patient was examined by another provider who found posterior vitreous detachment with a mild vitreous hemorrhage settled inferiorly in the left eye. Retinal detachment in the superotemporal periphery was also noted. On March 15, 2018, the patient underwent vitrectomy of the left eye without complication.

I deny the allegation that the patient presented to me on March 13, 2018 for a horseshoe retinal tear to the left eye supertemporally with surrounding hemorrhages. The patient did not report any specific reason for her evaluation. In addition, I did not receive any referral paperwork or other information from the referring provider suggesting there was a specific finding or reason for the patient's visit other than her stated complaints. At the time of my care, it was my understanding (based on the information I had) that the patient presented for evaluation complaints of floaters when her eyes moved. Neither the patient nor her referring provider indicated she had been diagnosed with possible retinal tear or hemorrhages.

It is further alleged that I failed to identify and diagnose the patient's retinal tear, which I also deny. The patient was examined, and multiple images of her eye were obtained. Specifically, we obtained a B-scan ultrasound and macular optical coherence tomography (OCT), which allows high-resolution cross-sectional imaging of the retina. These imaging tests are very reliable in identifying possible retinal tears or vitreous detachment. Neither of which showed evidence retinal detachment. Scleral depression also did not reveal detachment or tear. Unfortunately, my examination was quite limited by the patient's inability to tolerate the exam. The imaging also is dependent, in part, on the patient's cooperation. However, based on the examination I was able to perform and the imaging, there was no evidence of retinal tear. I specifically told the patient that I did not find evidence of retinal tear and was never told that any prior provider found evidence of a retinal tear. I instructed the patient to return if she noticed any visual decline. This information was also provided to the referring provider.

I respectfully deny the allegation that the patient developed complications including posterior vitreous detachment as a result of my failure to diagnose retinal tear. As discussed above, there was no evidence of retinal tear based on my examination and imaging. I believe my exam met the standard of care and was reasonable based on the circumstances. I understand the patient subsequently underwent vitrectomy, but this may have been necessary even if I diagnosed a retinal tear on March 13th. It is unfortunate that the patient required surgical repair of the retinal tear, but I do not believe it is due to any substandard care on my part.

The patient filed a lawsuit and I made the difficult decision to settle the case rather than expend further time and resources away from my practice. As part of the settlement, I expressly denied liability as I believe I complied with the standard of care during my involvement in this patient's care. The settlement was made in light of economic considerations and my desire to put the case behind me so I could focus on my continued care of patients. As such, there was no finding of malpractice pursuant to NRS 630.301(4). I respectfully request that the Board close this matter with no further action. Please do not hesitate to contact me should you need any further information.

Sincerely,

Roy Loo, M.D.

EXHIBIT 3

EXHIBIT 3

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ROY HAN-HUI LOO, M.D.,** **Respondent.**	**Case No. 23-25326-1** FILED JUN - 8 2023 NEVADA STATE BOARD OF MEDICAL EXAMINERS By: ________

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Roy Han-Hui Loo, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 10129). Respondent was originally licensed by the Board on April 1, 2002.

2. Patient A[2] was a forty-six (46) year-old female at the time of the events at issue.

3. On the morning of March 13, 2018, Patient A was diagnosed by an optometrist with an acute retinal horseshoe tear in the supertemporal quadrant of the left eye, following complaints of loss of vision.

4. Patient A was immediately referred to Respondent following her diagnosis on March 13, 2018.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Aury Nagy, M.D., Nicola (Nick) M. Spirtos, M.D., F.A.C.O.G., and Ms. Maggie Arias-Petrel.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

5. On March 13, 2018, Patient A presented to Respondent. Respondent did not note a reason for the emergency referral, nor inquire to the referring optometrist for referral paperwork. Respondent documented Patient A had complaints of floaters in the left eye.

6. Respondent examined Patient A and documented the presence of vitreous floaters but failed to diagnose Patient A's retinal tear and intervene.

7. On March 14, 2018, Patient A developed decreased vision and was diagnosed with a retinal tear and detachment of the left eye by a different ophthalmologist. Patient A underwent urgent surgical repair on the evening of March 14, 2018.

COUNT I

NRS 630.301(4) - Malpractice

8. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

9. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

10. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

11. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A by failing to diagnose and treat Patient A's retinal tear, leading to detachment of the retina in Patient A's left eye.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

///

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Nevada State Board of Medical Examiners
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Reno, Nevada 89521
(775) 688-2559

14. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment, and care of Patient A, by failing to correctly obtain and note Patient A's reason for referral.

16. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________
IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

1
VERIFICATION

2 STATE OF NEVADA)
: ss.
3 COUNTY OF CLARK)

4 Aury Nagy, M.D., having been duly sworn, hereby deposes and states under penalty of
5 perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of
6 Medical Examiners that authorized the Complaint against the Respondent herein; that he has read
7 the foregoing Complaint; and that based upon information discovered in the course of the
8 investigation into a complaint against Respondent, he believes that the allegations and charges in
9 the foregoing Complaint against Respondent are true, accurate and correct.

10 DATED this 8th day of June, 2023.

11 INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS
12

13 By: ______________________________

14 AURY NAGY, M.D.
Chairman of the Investigative Committee

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EXHIBIT 4

EXHIBIT 4

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 5

EXHIBIT 5

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 6

EXHIBIT 6

Curriculum Vitae

STEVEN M. FRIEDLANDER
Nevada Retina Associates
610 Sierra Rose Drive
Reno, Nevada 89511
(775) 356-7272 (o)
(775) 848-1014 (c)
(775) 356-2922 (f)
friedlan@yahoo.com

EDUCATION:

M.D., Hahnemann University School of Medicine
Philadelphia, Pennsylvania
August 1988-May 1992

B.A., University of California, Berkeley
Major in Psychology
August 1983-May 1987

POSTGRADUATE TRAINING:

Vitreoretinal Fellowship
University of Illinois, Chicago
Illinois Eye and Ear Infirmary
Chicago, Illinois
July 1996-June 1998

Residency in Ophthalmology
University of California, San Diego
Shiley Eye Center
La Jolla, California
July 1993-June 1996

Transitional Internship with emphasis in Internal Medicine
Crozer-Chester Medical Center
Upland, Pennsylvania
June 1992-June 1993

CERTIFICATION:

Board-Certified, American Board of Ophthalmology 1998-2028
Diplomate, National Board of Medical Examiners
Nevada License # 8714

APPOINTMENTS:

- Clinical Assistant Professor, Department of Surgery, University of Nevada
- Staff Physician, Renown Regional Medical Center (Washoe Medical Center), Reno, Nevada
- Staff Physician, St. Mary's Medical Center, Reno, Nevada
- Staff Physician, Northern Nevada Medical Center, Reno, Nevada
- Reviewer, *Ophthalmology*

ORGANIZATIONS/OFFICES:

- Regional Representative, AAO Secretariat for State Affairs, 2014-2018
- AAO Council State Section Nominating Committee, 2012
- Councilor for Nevada, American Academy of Ophthalmology, 2010-2016
- Nevada Coordinator for Federal Advocacy, American Academy of Ophthalmology, 2009-2018
- Chairman, Renown Regional Medical Center Department of Ophthalmology, 2008-2010
- Section Chief, Saint Mary's Regional Medical Center, Ophthalmology Section, 2008-2010
- Participant, AAO Leadership Development Program, (LDP X) 2007-2008
- Member, Physicians for Clinical Responsibility, 2006-present
- President, Nevada Academy of Ophthalmology, 2006-2008
- Alternate Councilor for Nevada, American Academy of Ophthalmology, 2006-2009
- NSMA Delegate, Washoe County Medical Society, 2006-2009
- Fellow, American College of Surgeons, 2001- present
- Treasurer, Nevada Academy of Ophthalmology, 2000-2012
- Member, American Association of Physicians and Surgeons (AAPS), 1999-present
- Board of Directors, Surgical Arts Surgery Center, 2000-2002
- Member, American Society of Retina Specialists (The Vitreous Society), 1999-present
- Member, Association for Research in Vision and Ophthalmology, 1996, 2011
- Fellow, American Academy of Ophthalmology, 1994-present
- Representative, UCSD House Staff Association, 1993-1994
- Founder, Hahnemann Environmental Coalition, 1990
- Vice-President, Hahnemann University School of Medicine Class of 1992, 1989-1992
- Student Representative, School of Medicine Curriculum Committee, 1988-1989

AWARDS/HONORS:

- Achievement Award, American Academy of Ophthalmology, 2013
- Special Recognition Award, American Academy of Ophthalmology, 2013
  (Presented to the AAO Leadership Development Program)
- Distinguished Service Award, American Academy of Ophthalmology, 2011
  (Presented to the AAO Council)
- Secretariat Award, American Academy of Ophthalmology, 2010
- State Proactive Champion, American Academy of Ophthalmology, 2009
  (On behalf of the Nevada Academy of Ophthalmology)
- State Proactive Action Champion, American Academy of Ophthalmology, 2007
  (On behalf of the Nevada Ophthalmological Society)
- Distinguished Service Award, American Academy of Ophthalmology, 2007
- Morton F. Goldberg Award, 1997, 1998
- Chief Resident, UCSD Department of Ophthalmology, 1995-1996
- Hahnemann University Medical Staff Award, May 1992 (Highest Attainment in the National Boards)
- Diagnostic Radiology Award, May 1992
- George D. Lumb Award, May 1992 (Excellence in Pathology)
- Distinguished Academic Performance in Internal Medicine, May 1992
- Alpha Omega Alpha (AOA), Elected February 1991
- National Dean's List, 1989-1991
- Read, George and Laughlin Merit Scholarships, 1989-1991
- American Society of Clinical Pathologists' Award for Academic Excellence, May 1990
- Annette and Kermit Berman Scholarship, May 1989 (Highest Attainment in the freshman class)
- McGraw-Hill Book Prize, May 1989

