NEVADA STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

ANNABEL ELIZABETH BARBER, M.D.

ADJUDICATION

Case No: 23-11660-1

Date: December 12, 2025

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 17 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018, when he presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Respondent ordered a CT scan "to define anatomy better."

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[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., 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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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4. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he had acquired short bowel syndrome.

5. Upon healing from those surgeries, Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

6. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laparoscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

7. Upon information and belief, during the surgery on February 22, 2019, Respondent made an attempt to gain laparoscopic access to the peritoneum via the right lower quadrant. When Respondent was unable to gain peritoneal access, it appears from her operative note that she tried to gain access via the left lower quadrant but was also unsuccessful. It appears, upon information and belief, that Respondent then attempted to access the peritoneum via a midline incision and immediately noticed that she had injured Patient A's bowel.

8. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision.

9. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures.

10. Respondent then closed the incision and discharged Patient A without having repaired Patient A's left inguinal hernia.

11. There was no documentation of the injury in the operative note which was unintelligibly written.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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14. 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."

15. 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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

16. 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

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

18. 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.

19. Respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

20. 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 her and give her notice that she 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;

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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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
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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 17th day of November, 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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2

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

FILED
AUG 29 2025
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

FINDINGS AND RECOMMENDATIONS

1. Introduction.

The above-referenced matter came for hearing initially on June 4, 2024 before another hearing officer, and was continued to April 3, 2025 through April 4, 2025, and then continued again to April 10, 2025. The hearing was initially continued from June 4, 2024 based upon an Order for Matter to Proceed to Continued Hearing, issued by the undersigned hearing officer on November 1, 2024, which is incorporated herein by reference.

The continued hearing was held in person at the State of Nevada Board of Medical Examiners' Reno office, with counsel for the Investigative Committee of the State of Nevada Board of Medical Examiners Donald K. White (the "IC"); Respondent Dr. Annabel Barber ("Respondent"); and Respondent's counsel Patricia Egan Daehnke, Esq. appearing in person. The

final day of the hearing, April 10, 2025, was held remotely by and through the Zoom application by consent of the parties.

The charges at issue were set forth in the Complaint, filed on November 17, 2023, which sets forth Count I, Malpractice, a violation of NRS 630.301(4), premised upon Respondent making a surgical decision to pursue a midline incision to repair a hernia when the patient was known to have "an extensive surgical history and surgical scarring" in the abdomen. Count II is for Failure to Maintain Proper Medical Records, a violation of NRS 630.3062(1)(a), and is premised upon Respondent's failure to maintain legible and complete medical records in relation to the surgical procedure at issue, specifically failing to "correctly" document her actions and her failure to note the patient's "extensive medical history."

The parties stipulated to the admission of IC Exhibits 1-5, with IC Exhibit 5 being an updated version of Dr. Nicholas Spoerke's curriculum vitae. The parties also stipulated to the admission of Respondent's Exhibits 1-13.

Respondent further requested that the proceedings in matter number 22-11660-1 be made part of this record, which undersigned indicated would be addressed in the findings. It remains that matter number 22-11660-1 has never been before the undersigned hearing officer but entails a prior Complaint, filed on September 20, 2022, against Respondent for the same counts and in relation to the same patient and underlying facts (the "Prior Complaint"). Based upon discussions with the parties, it is undersigned's understanding that the panel that reviewed and approved the issuance of the Prior Complaint included a cardiologist that had cleared the patient at issue for surgery either related to the procedure that is the subject of the current Complaint or the surgery the patient had just after (given the passage of time, counsel for the parties did not recall which at the time of the discussion). It is also undersigned's understanding, based upon discussions with the parties, that another hearing officer had circulated a draft order dismissing the Prior Complaint based upon that being a conflict (presumably it was a dismissal without prejudice); but, before that order had been finalized, the IC caused the charges to be reviewed by an alternate panel and then dismissed the Prior Complaint on its own initiative and without prejudice on November 16, 2023, the day before the current Complaint was filed. To the extent Respondent asked that the

issue be preserved, it is outlined as provided above and undersigned takes no position with respect thereto as it is not subject to adjudication in this proceeding and does not go to the merits of the current Complaint.