OUTSIDE INTERESTS:

- Member, Astronomical Society of Nevada, 2005
- Member, MENSA, 2001
- Endowment Life Member, National Rifle Association, 2000

PUBLICATIONS:

Greenberg, Belin, Butler, Feiler, Mueller, Tye, Friedlander, **Emerson, Ferrone:** Aflibercept-Related Sterile Intraocular Inflammation Outcomes. *Ophthalmology Retina* 3(9): 753-759, 2019

Friedlander, Welch: Vanishing disc neovascularization following intravitreal bevacizumab (avastin) injection. *Arch Ophthalmol* 124(9):1365, 2006

Friedlander: Moral Leverage Won't Work! *The Pharos* 68 (1): 52, 2005

Goldstein, Mouritsen, **Friedlander**, Tessler, Edward: Acute Endogenous Endophthalmitis due to Bartonella Henselae. *Clin Infect Dis* 33(5):718-21, 2001

Fiscella, Nguyen, Cwik, Philpotts, **Friedlander**, Alter, Shapiro, Blair, Gieser: Aqueous and Vitreous
Penetration of Levofloxacin after Oral Administration. *Ophthalmology* 106(12):2286-90, 1999

Blair, Kim, **Friedlander**: Cystoid Macular Edema After Ocular Surgery. In *Principles and Practice of Ophthalmology,* second edition, edited by Albert and Jakobiec. New York, W B Saunders Co. 1999

Friedlander, Goldstein: Early reactivation of cytomegalovirus retinitis following placement of a ganciclovir implant. *Arch Ophthalmol* 115(6):802-803, 1997

Friedlander, Rahhal, Ericson, Arevalo, Hughes, Levi, Wiley, Graham, Freeman: Optic neuropathy preceding acute retinal necrosis in AIDS. *Arch Ophthalmol* 114(12):1481-1485, 1996

Friedlander, Raphaelian, Granet, Goldbaum: Endogenous E. coli endophthalmitis in a neonate with meningitis. *Retina* 16(4):341-343, 1996

Arevalo, Munguia, Faber, **Friedlander**, Quiceno, Rahhal, Kirsch, Freeman: Intraocular pressure in human immunodeficiency virus-positive patients with and without Cytomegalovirus retinitis: Correlation with CD4 lymphocyte count. *Am J Ophthalmol* 122(1):91-96, 1996

Abstracts:

Davis, Lin, Chang, Samuel, Bhatti, **Friedlander,** Patel, Dugel: Outbreak of Fusarium Endophthalmitis following Brilliant Blue G (BBG) dye-assisted vitrectomy procedures. Poster Presentation, American Academy of Ophthalmology Annual Meeting, Chicago, Illinois, 2012.

Davis, Lin, Chang, Samuel, Bhatti, Dugel, **Friedlander**, Culotta, Hau, Sastillo Salazar, Parel, Theodore, Sedeek, Suk: Outbreak of Fusarium Endophthalmitis following Brilliant Blue G (BBG) dye-assisted vitrectomy procedures. Abstract from the 2012 ASRS meeting, Las Vegas, Nevada.

Calvo, **Friedlander**, Hilliard, Swarts, Nielsen, Dhindsa, Welch, Dix. Case Report: Reactivation Of Latent B Virus (Macacine Herpesvirus 1) Presenting As Bilateral Uveitis, Retinal Vasculitis And Necrotizing Herpetic Retinitis. *Invest Ophthalmol Vis Sci* 2011;52: E-Abstract 2975, 2011

Friedlander, Alter, Shapiro: Inferior fornix incision with conjunctival retraction for scleral buckle release or removal after neonatal surgery. *Invest Ophthalmol Vis Sci* 39:S1004, 1998

Gramates, Goldstein, **Friedlander**, Phillpotts, Jagielski, Khanna: Screening for CMV retinitis in asymptomatic HIV positive patients. *Invest Ophthalmol Vis Sci* 38:S738, 1997

Wu, Williams, Phillips, Khanna, **Friedlander**, Goldstein: Loss of accommodative amplitude in AIDS patients. *Invest Ophthalmol Vis Sci* 38:S1101, 1997

Williams, **Friedlander**, Shapiro, Resnick, Gieser, Blair: The outcome of photocoagulation for diabetic macular edema in patients with poor initial visual acuity. *Invest Ophthalmol Vis Sci* 38:S766, 1997

Caserta, Goldstein, Gramates, **Friedlander**, Khanna: Does intravitreal therapy for CMV retinitis increase the risk of retinal detachment? *Invest Ophthalmol Vis Sci* 38:S740, 1997

Friedlander, Rahhal, Fiscella, McGuire, Goldstein, Cwik: A safe and effective intravitreal dose of cidofovir can be prepared from the commercially available intravenous preparation. *Invest Ophthalmol Vis Sci* 38:S1100, 1997

Werner, **Friedlander**, Bacharach, Balazsi: Pathologic and normal test locations of similar threshold show the same degree of long-term fluctuation regardless of location in the visual field of glaucoma patients. *Invest Ophthalmol Vis Sci* 33:1387, 1992

Friedlander, DeMaio, Sinclair, Werner: The acute effect of betaxolol on human macular hemodynamics in normals. *Invest Ophthalmol Vis Sci* 33:810, 1992

EXHIBIT "1"

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against:

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

FILED

JUN - 8 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ____________

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Roy Han-Hui Loo, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 10129). Respondent was originally licensed by the Board on April 1, 2002.

2. Patient A[2] was a forty-six (46) year-old female at the time of the events at issue.

3. On the morning of March 13, 2018, Patient A was diagnosed by an optometrist with an acute retinal horseshoe tear in the supertemporal quadrant of the left eye, following complaints of loss of vision.

4. Patient A was immediately referred to Respondent following her diagnosis on March 13, 2018.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Aury Nagy, M.D., Nicola (Nick) M. Spirtos, M.D., F.A.C.O.G., and Ms. Maggie Arias-Petrel.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

5. On March 13, 2018, Patient A presented to Respondent. Respondent did not note a reason for the emergency referral, nor inquire to the referring optometrist for referral paperwork. Respondent documented Patient A had complaints of floaters in the left eye.

6. Respondent examined Patient A and documented the presence of vitreous floaters but failed to diagnose Patient A's retinal tear and intervene.

7. On March 14, 2018, Patient A developed decreased vision and was diagnosed with a retinal tear and detachment of the left eye by a different ophthalmologist. Patient A underwent urgent surgical repair on the evening of March 14, 2018.

COUNT I

NRS 630.301(4) - Malpractice

8. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

9. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

10. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

11. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A by failing to diagnose and treat Patient A's retinal tear, leading to detachment of the retina in Patient A's left eye.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

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Nevada State Board of Medical Examiners
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Reno, Nevada 89521
(775) 688-2559

14. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment, and care of Patient A, by failing to correctly obtain and note Patient A's reason for referral.

16. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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Reno, Nevada 89521
(775) 688-2559

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________
IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov
Attorney for the Investigative Committee

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________
AURY NAGY, M.D.
Chairman of the Investigative Committee

1 BEFORE THE BOARD OF MEDICAL EXAMINERS
2 OF THE STATE OF NEVADA
3 * * * * *
4
5 In the Matter of Charges and Complaint
6 Against:
7 ROY HAN-HUI LOO, M.D.,
8 Respondent.
9

Case No. 23-25326-1

(FILED UNDER SEAL)

FILED

JUN - 8 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ____

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11 PATIENT DESIGNATION
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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits its **PATIENT DESIGNATION** to identify the true and correct identity of the patient(s) referenced in the filed formal Complaint, Case No. 23-25326-1.

1. Name: [redacted]
   DOB: [redacted]

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________

IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT “2”

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against ROY HAN-HUI LOO, M.D., Respondent.

Case No. 23-25326-1

FILED
JUL 11 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ______

ROY HAN-HUI LOO, M.D.'S ANSWER TO COMPLAINT

COMES NOW, Respondent ROY HAN-HUI LOO, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and CHELSEA R. HUETH, ESQ., of the law firm of McBRIDE HALL and for his Answer to the State of Nevada Board of Medical Examiners' (hereinafter "Board") Complaint, admits, denies, and alleges as follows:

1. This answering Respondent admits those allegations contained in Paragraph 1 of the Board's Complaint.

2. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 2 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

3. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 3 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

4. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 4 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

5. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 5

of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

6. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 6 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

7. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 7 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

COUNT I

NRS 630.301(4) - Malpractice

8. Answering Paragraph 8 of the Board's Complaint, Respondent repeats each and every response to Paragraphs 1 through 7, inclusive, and incorporates the same by reference as though set forth fully herein.