This matter was also subject to a prior hearing cut short due to disagreement about the release of the IC's investigative file with regard to which the parties continue to maintain their prior positions and related objections. In moving forward from that issue based upon the Order for Matter to Proceed to Continued Hearing referenced *supra*, the parties referred to their opening statements as already given on the record and reflected in the June 4, 2024 transcript, and the IC deferred to the testimony of its investigator, Monica Gustafson, as also recorded in the June 4, 2024 transcript, by which Ms. Gustafson authenticated documentation in the midst of questions and argument related to the IC Investigative File.

Due to the state of the record, the IC commenced anew with Dr. Spoerke's testimony. While the rule of exclusion was invoked, each party's expert was excepted therefrom and allowed to sit in on the other expert's testimony. However, neither party's expert did so and it was instead relayed that Respondent's counsel had conveyed the substance of Dr. Spoerke's prior testimony to her expert Dr. Baskies.

2. Testimony.

After addressing his training and experience (*see* IC Exhibit 5, as well as the April 4, 2025 Transcript pp. 17-14, 21-22 [abbreviated as "T" followed by the referenced page numbers]), Dr. Spoerke explained the difference between a laparoscopic hernia surgery and an open hernia surgery, with an open surgery being an incision followed by dissection of tissue and repair (T 20-21), versus a laparoscopic surgery being a three incision procedure, one to gain access to the abdomen and utilized to inflate the abdomen with carbon dioxide, and two more incisions to accommodate working ports for the repair instruments (T 21).

Dr. Spoerke then went over IC Exhibit 4, specifically NSBME 108, as it related to Respondent's notation of the patient's history and, when discussing the patient was born with "an omphalocele," testified that a risk factor of this condition is developing intraabdominal scar tissue

later in life.[1] T 26. Dr. Spoerke also testified that the patient had suffered from a bowel blockage that resulted in a large amount of the small bowel being removed. T 27. The record also reflected that a right hernia had been repaired. T 28.

Next, Dr. Spoerke testified that Respondent's record commencing at NSBME 108 lacks critical detail because the type of hernia is not sufficiently detailed as well as its location as to left or right, although "left" is indicated later in the document. T 28-31; 150-152. Dr. Spoerke then testified that there is no way to know with certainty what kind of internal scarring a patient has without actually cutting an incision and investigating, but that he would assume that a patient with this particular history would have a considerable amount of scar tissue, which would be a normal result of the kind of surgeries the patient had. T 31-32, 36-37. While some scarring could "fade away," it is less common; and, generally, once scarring occurs, the patient tends to form adhesions, which means that scarring tissue adheres to organs such as, in this instance, the patient's bowel. T 33, 37-38.

According to Dr. Spoerke, the notes at IC Exhibit 4, NSBME 111 indicate and open surgery was contemplated. T 39. He opines that a laparoscopic surgery is "probably a better repair overall" but maintains that an open surgery would be considered when a laparoscopic surgery could not be done or where the patient has had a lot of prior abdominal operations, which would make a laparoscopic surgery more difficult because it would be harder to see due to the adhesion scarring that would prevent the abdomen being lifted from the bowel with use of the carbon dioxide inflation that would be used for a laparoscopic procedure. T 39-42.

Dr. Spoerke continued testifying with regard to his opinion that the record keeping by Respondent was poor. T 44-47; 92-95. He then described Respondent's operation as notated by her at IC Exhibit 4, NSBME 115 (the post-operative report), as having started with an incision on the right with no visualization due to scarring, then an incision on the left with no visualization due to scarring; then an incision and attempt to visualize at the midline, acknowledging that when

[1] An omphalocele was described by Dr. Spoerke as a condition where the abdominal wall does not fully close and so abdominal contents or bowels tend to protrude. T 24-25. The condition is corrected with multiple staged operations to stretch the abdominal wall to eventually be closed over any protrusion. T 25-26.