9. Answering Paragraph 9 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee but specifically denies committing malpractice.

10. Answering Paragraph 10 of the Board's Complaint, this answering Respondent admits that Nevada Administrative Code Section 630.040 defines malpractice but specifically denies committing malpractice.

11. This answering Respondent denies the allegations contained in Paragraph 11 of the Board's Complaint.

12. This answering Respondent denies the allegations contained in Paragraph 12 of the Board's Complaint.

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COUNT III

(NRS 630.3062(1)(a) – Failure to Maintain Appropriate Medical Records

13. Answering Paragraph 13 of the Board's Complaint, Respondent repeats each and every response to Paragraphs 1 through 12, inclusive, and incorporates the same by reference as though set forth fully herein.

14. Answering Paragraph 14 of the Board's Complaint, this answering Respondent admits that NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment, and care of a patient adopted by the Board is grounds for initiating disciplinary action against a licensee but specifically denies failing to maintain timely, legible, accurate, and complete medical records relating to the diagnosis, treatment, and care of a patient.

15. This answering Respondent denies the allegations contained in Paragraph 15 of the Board's Complaint.

16. This answering Respondent denies the allegations contained in Paragraph 16 of the Board's Complaint.

FIRST AFFIRMATIVE DEFENSE

Respondent alleges that The Nevada State Board of Medical Examiners' Complaint on file herein fails to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

N.R.S. 630.301(4) is in whole or in part, void for vagueness, violative of Respondent's due process rights under the Constitutions of the State of Nevada and the United States of America, and can serve as no basis for discipline of Respondent.

THIRD AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners has failed to comply with the requirements of N.R.S. 630, et seq. and N.A.C. 630 et seq.

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FOURTH AFFIRMATIVE DEFENSE

Respondent fully performed and discharged all obligations owed to the patient, including satisfying the requisite standard of care to which the patient was entitled.

FIFTH AFFIRMATIVE DEFENSE

If a violation occurred it was the result of intervening and/or superseding events, factors, occurrences, or conditions, which were in no way caused by Respondent, and for which Respondent is not responsible.

SIXTH AFFIRMATIVE DEFENSE

All possible affirmative defenses may not have been alleged herein so far as sufficient facts were not available after reasonable inquiry upon filing of this answering Respondent's Answer and, therefore, this answering Respondent reserves the right to amend his Answer to include additional affirmative defenses, if subsequent investigation so warrants.

WHEREFORE, the Respondent prays that The Nevada State Board of Medical Examiners take nothing by way of the Complaint on file herein; and that Respondent recover all costs and attorneys' fees incurred.

DATED this 11th day of July 2023.

McBRIDE HALL

By: */s/ Chelsea R. Hueth*

ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
CHELSEA R. HUETH, ESQ.
Nevada Bar No.: 10904
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Roy Han-Hui Loo, M.D.

1 CERTIFICATE OF SERVICE

2 I hereby certify that on the 11th day of July 2023, I served a true correct copy **ROY HAN-**

3 **HUI LOO, M.D.'S ANSWER TO COMPLAINT**, by sending via electronic mail and via United

4 States mail to the following:

5

6 Ian J. Cumings, Esq.
Nevada State Board of Medical Examiners
7 9600 Gateway Drive
Reno, NV 89521
8 icumings@medboard.nv.gov
Attorney for the Investigative Committee

9

10

11 *__/s/ Lauren Smith______________________*

12 An Employee of McBride Hall

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EXHIBIT “3”

Roger M. Simon, M.D.
R. Jeffrey Parker, M.D.
Rodney D. Hollifield, M.D.
Roy H. Loo, M.D.
Allen B. Thach, M.D.
Meher Yepremyan, M.D.
Jason C. Wickens, M.D.
Matthew S. Pezda, M.D.
Judy C. Liu, M.D.
Charles M. Calvo, M.D.

March 30, 2021

VIA ELECTRONIC MAIL
(dandreas@medboard.nv.gov)

Nevada State Board of Medical Examiners
Don Andreas, Senior Investigator
325 E. Warm Springs Road, Suite 225
Las Vegas, NV 89119

RE: BME CASE #: 21-20008
PATIENT: [redacted]

Dear Mr. Andreas:

Thank you for the opportunity to respond to the Board's March 9, 2021 correspondence regarding patient, [redacted] Attached is a copy of the patient's records. However, the custodian of records is Retina Consultants of Nevada.

The patient first presented to me on March 13, 2018 with complaints of floaters in the left eye. The patient indicated she was referred to my office by her optometrist, but I did not receive any referral paperwork indicating a specific reason for the visit. The patient's past history was significant for high myopia, intraocular lens placement (IOP) in both eyes, and a YAG laser capsulotomy to the left eye. The patient's visual acuity was 20/25 in the right eye and 20/80 in the left. I performed a slip lamp evaluation which revealed white and quiet conjunctiva, clear cornea, deep and quiet anterior chamber, normal iris, and posterior chamber intraocular lens in each eye. In the right eye, I noticed 1+ posterior opacification and the left posterior capsule was open in the left eye. A dilated fundus examination was also performed and demonstrated vitreous syneresis, 0.25 cup to disc optic nerve, normal vasculature, and attached periphery on 360°. Unfortunately, my examination was limited as the patient reported she could not tolerate keeping her eye open, light sensitivity, and discomfort. I tried to minimize discomfort as much as possible, but the patient was difficult to examine resulting in a limited examination.

We also performed a B-scan ultrasound of the left eye and there was no retinal detachment seen. Based on the imaging and limited examination I was able to perform, it was my impression that the patient had floaters in each eye. I discussed my findings with the patient and instructed her to return for further evaluation if she noticed any changes in her vision. I also discussed with the patient referring her for a neuro-ophthalmology evaluation to

653 N. Town Center Drive, Suite 518 • Las Vegas, Nevada 89144
(702) 369-0200
(800) 228-5810

determine if there was another explanation for the patient's complaints. I did not have any further involvement in the patient's care or treatment.

It is my understanding that the patient returned to the office the next day reporting she had significantly decreased vision in the left eye since that morning. The patient was examined by another provider who found posterior vitreous detachment with a mild vitreous hemorrhage settled inferiorly in the left eye. Retinal detachment in the superotemporal periphery was also noted. On March 15, 2018, the patient underwent vitrectomy of the left eye without complication.

I deny the allegation that the patient presented to me on March 13, 2018 for a horseshoe retinal tear to the left eye supertemporally with surrounding hemorrhages. The patient did not report any specific reason for her evaluation. In addition, I did not receive any referral paperwork or other information from the referring provider suggesting there was a specific finding or reason for the patient's visit other than her stated complaints. At the time of my care, it was my understanding (based on the information I had) that the patient presented for evaluation complaints of floaters when her eyes moved. Neither the patient nor her referring provider indicated she had been diagnosed with possible retinal tear or hemorrhages.

It is further alleged that I failed to identify and diagnose the patient's retinal tear, which I also deny. The patient was examined, and multiple images of her eye were obtained. Specifically, we obtained a B-scan ultrasound and macular optical coherence tomography (OCT), which allows high-resolution cross-sectional imaging of the retina. These imaging tests are very reliable in identifying possible retinal tears or vitreous detachment. Neither of which showed evidence retinal detachment. Scleral depression also did not reveal detachment or tear. Unfortunately, my examination was quite limited by the patient's inability to tolerate the exam. The imaging also is dependent, in part, on the patient's cooperation. However, based on the examination I was able to perform and the imaging, there was no evidence of retinal tear. I specifically told the patient that I did not find evidence of retinal tear and was never told that any prior provider found evidence of a retinal tear. I instructed the patient to return if she noticed any visual decline. This information was also provided to the referring provider.

I respectfully deny the allegation that the patient developed complications including posterior vitreous detachment as a result of my failure to diagnose retinal tear. As discussed above, there was no evidence of retinal tear based on my examination and imaging. I believe my exam met the standard of care and was reasonable based on the circumstances. I understand the patient subsequently underwent vitrectomy, but this may have been necessary even if I diagnosed a retinal tear on March 13th. It is unfortunate that the patient required surgical repair of the retinal tear, but I do not believe it is due to any substandard care on my part.

The patient filed a lawsuit and I made the difficult decision to settle the case rather than expend further time and resources away from my practice. As part of the settlement, I expressly denied liability as I believe I complied with the standard of care during my involvement in this patient's care. The settlement was made in light of economic considerations and my desire to put the case behind me so I could focus on my continued care of patients. As such, there was no finding of malpractice pursuant to NRS 630.301(4). I respectfully request that the Board close this matter with no further action. Please do not hesitate to contact me should you need any further information.

Sincerely,

Roy Loo, M.D.

EXHIBIT “4”

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT “5”

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT “6”

KIRK KOHWA HOU, MD., PhD.