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one cannot visualize what needs to be seen, the tools being utilized are pulled and another area is attempted or the procedure is converted to "another operation." T 48-52. Dr. Spoerke then noted that the patient's prior surgeries were at the midline area, which would indicate scarring in that location. T 52-53. Therefore, because there was scarring at the right and left sides already that precluded visualization, Dr. Spoerke opined that going in through the midline "is not a good idea" and the surgery should have been converted to an open repair. T 53-55, 70-71.

At the midline attempt, Respondent punctured the patient's bowel, with the odds of having punctured the bowel having been increased given the scarring. T 55-60, 66-67. Regardless of what procedure was used, Dr. Spoerke acknowledged that they all carry a risk of injury to the bowel. T 72. However, Dr. Spoerke deemed having gone into the midline with the patient's history after no visualization from the right or left to be malpractice, and stated that the perforation, despite having been subject to repair at the time, resulted in the patient later having the punctured portion of his bowel removed due to leakage. T 72-73, 79-89. According to Dr. Spoerke, due to visualization considerations in light of the scarring, there was more risk for the patient to do the surgery laparoscopically, which is why he opined it should have been converted to an open surgery after failed visualization on attempts to repair from the right and left sides of the abdomen. T 96-97.

Dr. Spoerke addressed Respondent's records of the surgery and how they are generally made through dictation and then transcribed by a third party subject to review and signature by the physician. T 61-62. In this instance, the post-operative record was signed by Respondent with no apparent corrections after the transcription. T 63 referring to IC Exhibit 4 NSBME 116. Per Dr. Spoerke, corrections could have been undertaken by calling the transcription service and having them make the corrections, although it is standard to be able to make the corrections from the system where the record is sent. T 63-64. Dr. Spoerke testified that, as transcribed, he would not have signed the record because it was not sufficient with respect to pertinent details. T 64-65, 73-74.

On cross-examination, Respondent, through counsel, contrasted Dr. Spoerke's experience with that of Respondent and made the point that a physician's comfort level doing surgery

laparoscopically is relevant. T 105-108 (confirming that Dr. Spoerke had done five to ten laparoscopic hernia repairs in his career), 113-117. Respondent also addressed the History and Physical Operative Note (IC Exhibit 4, NSBME 107) being a summary form required by the surgery center that, in this case, was supplemented by a more thorough record, but which Dr. Spoerke says he would have nonetheless filled out more specifically – for instance the notation at GU/Pelvic is not clear and utilizing abbreviations such as appears to be utilized is contrary to current medical standards (referencing JCAHO). T 121-139, 146-148.

On redirect, Dr. Spoerke opined that, with all her experience, Respondent should have aborted her efforts before the midline entry and converted to an open surgery. T 144-145. As to the supplement to the History and Physical Operative Note, Dr. Spoerke testified that he has no indication that it was actually supplemented and that a reference to supplemental records on the form itself was not made. T 145-146. Dr. Spoerke further took issue with the legibility of the History and Physical Operative Note (IC Exhibit 4, NSBME 107). T 149-150.

On recross, Respondent sought to emphasize her experience and Dr. Spoerke's lack of familiarity with her as an experienced professional in her field. T 154-155. Upon the conclusion of Dr. Spoerke's testimony, the IC rested.

Respondent testified on her own behalf, commencing with addressing her training and experience (*see* Respondent's Exhibit 8), which includes, but is not limited to, teaching surgery at the University of Nevada Medical School as well as at Texas Tech. T 159-163, 175-186. Respondent also testified to a research background that included development of nutritional supplementation that could mitigate shock and that was a precursor to the development of Juven, a therapeutic nutritional supplement that she had prescribed to the patient at issue prior to the surgery. T 164-175.