800 S. Fairmount Ave. Suite 215
Pasadena, CA. 91105
(626)817-4747
khou@mednet.ucla.edu

EDUCATION

Undergraduate	Bachelor of Science and Engineering: Chemical Engineering Certificate in Materials Science and Engineering *Summa cum laude* Princeton University Princeton, NJ 2002-2006
Medical School	Medical Scientist Training Program Washington University in St Louis School of Medicine St. Louis, MO 2007-2015
Graduate School	Department of Computational and Molecular Biophysics Dissertation Title: Melittin-Derived Peptides for siRNA Delivery Laboratory of Samuel Wickline, MD Washington University in St Louis School of Medicine St. Louis, MO 2009-2013
Internship	Preliminary Year, Department of Medicine Barnes Jewish Hospital/Washington University in St. Louis School of Medicine St. Louis, MO 2015-2016
Residency	Department of Ophthalmology University of California - Los Angeles/Jules Stein Eye Institute Los Angeles, CA July 2016-June 2019
Fellowship	Vitreoretinal Surgery Fellowship Director: Allan Kreiger, MD University of California - Los Angeles/Jules Stein Eye Institute Los Angeles, CA July 2019-Present

LICENSURE: California Medical License, Certificate Number A143728
American Board of Ophthalmology

PROFESSIONAL ACTIVITIES

University of California – Los Angeles, Los Angeles, CA
Doheny Eye Institute – Vitreoretinal Surgery
Assistant Professor – Ophthalmology, 2021-present

University of California – Los Angeles, Los Angeles, CA
Clinical Instructor – Ophthalmology, 2019-2021

Washington University in St. Louis, St. Louis, MO
Graduate Research Assistant, 2009-2013
Laboratory of Dr. Samuel Wickline, MD. Department of Internal Medicine, Division of Cardiovascular Disease

Washington University in St. Louis, St. Louis, MO
Teaching Assistant, 2009-2010
Course Professor Dr. Paul Bridgman, PhD. Cell and Organs Systems

Washington University in St. Louis, St. Louis, MO
Laboratory Technician, 2006-2007
Laboratory of Dr. Andrey Shaw, MD. Department of Pathology and Immunology

Princeton University, Princeton, NJ
Undergraduate Research Assistant, 2005-2006
Laboratory of Prof. Ilhan Aksay, PhD. Chemical Engineering

Princeton University, Princeton, NJ
Undergraduate Research Assistant, 2004-2005
Laboratory of Dr. Nan Yao, PhD. PRISM Imaging and Analysis Center

Mallinckrodt Pharmaceuticals, St. Louis, MO
Summer Internship, 2003
Health, Safety, and Environmental Department

PROFESSIONAL ASSOCIATIONS

American Academy of Ophthalmology (2016-present)
American Society of Retina Specialists (2019-present)
American Society of Cataract and Refractive Surgery (2016-2019)

HONORS AND SPECIAL AWARDS

Fellow Teaching Award, University of California - Los Angeles, 2021
Resident Teaching Award, University of California - Los Angeles, 2019
Needleman Prize in Pharmacology, Washington University in St. Louis, 2015
Alpha Omega Alpha Medical Honor Society, Washington University in St. Louis, 2015
Phi Beta Kappa Academic Honor Society, Princeton University, 2006
Sigma Xi Scientific Research Honor Society, Princeton University, 2006
Tau Beta Pi Engineering Society, Princeton University, 2006
Richard K Toner Prize, Princeton University, Excellence in Thermodynamics, 2006
Procter & Gamble Award, Princeton University, Outstanding Design Project, 2006
Ticona Senior Thesis Award, Princeton University**,** Outstanding Senior Thesis, 2006
National Merit Scholar, Parkway Central High School, 2002

RESEARCH GRANTS AND FELLOWSHIPS

John and Theiline McCone Fellowship, University of California - Los Angeles, 2019-2020
Heed Fellowship, The Heed Ophthalmic Foundation, 2019-2020
Sigma-Aldrich Pre-Doctoral Fellowship, Washington University in St. Louis, 2011-2013

LECTURES AND PRESENTATIONS

Hou KK. Speed Racer: Mucor Orbitopathy, Ophthalmology Department Grand Rounds, Washington University in St. Louis School of Medicine, St, Louis, MO. June 2014.

Hou KK. Idiopathic Orbital Inflammation, Clinical Pathology Conference, UCLA/Stein Eye Institute, Los Angeles. CA. July 2016.

Hou KK. Rogue Lens – A Marfan’s Story, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. January 2017.

Hou KK. Papilledema vs Pseudopapilledema, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. February 2017.

Hou KK. Downbeat Nystagmus, Neuro-Ophthalmology Conference, UCLA/Stein Eye Institute, Los Angeles. CA. April 2017.

Hou KK. Lowe’s Syndrome. Pediatric Ophthalmology Conference, UCLA/Stein Eye Institute, Los Angeles. CA. May 2017.

Hou KK. Iatrogenic Cyclodialysis after MIGS, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. May 2017.

Hou KK. Medullepithelioma Presenting as Unilateral Pediatric Glaucoma, Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. June 2017.

Hou KK. OCTA Type 1 Neovascularization, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. September 2017.

Hou KK. Orbital Problems. Orbit Conference, Harbor-UCLA, Torrance, CA. October 2017.

Hou KK. Thyroid Orbitopathy, Clinical Pathology Conference, UCLA/Stein Eye Institute, Los Angeles. CA. October 2017.

Hou KK. Divergence Insufficiency, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. October 2017.

Hou KK Biopsy Negative Giant Cell Arteritis, Neuro-Ophthalmology Conference, UCLA/Stein Eye Institute, Los Angeles. CA. November 2017.

Hou KK. Choroideremia Carrier, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. February 2018.

Hou KK and Sarraf D. What Lies Beneath**,** IRIS Doheny/Stein Case Conference, Los Angeles, CA. February 2018.

Hou KK. Internal Carotid Artery Dissection. Pediatric Ophthalmology Conference, UCLA/Stein Eye Institute, Los Angeles. CA. April 2018.

Hou KK. Dural Venous Sinus Compression, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. April 2018.

Hou KK and Sarraf D. OCTA pseudoflow in eyes with macular edema, Ophthalmology Times Research Scholar Honoree Program, Chicago IL. October 2018.

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. October 2018.

Hou KK. Treatment Options for Aniridia, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. November 2018.

Hou KK. Supernumary Bands, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. February 2019.

Hou KK and Sarraf D. Peripheral aneurysmal Type 1 Neovascularization, IRIS Doheny/Stein Case Conference, Los Angeles, CA. March 2019.

Hou KK. Physician Burnout, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. April 2019.

Hou KK and Sarraf D. Persistent placoid maculopathy, MaculART, Paris, France. June 2019

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. August 2019.

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. December 2019.

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. February 2020.

Hou KK. Choroidal Melanoma Masquerading as CSR, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. February 2020.

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. May 2020.

Hou KK, Doshi R, and Sarraf D. Where did my EZ go?, Zooming in on Retina – Retina Fellows Forum, May 2020.

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. August 2020.

Hou KK, Au A, and Sarraf D. Tamoxifen maculopathy. Zooming in on Retina – Retina Fellows Forum, August 2020.

Hou KK. Pneumatic Retinopexy during COVID, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. September 2020.

Hou KK. Nanotechnology and Ophthalmology, Ophthalmology Department Grand Rounds, UCLA/Stein Eye Institute, Los Angeles. CA. October 2020.

Hou KK. Multimodal Imaging Conference, UCLA/Stein Eye Institute, Los Angeles. CA. January 2021.

Hou KK. Diabetic Vitrectomy, Vitreoretinal Surgery Fellowship Lecture Series, UCLA/Stein Eye Institute, Los Angeles, CA. February 2022

Hou KK. Retinal Genetics and Toxicities, Stein Doheny Annual Review Course, UCLA/Stein Eye Institute, Los Angeles, CA. February 2022.

PUBLICATIONS

RESEARCH PAPERS (PEER REVIEWED - PUBLISHED)

Yao N, **Hou KK,** Haines CD, Etessami N, Ranganathan V, Halpern SB, Kear BH, Klein LC, and Sigel GH. Nanostructure of Er^{+3} doped silicates. *J. Electron Microsc.* **2005** (54) 309-315.

Lin J, **Hou KK,** Piwnicia-Worms H, and Shaw AS. The polarity protein Par1b/EMK/MARK2 regulates T cell receptor-induced microtubule-organizing center polarization. *J. Immunol.* **2009** (183) 1215-1221.

Rycenga M, **Hou KK,** Cobley CM, Schwartch AG, Camargo PH, and Xia Y. Probing the surface-enhanced Raman scattering properties of Au-Ag nanocages at two different excitation wavelengths. *Phys. Chem. Chem. Phys.* **2009** (11) 5903-5908.

Pan H, Myerson JW, Hu L, Marsh JN, **Hou KK,** Scott MJ, Allen JS, Hu G, San Roman S, Lanza GM, Schreiber RD, Schlesinger PH, and Wickline SA. Programmable nanoparticle functionalization for *in vivo* targeting. *FASEB J.* **2013** (27) 255-264.

Li-Byarlay H, Li Y, Stroud H, Feng S, Newman TC, Kaneda MM, **Hou KK,** Worley KC, Elsik CG, Wickline SA, Jacobsen SE, Ma J, and Robinson GE. RNA interference knockdown of DNA methyl-transferase 3 affects gene alternative splicing in the honey bee. *Proc. Natl. Acad. Sci.* **2013** (110) 12750-12755.

Hou K.K, Pan H, Lanza GM, and Wickline SA Melittin derived peptides for nanoparticle based siRNA transfection. *Biomaterials*. **2013** (34) 3110-3119.

Hou, KK, Pan H, Ratner L, Schlesinger P, and Wickline SA. Mechanisms of nanoparticle mediated siRNA transfection by melittin-derived peptides. *ACS Nano*. **2013** (22) 8605-8615.

Zhou H, Yan H, Pan H, **Hou KK,** Antonina A, Springer L, Hu Y, Allen JS, Wickline SA, and Pham CTN. Self-assembling peptide-siRNA nanocomplexes targeting the NF-kB p65 subunit rapidly suppress murine arthritis. *JCI*. **2014** (24) 4363-74.

Hou KK, Pan H, Schlesinger PH, and Wickline SA. A role for peptides in overcoming endosomal entrapment in siRNA delivery – A focus on melittin. *Biotechnol. Adv.* **2015** (33) 931-940.

Hua P, Palekar R, **Hou KK,** Bacon J, Yan H, Springer L, Antonina AKK, Yang L, Miller M, Pham CTN, Schlesinger P, and Wickline SA. Anti-JNK2 Peptide-siRNA Nanostructures improve plaque endothelium and reduce thrombotic risk in Atherosclerotic Mice, *Int. J Nanomed.* **2018** (13) 5187-5205.

Au A, **Hou KK,** Baumal CR, and Sarraf D. Radial hemorrhage in henle's layer in macular telangiectasia Type 2. *JAMA Ophthalmol.* **2018** (136) 1182-1185.

Hou KK, Au A, Kashani AH, Freund KB, Sadda SR, and Sarraf D. Pseudoflow with OCT Angiography in Eyes with Hard Exudates and Macular Drusen, *TVST.* **2019** (8) 50.

Au A, **Hou KK,** Davila JP, Gunnemann F, Fragiotta S, Arya M, Pauleikhoff D, Querques G, Waheed N, Freund KB, Sadda S, and Sarraf D. Volumetric analysis of vascularized serous pigment epithelial detachment progression in neovascular AMD using OCT angiography, *IOVS.* **2019** (60) 3310-3319.

Lenis T, Au A, **Hou KK**, Govetto A, and Sarraf D. Alterations of the foveal central bouquet associated with cystoid macular edema, *Canadian Journal of Ophthalmology.* **2020** (44) 301-309.

Rossin EJ, Tsui I, Wong SC, **Hou KK**, et al. Traumatic Retinal Detachment in Patients with Self-Injurious Behavior: An International Multicenter Study. *Ophthalmol Retina*. 2**021** (8) 805-814.

Dow E, **Hou KK**, Abassi S, Ransome S, and Tsui E. Posterior uveitis associated with cemiplimab-rwlc, *Ocul Immunol Inflamm.* **2021** (1) 1-3.

Hubschman S, **Hou KK**, Sarraf D, and Tsui I. An unusual presentation of peripapillary pachychoroid syndrome, *AJO Case Reports*. **2022** (25) 101338.

RESEARCH PAPERS (NON-PEER REVIEWED - PUBLISHED)

Hou KK, Tsui E, and Sarraf D. ASRS X-files "An atypical case of VKH", *Retina Times.* **2020** https://www.asrs.org/publications/retina-times/details/4954/the-asrs-x-files.

Fogel Levin M, Au A, Hou KK, Sarraf D. OCTA: Pearls and Pitfalls. *Retina Today.* **2021** https://retinatoday.com/articles/2021-apr/octa-pearls-and-pitfalls

PATENTS

Wickline SA and **Hou KK**. Composition and methods for polynucleotide transfection **2014**, US provisional application number 61/748,615.

BOOK CHAPTERS

Hou KK and Nan Y. Application for biological materials. *Focused Ion Beam Systems.* Yao, N (Ed.) **2007** Cambridge, England: Cambridge University Press.

Hou KK, Garrity S, Au A, and Sarraf D. OCTA of type 3 CNV in ARMD, *Clinical Applications of Optical Coherence Tomography Angiography.* Querques G (Ed.) **2021,** Basel, Switzerland: Karger.

Hou KK, Au A, Corradetti G, and Sarraf D. Optical Coherence Tomography Angiography, *Ryan's Retina*. Sadda S (Ed.) **2021**, Elsevier (In Press).

PAPERS IN PREPARATION

Hou KK, Soberon, V, and McCannel TA. Longitudinal SD-OCT evaluation of pigment epithelial detachments associated with choroidal nevi, *Ocular Oncology and Pathology.* (In preparation).

Hou KK, Aldave A, and Kreiger A. Chronic hypotony in a case of chronic uveitis managed with pars plana vitrectomy, silicone oil tamponade, and permanent keratoprosthesis, *Retinal Cases and Brief Reports*. (Submitted).

ABSTRACTS

Hou KK, Soberon V, and McCannel T. Serous pigment epithelial detachments associated with choroidal nevi, ARVO, **2019** Vancouver, Canada.

Hou KK, Au A, and Sarraf D. Evaluation of pseudoflow artifact with OCT angiography. ARVO **2018**. Honolulu, HI.

Hou KK and Devgan U. 3-D "Super Surface" formula for maximal IOL accuracy. MillennialEYE, **2017**. Nashville, TN.

Hou KK and Wickline SA. A novel melittin-derived peptide nanoparticle delivery system for STAT3 siRNA mediated killing of B16 melanoma cells, Experimental Biology, **2012**. San Diego, CA.

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against:

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

FILED
JUN - 8 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ____

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Roy Han-Hui Loo, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 10129). Respondent was originally licensed by the Board on April 1, 2002.

2. Patient A[2] was a forty-six (46) year-old female at the time of the events at issue.

3. On the morning of March 13, 2018, Patient A was diagnosed by an optometrist with an acute retinal horseshoe tear in the supertemporal quadrant of the left eye, following complaints of loss of vision.

4. Patient A was immediately referred to Respondent following her diagnosis on March 13, 2018.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Aury Nagy, M.D., Nicola (Nick) M. Spirtos, M.D., F.A.C.O.G., and Ms. Maggie Arias-Petrel.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

5. On March 13, 2018, Patient A presented to Respondent. Respondent did not note a reason for the emergency referral, nor inquire to the referring optometrist for referral paperwork. Respondent documented Patient A had complaints of floaters in the left eye.

6. Respondent examined Patient A and documented the presence of vitreous floaters but failed to diagnose Patient A's retinal tear and intervene.

7. On March 14, 2018, Patient A developed decreased vision and was diagnosed with a retinal tear and detachment of the left eye by a different ophthalmologist. Patient A underwent urgent surgical repair on the evening of March 14, 2018.

COUNT I

NRS 630.301(4) - Malpractice

8. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

9. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

10. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

11. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A by failing to diagnose and treat Patient A's retinal tear, leading to detachment of the retina in Patient A's left eye.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

14. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment, and care of Patient A, by failing to correctly obtain and note Patient A's reason for referral.

16. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________
IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
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(775) 688-2559

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________
AURY NAGY, M.D.
Chairman of the Investigative Committee

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: ROY HAN-HUI LOO, M.D., Respondent.	Case No. 23-25326-1 (FILED UNDER SEAL)

FILED
JUN - 8 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ______

PATIENT DESIGNATION

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits its **PATIENT DESIGNATION** to identify the true and correct identity of the patient(s) referenced in the filed formal Complaint, Case No. 23-25326-1.

1. Name: [REDACTED]
   DOB: [REDACTED]

DATED this 8th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________

IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov
Attorney for the Investigative Committee

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: ROY HAN-HUI LOO, M.D., Respondent.	Case No. 23-25326-1

FILED
JUN 21 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: [signature]

PROOF OF SERVICE

I, Meg Byrd, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on June 13, 2023, I sent the **COMPLAINT** and **PATIENT DESIGNATION**, as well as required fingerprinting card with instructions to:

Roy Han-Hui Loo, M.D.
Retina Consultants of Nevada
653 N. Town Center Drive, Suite 518
Las Vegas, NV 89144

via USPS Certified Mail Tracking number 9171969009350255699230 and was delivered on June 15, 2023. *See* **Exhibit 1**.

DATED this 21st day of June, 2023.

[signature]
MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT 1

EXHIBIT 1

June 21, 2023

Dear Meg Byrd:

The following is in response to your request for proof of delivery on your item with the tracking number: **9171 9690 0935 0255 6992 30**.

Item Details

Status:	Delivered, Front Desk/Reception/Mail Room
Status Date / Time:	June 15, 2023, 4:05 pm
Location:	LAS VEGAS, NV 89144
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™ Return Receipt Electronic

Shipment Details

Weight:	0.6oz

Recipient Signature

Signature of Recipient:	
Address of Recipient:	653 N TOWN CENTER DR, LAS VEGAS, NV 89144

Note: Scanned image may reflect a different destination address due to Intended Recipient's delivery instructions on file.

Thank you for selecting the United States Postal Service® for your mailing needs. If you require additional assistance, please contact your local Post Office™ or a Postal representative at 1-800-222-1811.

Sincerely,
United States Postal Service®
475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

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FAQs >

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Tracking Number:

9171969009350255699230

Copy Add to Informed Delivery (https://informeddelivery.usps.com/)

Latest Update

Your item was delivered to the front desk, reception area, or mail room at 4:05 pm on June 15, 2023 in LAS VEGAS, NV 89144.