Respondent testified to having done hundreds of laparoscopic surgeries and having done ten in just the week prior to testifying, as well as to being on-call and performing many different abdominal surgeries and consulting with other surgeons on difficult cases. T 186-191. Respondent testified that she believed it was safe to have performed the laparoscopic surgery at issue given that scarring is completely unpredictable, and that the patient's surgeries as a baby

were not an indication of adult scarring and adhesion. T 191-192. Respondent acknowledged that there was a "generation" that believed if you had surgery before you were not a candidate for a following laparoscopic surgery but says that has changed. T 193. Because she was concerned about the patient's wound healing, she felt laparoscopic surgery would be beneficial. T 193, 198-199, 202-205.

Respondent testified that her plan was laparoscopic surgery with possible open surgery and had ordered a CAT scan to see if she could identify "adhesive disease," which was not apparent from the scan. T 194-197. Respondent said she did not have the patient's prior abdominal surgery records and, therefore, relied upon what the patient told her as well as relying upon the CAT scan. T 197-198.

Respondent explained the procedure and how she had no visualization going in on the right side. T 199-201. Respondent also indicated that it is often considered safer to do a laparoscopic surgery from the opposite side of the hernia (this being a left side hernia; thus, why she started from the right) so one is not cutting through areas that have already been cut through if there was a prior open surgery on the hernia side. T 203. Respondent then testified how she went in on the left side, which would be a normal attempt to make. T 206, 221. As to the midline, Respondent testified that, when she looked in, it looked as though there was an injury to the bowel so she did a laparotomy, which is an abdominal incision to access the abdominal organs. T 209, 212. Respondent testified that she assumed it was an injury caused by the trocar used for the laparoscopic surgery, which is a recognized risk of the procedure. T 209-213, 225-226.

Upon accessing the bowel, Respondent testified that it was very unhealthy and referred to it as "friable," which was a reference to its fragility with respect to tearing and bleeding upon contact. T 213-214; T 128-141; T3 10-13 and 26-27. Having spotted the injury, and the bowel not holding sutures well, for purposes of repair to the perforation, Respondent also added a staple line and did not undertake to repair the hernia because she wanted to get the patient into recovery due to the blood loss. T 214-215, 221-223; T2 58-59 and 128-141; T3 10-17. Respondent testified that with the unexpected perforation and bleeding it was better to get the patient out of surgery and make sure he would recover from what had already taken place without repair to the

hernia. T 223-224. According to Respondent, the patient was stable and so she felt it was appropriate for him to be released. T 226-227.

Per Respondent, the hernia repair surgery was elective. April 5, 2025 Transcript (T2), p. 17. With respect to the History and Physical Operative Note (IC Exhibit 4, NSBME 107) Respondent testified that it was a presurgical form required by the surgery center and went through its notations. T2 17-21. Respondent also testified as to the patient having been cleared for the planned surgery and anesthesia from a cardiac standpoint by a cardiologist and all other presurgical evaluations showing only that the patient was slightly anemic. T2 21-23.

Respondent testified that it was unnecessary to note on the presurgical form whether the hernia was reducible or incarcerated because the surgery is the same. T2 24-25. In further addressing the presurgical form, Respondent noted that, for the pelvic exam, the form provides for downward pointing arrows, meaning the patient's testes were both descended. T2 25. Respondent described this as a note to herself and did not expand upon why Dr. Spoerke deemed the notation inappropriate. T2 25-26. Respondent also indicated she would have prior records from her office with her for review in preparation for the surgery. T2 27-29. Per Respondent, the presurgical form is from the surgical center and is the same for several surgical centers, but is different at the hospitals, and includes a post-op note for aftercare, which Respondent addressed. T2 30-32.