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USPS Tracking Plus®

Feedback

Delivered

Delivered, Front Desk/Reception/Mail Room

LAS VEGAS, NV 89144
June 15, 2023, 4:05 pm

Out for Delivery

LAS VEGAS, NV 89144
June 15, 2023, 6:10 am

Arrived at Post Office

LAS VEGAS, NV 89134
June 15, 2023, 4:42 am

Arrived at USPS Facility

LAS VEGAS, NV 89134
June 14, 2023, 11:52 pm

Departed USPS Regional Facility

LAS VEGAS NV DISTRIBUTION CENTER
June 14, 2023, 11:19 pm

Arrived at USPS Regional Facility

LAS VEGAS NV DISTRIBUTION CENTER
June 14, 2023, 2:29 pm

Departed USPS Facility

TONOPAH, NV 89049
June 14, 2023, 10:17 am

Departed USPS Regional Facility

RENO NV DISTRIBUTION CENTER
June 14, 2023, 4:41 am

Arrived at USPS Regional Origin Facility

RENO NV DISTRIBUTION CENTER
June 13, 2023, 9:49 pm

USPS picked up item

RENO, NV 89521
June 13, 2023, 12:18 pm

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FAQs

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against	)	**Case No. 23-25326-1**
ROY HAN-HUI LOO, M.D.,	)	
Respondent.	)	

FILED
JUL 1 1 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ________

ROY HAN-HUI LOO, M.D.'S ANSWER TO COMPLAINT

COMES NOW, Respondent ROY HAN-HUI LOO, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and CHELSEA R. HUETH, ESQ., of the law firm of McBRIDE HALL and for his Answer to the State of Nevada Board of Medical Examiners' (hereinafter "Board") Complaint, admits, denies, and alleges as follows:

1. This answering Respondent admits those allegations contained in Paragraph 1 of the Board's Complaint.

2. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 2 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

3. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 3 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

4. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 4 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

5. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 5

of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

6. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 6 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

7. This answering Respondent states that he does not have sufficient knowledge or information upon which to base a belief as to the truth of the allegations contained in Paragraph 7 of the Board's Complaint, and upon said grounds denies each and every allegation contained therein.

COUNT I

NRS 630.301(4) - Malpractice

8. Answering Paragraph 8 of the Board's Complaint, Respondent repeats each and every response to Paragraphs 1 through 7, inclusive, and incorporates the same by reference as though set forth fully herein.

9. Answering Paragraph 9 of the Board's Complaint, this answering Respondent admits that Nevada Revised Statute Section 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee but specifically denies committing malpractice.

10. Answering Paragraph 10 of the Board's Complaint, this answering Respondent admits that Nevada Administrative Code Section 630.040 defines malpractice but specifically denies committing malpractice.

11. This answering Respondent denies the allegations contained in Paragraph 11 of the Board's Complaint.

12. This answering Respondent denies the allegations contained in Paragraph 12 of the Board's Complaint.

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COUNT III

(NRS 630.3062(1)(a) – Failure to Maintain Appropriate Medical Records

13. Answering Paragraph 13 of the Board's Complaint, Respondent repeats each and every response to Paragraphs 1 through 12, inclusive, and incorporates the same by reference as though set forth fully herein.

14. Answering Paragraph 14 of the Board's Complaint, this answering Respondent admits that NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment, and care of a patient adopted by the Board is grounds for initiating disciplinary action against a licensee but specifically denies failing to maintain timely, legible, accurate, and complete medical records relating to the diagnosis, treatment, and care of a patient.

15. This answering Respondent denies the allegations contained in Paragraph 15 of the Board's Complaint.

16. This answering Respondent denies the allegations contained in Paragraph 16 of the Board's Complaint.

FIRST AFFIRMATIVE DEFENSE

Respondent alleges that The Nevada State Board of Medical Examiners' Complaint on file herein fails to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

N.R.S. 630.301(4) is in whole or in part, void for vagueness, violative of Respondent's due process rights under the Constitutions of the State of Nevada and the United States of America, and can serve as no basis for discipline of Respondent.

THIRD AFFIRMATIVE DEFENSE

The Nevada State Board of Medical Examiners has failed to comply with the requirements of N.R.S. 630, et seq. and N.A.C. 630 et seq.

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FOURTH AFFIRMATIVE DEFENSE

Respondent fully performed and discharged all obligations owed to the patient, including satisfying the requisite standard of care to which the patient was entitled.

FIFTH AFFIRMATIVE DEFENSE

If a violation occurred it was the result of intervening and/or superseding events, factors, occurrences, or conditions, which were in no way caused by Respondent, and for which Respondent is not responsible.

SIXTH AFFIRMATIVE DEFENSE

All possible affirmative defenses may not have been alleged herein so far as sufficient facts were not available after reasonable inquiry upon filing of this answering Respondent's Answer and, therefore, this answering Respondent reserves the right to amend his Answer to include additional affirmative defenses, if subsequent investigation so warrants.

WHEREFORE, the Respondent prays that The Nevada State Board of Medical Examiners take nothing by way of the Complaint on file herein; and that Respondent recover all costs and attorneys' fees incurred.

DATED this 11th day of July 2023.

McBRIDE HALL

By: *<u>/s/ Chelsea R. Hueth</u>*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
CHELSEA R. HUETH, ESQ.
Nevada Bar No.: 10904
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Roy Han-Hui Loo, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on the 11th day of July 2023, I served a true correct copy **ROY HAN-HUI LOO, M.D.'S ANSWER TO COMPLAINT**, by sending via electronic mail and via United States mail to the following:

Ian J. Cumings, Esq.
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
icumings@medboard.nv.gov
Attorney for the Investigative Committee

/s/ Lauren Smith
An Employee of McBride Hall

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and
Complaint Against

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

Early Case Conference Date: July 20, 2023
@ 10:00 a.m.

FILED
JUL 17 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

ORDER SCHEDULING EARLY CASE CONFERENCE

TO: Ian Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
Olivia Campbell, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

NOTICE IS HEREBY GIVEN that, in compliance with NRS 630.339(3), **an Early Case Conference will be conducted on July 20, 2023 beginning at the hour of 10:00 a.m.** The Early Case Conference will be held via conference call. The conference call number is 1-605-475-2200 and the access code is 8792457.[1]

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[1] NRS 630.339(3) provides as follows:

> Within 20 days after the filing of the answer, the parties shall hold an early case conference at which the parties and the hearing officer appointed by the Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:
>
> (a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the Board, including the estimated duration of the hearing:
>
> (b) Set dates:

The scheduled Early Case Conference shall be attended by the parties in person or by any party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss and designate the dates for the Pre-Hearing Conference and Hearing and the other procedural matters established in NRS 630.339. The parties must also provide an estimate, to the nearest hour, of the time required for presentation of their respective cases.

At the Pre-Hearing Conference, in accordance with NAC 630.465,[2] each party shall provide the other party with a copy of the list of witnesses they intend to call to testify, including therewith, the qualifications of each witness so identified and a summary of the testimony of each witness. If a witness is not on the list of witnesses, that witness may subsequently not be allowed to testify at the Hearing unless good cause is shown for omitting the witness from said list.[3] Likewise, all

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(1) By which all documents must be exchanged;
(2) By which all prehearing motions and responses thereto must be filed;
(3) On which to hold the prehearing conference; and
(4) For any other foreseeable actions that may facilitate the timely and fair conduct of the matter.

(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;
(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and
(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

[2] NAC 630.465 provides as follows:

> 1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.
>
> 2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.
>
> 3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.
>
> 4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

[3] In identifying a patient as a witness the parties are cautioned to omit from any pleadings filed with undersigned Hearing Officer any addresses, telephone numbers, social security numbers, or other personal information regarding such

evidence, except rebuttal evidence, that is not provided to each party at the Pre-Hearing Conference may also not be introduced or admitted at the Hearing unless good cause is shown.

Counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that the possible sanctions authorized by NRS 630.352, NAC 630.555, and NRS 622.400 upon a finding of guilt to one or more of the Counts raised in said Board Complaint include the following:

A. Placement on probation for a specified period on any of the conditions specified in an order issued by the Board;

B. Administration of a public reprimand;

C. Placement of a limitation on Respondent's practice, or exclusion of one or more specified branches of medicine from Respondent's practice;

D. Suspension of Respondent's license for a specified period or until further order of the Board;

E. Revocation of Respondent's license to practice medicine;

F. A requirement that Respondent participate in a program to correct alcohol or drug dependence or any other impairment;

G. A requirement that there be specified supervision of Respondent's practice;

H. A requirement that Respondent perform public service without compensation;

I. A requirement that Respondent take a physical or mental examination, or an examination testing Respondent's competence;

J. A requirement that Respondent fulfill certain training or educational requirements, or both, as specified by the Board;

K. A fine not to exceed $5,000.00;

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individual and to confine their submissions in this regard to the name of the witness, the relevancy of any testimony sought to be elicited from that witness, and a summary of the anticipated testimony.

L. A requirement that the Respondent pay all costs incurred by the Board relating to this disciplinary proceeding, as more fully set forth in NRS 622.400.

DATED this 14th day of July 2023.

By: ______________________

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

1
CERTIFICATE OF SERVICE

2 I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno,
3 Nevada, a true file-stamped copy of the foregoing ORDER SCHEDULING EARLY CASE
4 CONFERENCE addressed as follows:

5 Ian Cumings
6 Deputy General Counsel
7 Nevada State Board of Medical Examiners
8 9600 Gateway Drive
Reno, Nevada 89521

9 Roy Han-Hui Loo, M.D.
10 c/o Chelsea R. Hueth, Esq. and
11 Olivia Campbell, Esq.
McBride Hall
12 8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

13 DATED this ________ day of ________________ 2023.

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15 ________________________________
16 Signature

17 ________________________________
18 Print

19 ________________________________
20 Title

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and

Complaint Against

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

Hearing Date: February 1-2, 2024 @ 8:30 a.m.

SCHEDULING ORDER

FILED

JUL 20 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: [signature]

TO: Ian Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
Olivia Campbell, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

In compliance with NAC 630.465, a pre-hearing conference will be conducted on **October 6, 2023**, beginning at the hour of 10:00 a.m., Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time of the pre-hearing conference, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call by and through counsel and the conference will be conducted before the undersigned hearing officer.

By the pre-hearing conference, each party shall provide the other party with a copy of the list of witnesses he or she intends to call to testify, including the witness' qualifications as well as a brief summary of the witness' anticipated testimony. If a witness is not included in the list of witnesses, that witness may not be allowed to testify at the hearing unless good cause is shown.

Likewise, all documentation sought to be relied upon at the formal hearing shall be identified and any documentation not already exchanged pursuant to NRS 622A.330 shall be exchanged. If at the formal hearing any party seeks to rely upon documentation not previously produced as ordered, such documentation will not be permitted unless good cause is shown.

Any and all pre-hearing motions shall be served and submitted to the undersigned hearing officer on or before **November 20, 2023**. Any oppositions or responses thereto shall be served and submitted to the undersigned hearing officer on or before **December 6, 2023**. Any and all replies shall be served and submitted to the below hearing officer on or before **December 15, 2023**.

The formal hearing in this matter is hereby scheduled for **February 1, 2024 through February 2, 2024**, starting at 8:30 a.m. on both days. Unless otherwise determined, Counsel for the IC and the undersigned hearing officer shall attend from the Reno office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. Respondent and counsel on Respondent's behalf may attend from the Las Vegas Office of the Nevada State Board of Medical Examiners, 325 E. Warm Springs Road, Suite 225, Las Vegas, Nevada 89119. Unless stipulated to, permission for the remote appearance by any witness must be sought from and approved by the undersigned hearing officer, and any such request shall be in writing and submitted on or before **December 15, 2023.**

Following the hearing, the undersigned hearing officer will submit to the Board written findings and recommendations pursuant to NRS 622A.300 that, pursuant to NAC 630.470, will include a synopsis of the testimony taken at the hearing as well as a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor. Thereafter the Board will render its decision. NAC 630.470.

Should the parties deem a status conference necessary at any juncture of the proceeding, they shall coordinate at least three proposed dates and times and may jointly email the undersigned hearing officer with the proposed dates and times and request a status conference and state the basis for the request.

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Both parties shall keep the undersigned hearing officer apprised of each issue that has been resolved by negotiation or stipulation or any other change in the status of this case.

DATED this 20th day of July 2023.

By: ______________________
Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

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CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing SCHEDULING ORDER addressed as follows:

Ian Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
Olivia Campbell, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

DATED this 20th day of July 2023.

Meg Byrd
Signature

Meg Byrd
Print

Legal Assistant
Title

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and

Complaint Against

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

Hearing Date: February 1-2, 2024 @ 8:30 a.m.

FILED

SEP 27 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ___

AMENDED SCHEDULING ORDER
(Pre-Hearing Conference Only)

TO: Ian Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
Olivia Campbell, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

By agreement of the parties and in compliance with NAC 630.465, a pre-hearing conference will be conducted on **October 26, 2023,** beginning at the hour of 2:00 p.m., Pacific Standard Time, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time of the pre-hearing conference, the conference call number will be 1-605-475-2200 and the access code will be 8792457. The parties shall participate in the conference call by and through counsel and the conference will be conducted before the undersigned hearing

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1 officer. All other matters addressed in the Scheduling Order filed on July 20, 2023 remain as set
2 forth therein.
3 DATED this 26th day of September 2023.
4 By: ______________________
Patricia Halstead, Esq.
5 Hearing Officer
(775) 322-2244
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1 CERTIFICATE OF SERVICE

2 I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno,
3 Nevada, a true file-stamped copy of the foregoing AMENDED SCHEDULING ORDER
4 addressed as follows:

5 Ian Cumings
6 Deputy General Counsel
Nevada State Board of Medical Examiners
7 9600 Gateway Drive
Reno, Nevada 89521
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9 Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
10 Olivia Campbell, Esq.
McBride Hall
11 8329 West Sunset Road, Ste 260
12 Las Vegas, NV 89113

13 DATED this 27th day of September 2023.
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15 [signature]
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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ROY HAN-HUI LOO, M.D.,** **Respondent.**	**Case No. 23-25326-1** **FILED** OCT 19 2023 NEVADA STATE BOARD OF MEDICAL EXAMINERS By: ________

PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Order filed on July 20, 2023.

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

a. Ernesto Diaz, Chief of Investigations or his Designee
Nevada State Board of Medical Examiners

Mr. Diaz or his Designee is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Roy Han-Hui Loo, M.D.

Dr. Loo is expected to testify regarding the facts and circumstances surrounding the formal Complaint in this case.

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

c. Steven M. Friedlander, M.D., FACS

Dr. Friedlander is a Board-Certified Ophthalmologist and is licensed to practice medicine in the State of Nevada. Dr. Friedlander has conducted a medical review of this case and is expected to testify regarding his medical review of this matter and the applicable standard of care.

d. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons he may call to testify at the hearing herein.

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1	Allegation Letter, dated March 9, 2021	0001-0002
2	Response to Allegation Letter by Dr. Loo, dated March 30, 2021	0003-0005
3	Complaint filed June 8, 2023	0006-0010
4	Medical records from Retina Consultants of Nevada for Patient A	0011-0089
5	Medical Records from Center of Sight for Patient A	0090-0128
6	Curriculum Vitae of Steven Friedlander, M.D., FACS	0129-0133

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

The IC reserves the right to use any exhibits relied upon or identified by Respondent and reserves the right to amend and supplement this list of exhibits as required.

DATED this 19th day of October, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________

IAN J. CUMINGS
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov

Attorney for the Investigative Committee

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 19th day of October, 2023, I served a file-stamped copy of the foregoing PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS, via Fed Ex 2Day delivery with postage pre-paid, to the following parties:

ROY HAN-HUI LOO, M.D.
c/o Chelsea R. Hueth, Esq.
8329 W. Sunset Road, Suite 260
Las Vegas, NV 89113

PATRICIA HALSTEAD, ESQ.
615 S. Arlington Ave.
Reno, NV 89509

Loo Tracking No.: 7738 0166 2648

Halstead Tracking No.: 7738 0204 2977

With courtesy copy by email to:

Chelsea R. Hueth, Esq. (crhueth@mcbridehall.com) without exhibits
Charles Woodman, Esq. (phalstead@halsteadlawoffices.com) without exhibits

DATED this 19th day of October, 2023.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

October 23, 2023

Dear Customer,

The following is the proof-of-delivery for tracking number: 773801662648

Delivery Information:

Status:	Delivered	**Delivered To:**	Receptionist/Front Desk
Signed for by:	D.DANIELLE	**Delivery Location:**	8329 W SUNSET RD 260
Service type:	FedEx 2Day		
Special Handling:	Deliver Weekday; Adult Signature Required		LAS VEGAS, NV, 89113
		Delivery date:	Oct 20, 2023 13:17

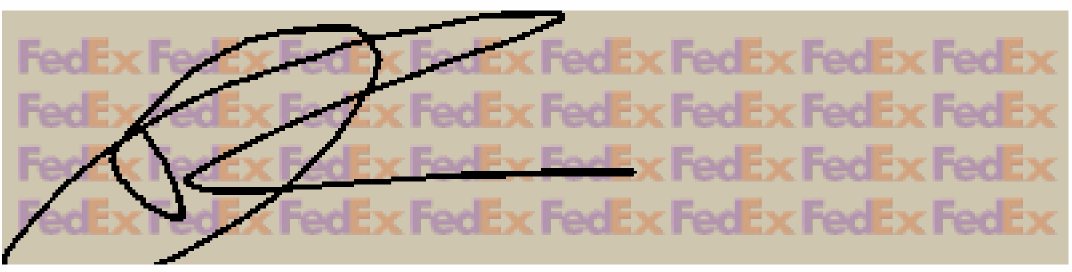
Shipping Information:

Tracking number:	773801662648	**Ship Date:**	Oct 19, 2023
		Weight:	0.5 LB/0.23 KG

Recipient:
Roy Han-Hui Loo, M.D., c/o Chelsea R. Hueth, Esq.
8329 W. Sunset Road
Suite 260
LAS VEGAS, NV, US, 89113

Shipper:
Meg Byrd, Nevada State Board of Med Exam
9600 Gateway Drive
RENO, NV, US, 89521

Reference NSBME Case No. 23-25326-1 Loo



Thank you for choosing FedEx

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against ROY HAN-HUI LOO, M.D., Respondent.	**Case No. 23-25326-1**

FILED
OCT 24 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: [signature]

ROY HAN-HUI LOO, M.D.'S PRE-HEARING DISCLOSURE

COMES NOW, Respondent ROY HAN-HUI LOO, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and CHELSEA R. HUETH, ESQ., of the law firm of McBRIDE HALL and the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Order filed September 27, 2023:

I. LIST OF WITNESSES

1. Roy Loo, M.D.
   c/o Robert C. McBride, Esq.
   Chelsea R. Hueth, Esq.
   McBRIDE HALL
   8329 W. Sunset Road, Suite 260
   Las Vegas, NV 89113
   (702) 792-5855

Respondent will testify regarding the care and treatment provided to Patient A, his custom and practice, and his medical records documenting Patient A's care and treatment. He will also provide testimony regarding the Board's Complaint and the allegations therein. Respondent will also testify that he complied with the standard of care based on his education, training, and background.