As to the surgery itself, Respondent testified that the patient had adhesion, a small bowel injury, and repair with no specimens removed, along with a lot of blood loss. T2 32-33. Respondent thought the bowel repair was good and released the patient, indicating that the patient could resume a normal diet and was to return for an appointment with her in three days. T2 34-35.

With respect to IC Exhibit 4, NSMBE 115-116, Respondent testified that it is a dictated record post-op and, when it was dictated, she was shaken because the surgery did not go as she had hoped. T2 36-39. At that particular surgery center, per Respondent, the dictation is not computer linked, so the notations cannot be corrected on a computer and you do not get the transcription back until it is handed to you in paper for when you return to the surgery center. T2 39-41, 53-54. Respondent indicates that she did not recall reading the dictated report before she

signed it and, therefore, did not notice the missing information indicated with blanks. T2 41. As for correcting the form by writing on it, Respondent says she could not do that because "it was a lot later." T2 42. Respondent also indicated there was no way to correct it because it was not an electronic record. T3 27-28. Respondent acknowledged some mistranscriptions and that the notation did not accurately reflect what was intended, in some sections being nonsensical. T2 43-48, 51-52, 54-55.

Within the post-op dictation, Respondent described the surgery as having made a first attempt in the right lower quadrant with no visualization of anything but bowel and no space. T2 49-50. A second attempt in the left lower quadrant with the same findings, and a third attempt in the midline where there was a suspicion of a small bowel injury, which resulted in a laparotomy and a great deal of bleeding. Id.; T2 80-81. While there were irregularities with the transcription, Respondent testified that pertinent information was nonetheless recorded and conveyed and, therefore, met applicable standards. T2 80-81.

The patient's history, recorded at Exhibit 1, NSBME 007-011, amongst other factors noted and testified to, included that the patient was born with an omphalocele and had a large reconstruction as a newborn as well as subsequently having a large amount of his small bowel removed and a right inguinal hernia repair. T2 65, 70-76. Respondent's record indicating the same also was acknowledged by Respondent to have transcription errors. T2 70. The form itself, however, is a standard form approved by a company called Epic, which ensures that such forms comply with applicable standards. T2 76-77.

In her testimony Respondent also indicated that the CAT Scan was a useful pre-surgery tool and that it did not indicate anything that would have precluded the surgery. T2 78; 110-115. According to Respondent, she proceeded properly and did not violate any standards that would support a finding of malpractice. T2 82-85.

On cross-examination, Respondent testified that she gave up her Texas and New York medical licenses. T2 87-88. Respondent also testified to having discussed laparoscopic and open surgery with the patient, has no recollection of the patient requesting an open surgery, and also has no documentation regarding the discussion. T2 89-90; 93-94; April 10, 2025 Transcript (T3)

6-7. Respondent also reiterated that scarring is unpredictable and perforating a bowel with a trocar is a known risk and is a risk even in an open surgery. T2 90-91; 102-103; 116-117. Respondent then answered questions related to her prescribing Juven pre-operatively to the patient, which she indicated would assist in healing following the surgery. T2 95-96, 101-102. Then, through a series of questioning, Respondent maintained the appropriateness of her records. T2 96-99. In summary, Respondent testified that she felt it was appropriate to do the surgery laparoscopically; that she did not feel an open surgery was necessary; that she has had a lot of success in other surgeries looking for alternative spaces that would permit a surgery to be done laparoscopically; and that laparoscopic surgery lends to faster healing. T2 103-109. Respondent also explained that laparoscopic surgery requires three entry points with one for the trocar with the camera and two others with instrumentation. T2 119. In particular, laparoscopic surgery is generally done through three incisions – one in the midline; one in the right lower quadrant; and one in the lower left quadrant. T2 120-125. In this instance, as testified to by Respondent, the patient's bowel was injured on her third attempt to place the trocar with the camera at the patient's midline, which Respondent conceded would not have happened if she had switched to an open surgery after the right and left entry attempts. T2 128.