2. Matthew Pezda, M.D.
   653 N. Town Center Drive, Suite 518
   Las Vegas, NV 89144

Dr. Pezda is expected to testify regarding his care and treatment of Patient A as well as his medical records documenting his care.

///

3. Ashlee Stoops
c/o Robert C. McBride, Esq.
Chelsea R. Hueth, Esq.
McBRIDE HALL
8329Sunset Road, Suite 260
Las Vegas, NV 89113
(702) 792-5855

Ms. Stoops is the Director of Clinic Operations for Comprehensive EyeCare Partners and Practice Administrator for Retina Consultants of Nevada. She is expected to testify regarding the office protocol for obtaining medical records of patients upon referral from an outside provider, scheduling patients for same day appointments, and maintenance of patient records. She may also provide testimony regarding the Board's Complaint and the allegations therein.

4. Kirk Hou, M.D.
800 South Fairmount Ave., Suite 215
Pasadena, CA 91105

Dr. Hou is a physician board-certified in ophthalmology and is expected to testify regarding his review of this case and the standard of care applicable to Dr. Loo's care and treatment of Patient A, and documentation of the same. Dr. Hou will also provide expert testimony regarding the Board's Complaint and the allegations contained therein.

Respondent reserves the right to call as expert witnesses any and all of the Board's designated expert witness(es) or any other witness designated by the Board.

II. LIST OF EXHIBITS

1. Board of Medical Examiners of the State of Nevada Complaint filed June 8, 2023.
2. Respondent Roy Loo, M.D.'s Answer to Complaint.
3. Respondent Roy Loo, M.D.'s Board Response Letter dated March 30, 2021.
4. Medical Records from Retina Consultants of Nevada.
5. Color scans of Patient A from Retina Consultants of Nevada.
6. Curriculum vitae of Kirk Hou, M.D.

Respondent reserves the right to use any and all of the documents, exhibits, reference materials and records disclosed by the Board or any other party. Respondent further reserves the right to amend and supplement this list as necessary for rebuttal and/or impeachment.

DATED this 24th day of October 2023.

McBRIDE HALL

By: */s/ Chelsea R. Hueth*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
CHELSEA R. HUETH, ESQ.
Nevada Bar No.: 10904
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Roy Han-Hui Loo, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on the 24th day of October 2023, I served a true correct copy **ROY HAN-HUI LOO, M.D.'S PRE-HEARING DISCLOSURE**, by sending via electronic mail and via United States mail to the following:

Ian J. Cumings, Esq.
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
icumings@medboard.nv.gov
Attorney for the Investigative Committee

Patricia Halstead, Esq.
Nevada State Board of Medical Examiners
615 S. Arlington Avenue
Reno, NV 89509
Hearing Officer

/s/ Lauren Smith
An Employee of McBride Hall

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA
* * * * *

In the Matter of Charges and Complaint Against ROY HAN-HUI LOO, M.D., Respondent.	Case No. 23-25326-1

FILED

DEC 15 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: [signature]

ROY HAN-HUI LOO, M.D.'S REQUEST FOR REMOTE APPEARANCE

COMES NOW, Respondent ROY HAN-HUI LOO, M.D., by and through his counsel of record, ROBERT C. McBRIDE, ESQ. and CHELSEA R. HUETH, ESQ., of the law firm of McBRIDE HALL and pursuant to the July 20, 2023 Scheduling Order, hereby requests that permission be given for witness, Kirk Hou, M.D. to appear and testify at the formal hearing in this matter via remote means.

DATED this 14th day of December, 2023.

McBRIDE HALL

By: */s/ Chelsea R. Hueth*
ROBERT C. McBRIDE, ESQ.
Nevada Bar No.: 7082
CHELSEA R. HUETH, ESQ.
Nevada Bar No.: 10904
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Respondent
Roy Han-Hui Loo, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of December, 2023, I served a true correct copy **ROY HAN-HUI LOO, M.D.'S REQUEST FOR REMOTE APPEARANCE**, by sending via electronic mail and via United States mail to the following:

Ian J. Cumings, Esq.
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
icumings@medboard.nv.gov
Attorney for the Investigative Committee

Patricia Halstead, Esq.
Nevada State Board of Medical Examiners
615 S. Arlington Avenue
Reno, NV 89509
Hearing Officer

/s/ Lauren Smith
An Employee of McBride Hall

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ROY HAN-HUI LOO, M.D.,

Respondent.

Case No. 23-25326-1

Hearing Date: February 1-2, 2024 @ 8:30 a.m.

ORDER GRANTING REMOTE APPEARANCE REQUEST

TO: Ian Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
Olivia Campbell, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

FILED
JAN 17 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: [signature]

A Scheduling Order was filed in this matter on July 20, 2023, which required that requests for witnesses to appear remotely must be in writing and filed by December 15, 2023. An Amended Scheduling Order was filed on September 27, 2023, which did not impact the stated deadline and only continued the pre-hearing conference.

On December 14, 2023, Respondent caused to have filed a Request for Remote Appearance, by which he requested permission for witness Kirk Hou, M.D. to appear remotely. No response to the request was filed by the IC.

On January 16, 2024, based upon there being no response to the remote appearance request, inquiry was made to counsel by undersigned to determine if there was a stipulation for the remote appearance. In relation to the inquiry, it was pointed out that, because of technology

Respondent expressed his willingness to have Kirk Hou, M.D. appear personally from Las Vegas if a continuation was granted to accommodate Kirk Hou, M.D.'s ability to rearrange his schedule and book travel but the IC is not amenable to continuing the hearing. It is also worth noting that it is the IC's own technology that precludes a witness from appearing remotely when parties are appearing from both the Reno and Las Vegas offices. It is also relevant that the IC is already remote from Respondent and Respondent's witnesses by virtue of being in Reno and not in Las Vegas where respondent and his witnesses would be appearing, therefore, even if Kirk Hou, M.D., were required to be in Las Vegas in person, he would still be appearing remotely to the IC.

While personal appearances have traditionally been favored for legal proceedings in light of witness assessment, which is deemed to be more effective in person, remote appearances have become somewhat of a norm and have been effective. Undersigned is also cognizant of the time and expense of requiring expert witnesses to personally appear, which is negated by a remote appearance.

Having previously engaged in a fully remote hearing undertaken to accommodate out of state expert witness appearances for both parties, and there having been no exceptional circumstances supporting the same outside of considerations of scheduling, expense, and convenience, undersigned is confident that the matter can proceed effectively if undertaken fully remotely, which, again, is the result of the manner by which the IC's technology is set up as between the Reno and Las Vegas offices. Further, the timing mandates the same given the IC's failure to respond to the filed request.

Notably, at the prior hearing undersigned participated in that was fully remote, both undersigned, the respondent therein, and respondent therein's counsel appeared from the Reno and Las Vegas offices. While the hearing was undertaken entirely by Zoom, each appeared from separate rooms so only the expert witness was not physically in the Reno or Las Vegas office (as the parties were in the hearing rooms, only undersigned took up a separate conference room). Both undersigned and Respondent offered the same concession (Respondent also offered to have only Kirk Hou, M.D.'s testimony be limited to the fully remote procedure), which was rejected by the IC based upon a concern about bandwidth, which was not an issue at the time of the prior

hearing. Based upon the IC's position as to the parties and undersigned themselves appearing personally from the Reno and Las Vegas offices, which undersigned would have otherwise ordered, this matter will be fully remote with all parties appearing from their respective locations. To that end, the parties are again reminded to ensure that undersigned has copies of all necessary documents to be able to effectively engage in the hearing.

DATED this 17th day of January 2024.

By: ______________________
Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing ORDER GRANTING REMOTE APPEARANCE REQUEST addressed as follows:

Ian Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Roy Han-Hui Loo, M.D.
c/o Chelsea R. Hueth, Esq. and
Olivia Campbell, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

DATED this 17th day of January 2024.

[signature]
Signature

Meg Byrd
Print

Legal Assistant
Title

January 25, 2024

Dear Meg Byrd:

The following is in response to your request for proof of delivery on your item with the tracking number:
9171 9690 0935 0241 6152 75.

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Status:	Delivered, Left with Individual
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