On redirect, Respondent indicated the plan from the beginning was to make three incisions and, to do so, she started on the right, then went to the left, then went to the midline, with the intention of clearing off the bowel from the midline to see whether she could expose the two areas she had attempted to access prior. T3 33-34. It was when she went into the midline that Respondent realized she had injured the bowel. T3 34. Respondent clarified, to perform a laparoscopic procedure, one needs at least three points of entry for placement of the trocars. T3 35-37.

Respondent called Dr. Arnold Baskies to testify on her behalf. Dr. Baskies testified to his background and experience. T148-152. Dr. Baskies then addressed the meaning of "friable" and how it is not a term that is generally used when speaking with laypersons. T2 152-154; 211-216; 249-250. Dr. Baskies then opined that Respondent had not committed malpractice and that the operative report at Exhibit 5, pp. 79-80 was sufficient in light of it being a transcription from a

surgery center. T2 156-169. Next Dr. Baskies opined that Respondent "was within the standard of care to attempt a laparoscopic approach in this particular case." T2 169-175. More to the point of the allegations, Dr. Baskies opined that laparoscopic hernia repair is preferred to save the patient from problems that can occur from an open surgery; that it is appropriate to start with a trocar entry on the opposite side of the hernia (as was done by Respondent); that scarring is unpredictable; that often patients will have had prior abdominal surgeries and that is not determinative; and that it was appropriate to attempt the midline even after failing to obtain visualization from the right and left initial entry attempts. T2 176-186; T2 232-237. Dr. Baskies also emphasized how common trocar injuries are and that they are a recognized complication of laparoscopic surgery. T2 186-187. Dr. Baskies then testified to the sufficiency of the one page pre-operative form and the post-operative dictation, noting that the significant and necessary information is included. T2 188-199; 217.

On cross-examination, Dr. Baskies was asked about testifying prior and his communications with Respondent and her counsel, as well as expert testimony he has given in other matters. T2 201-204. Inquiry was then made into his current practice and related undertakings, as well as his qualifications and understanding of Nevada's definition of malpractice. T2 204-210. Dr. Baskies then reiterated prior testimony and stated that Respondent should not be held responsible for the transcription of the post-operative report. T2 223-224. When asked if he would have signed it, he stated that it depended upon if there was enough of a problem with it but that to do so would be altering a medical record and, therefore, "[s]he's kind of stuck with the dictation the way it is," acknowledging that particular record is "awful." T2 225. Dr. Baskies also testified that there is no better way to see adhesions as between an open surgery or a laparoscopic surgery because you could see them both ways. T2 228-229. Dr. Baskies also reiterated that it was appropriate not to attempt to repair the hernia after discovering the bowel perforation. T2 187; 237-39. Dr. Baskies ended his cross-examination by reiterating that doing the patient's surgery laparoscopically was "absolutely" appropriate, and that the patient had a complication of the surgery that is a known complication and that there was no guarantee a complication would not have also occurred with an open surgery. T2 242-243; 245.

3. Findings.

Count I

The premise of Count I, the malpractice claim, is that Respondent committed malpractice by pursuing the midline incision for a laparoscopic left hernia repair, versus transitioning to an open surgery after failing to achieve visualization from already attempted right and left side trocar entries given that she was aware of the patient's prior surgical history, which lends itself to scarring in the midline, and that Respondent having done so "is contradicted by medical literature."

As an initial note, no medical literature was presented in support of the malpractice claim. When Dr. Spoerke was questioned about medical literature, he testified that he had read "thousands of pages of medical literature" "in all kinds of areas" but not specifically related to laparoscopic hernia repairs. T 104-105 (Q. Did you review anything relating to laparoscopic hernia repairs? A. No, not specifically"). When questioned further, he indicated he had read literature about open versus laparoscopic hernia repair and acknowledged that utilization between the two is "very contingent" upon the skill and comfort of a surgeon. T 106-107. With that, no evidence was presented that the manner by which Respondent proceeded "is contradicted by medical literature."

Instead, the IC relied solely upon Dr. Spoerke's opinion that, with all her experience, Respondent should have stopped proceeding laparoscopically before the midline entry and done an open surgery. T 144-145. Respondent's experience, however, is, in some weeks, ten laparoscopic hernia repairs, versus Dr. Spoerke having done five to ten laparoscopic hernia repairs in his career. T 20, 105-106, 186-187. With more direct experience, Respondent made it clear that she can frequently perform a successful laparoscopic hernia repair surgery despite a person having had a lot of prior abdominal surgery in that she can often times locate an entry point with less scarring where it is safe to proceed. T 193. This is particularly reasonable given that both experts and Respondent all agreed that scarring is unpredictable and, as Dr. Spoerke acknowledged, could, although not common, "fade away." T 33, 37-38.

Respondent made three entry points, which is consistent with a laparoscopic procedure whereby three entry points are utilized, so the number of times Respondent attempted entry to gain visualization was not excessive. The problem arose instead because Respondent perforated the patient's bowel in attempting the midline entry. The injury, however, was not the basis for the malpractice claim and, again, was acknowledged by each of the testifying professionals as a known complication. With that, it appeared that, to circumvent the fact that a known complication would not necessarily support a malpractice claim, the focus was instead shifted to the attempted midline entry that preceded the injury. Doing so, however, lends to a hindsight analysis that stems solely from the complication. Gros v. LAMMICO, 316 So. 3d 61, 69 (La. App. 2020) (appeal and affirmation of a defense verdict for a medical malpractice claim in relation to a bowel perforation caused during a laparoscopic hernia repair and noting, "[a] physician is not held to a standard of absolute precision; rather, his [or her] conduct and judgment are evaluated in terms of reasonableness under the circumstances existing when his professional judgment was exercised, and not on the basis of hindsight or in light of subsequent events").

As Dr. Baskies testified, the patient suffered a known complication and there was no guarantee that a complication would not have also occurred with an open surgery. T2 242-243; 245; *see also* T 72 at which Dr. Spoerke acknowledges that, regardless of what procedure was used, they all carry a risk of injury to the bowel.[2] Suffering from a known complication is not akin to the surgeon having committed malpractice. *See, e.g.,* Bristol v. Bunn, 189 A.D.3d 2114, 2116, 138 N.Y.S.3d 774, 777 (2020) ("Plaintiff's expert acknowledged that bowel perforation is a known complication from this type of surgery. Thus, plaintiff failed to raise a triable issue of fact with respect to the claims that defendant negligently caused the bowel perforation"). It was

[2] Although Respondent conceded that the bowel perforation would not have happened if she had switched to an open surgery after the right and left entry attempts, that was speculation on her part and, if anything, supports her confidence in her own surgical abilities to have assumed that would be true. T2 128. In reality, given no open surgery was attempted, one cannot speculate as to whether the complication would have nonetheless occurred given the complication was known with respect to both procedures. *See* the June 4, 2024 Transcript, p. 182 whereby Dr. Spoerke testifies that a bowel injury can still occur during an open operation.

evident that the patient's bowel was not in a healthy state and the surgery was unfortunately not successful. This does not *per se* lend to a finding of malpractice.

Respondent articulated why she chose to undertake the surgery laparoscopically and why she attempted the midline entry. Her reasoning was sound, was supported by her experience and skill, and was undertaken based upon what she deemed was best for the patient as far as recovery and healing. To fault her for a known complication and deem that malpractice is seemingly an effort to punish her for the complication, which would not be appropriate.

There is no doubt that the patient suffered a great deal due to the bowel perforation and that is not to be taken away or minimized by this recommendation. It remains, however, that even as conceded by Dr. Spoerke, "the laparoscopic approach is probably a better repair overall." T 40. While the surgery was not successful due to the bowel perforation, I cannot recommend a finding that the midline entry to try to perform the surgery was malpractice.

Count II

Count II is premised upon Respondent's alleged failure to correctly document her actions and the patient's medical history. Having reviewed the records, I find that the patient's medical history was sufficiently documented. The true focus of this claim lies with the dictated post-operative report at IC Exhibit 4, NSMBE 115, that even Dr. Baskies conceded was "awful." T2 225. Respondent also acknowledged some mistranscriptions with the report as well as acknowledging that the report did not accurately reflect what was intended and was in some sections nonsensical. T2 43-48, 51-52, 54-55.

Respondent candidly indicated that she did not recall reading the dictated report before she signed it and, therefore, did not notice the missing information indicated with blanks (T2 41) or presumably any of the other errors. In defense of the post-operative report not being legible, accurate, and complete, given the deficiencies acknowledged, Respondent states that she could not correct it because it was transcribed and not available electronically. To that end, Dr. Baskies testified that Respondent should not be held accountable for the errors of the transcriptionist.

The fault of this defense is that the transcriptionist is not responsible for the accuracy and completeness of Respondent's records – Respondent is. While Respondent received the report

sometime after the surgery, she clearly had the knowledge to know what she had intended to dictate and just as easily as she signed the report, she could have notated corrections and initialed the changes, or done so without signing off and the corrections she intended could have been written in and provided back to the transcription service, which could have then made the corrections and sent the report back again for signature as Dr. Spoerke somewhat suggested. T 63-64.

While undersigned is aware that a medical record is not to be altered once entered, that particular record was not signed off on and deemed complete until it had been signed by Respondent. Up until that point it was a draft someone else had undertaken in an attempt to understand what was meant to be conveyed; and, if that was an inaccurate depiction, then it was incumbent upon Respondent to correct the errors. Leaving a poor record because the procedure to correct it involves dealing with a hard copy versus an electronic copy that could be corrected electronically is not a sufficient excuse to leave a bad record. With that, I recommend that Respondent be held accountable for Count II; and, while I defer to the Board with respect to an appropriate sanction for the violation, I recommend that the sanction be relatively nominal as I have no doubt that Respondent, having had to go through these proceedings, which have been costly and time consuming, will no doubt be more careful in reviewing and correcting her dictated reporting in the future.

DATED this 25th day of August 2025.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

OFFICE OF THE GENERAL COUNSEL
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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 29th day of August, 2025, I served a file-stamped copy of the foregoing **FINDINGS AND RECOMMENDATIONS** via USPS Certified Mail to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Egan Daehnke, Esq. & Amanda Rosenthal, Esq.
DRR Law Group
2110 E. Flamingo Rd., Suite 212
Las Vegas, NV 89119
Attorney for Respondent

Tracking No. 9171 9690 0935 0255 6845 40

With courtesy copy by email to:

Patricia Egan Daehnke, Esq., at [pdaehnke@drrlawgroup.com]
Amanda Rosenthal, Esq. at [arosenthal@drrlawgroup.com]
Donald K. White, Esq. at [dwhite@medboard.nv.gov]
Patricia Halstead, Esq. at [phalstead@halsteadlawoffices.com]

DATED this 29th day of August, 2025.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED
JUN 18 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

In the Matter of the Charges and Complaint Against:
ANNABEL ELIZABETH BARBER, M.D.,
Respondent.
_____/

Case No. 23-11660-1

TRANSCRIPT OF HEARING PROCEEDINGS

Held at the Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada

Tuesday, June 4, 2024

Reported by: Brandi Ann Vianney Smith
Job Number: 6503788

A P P E A R A N C E S:

THE HEARING OFFICER:	CHARLES WOODMAN, ESQ.
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	DONALD K. WHITE, ESQ. Sr. Deputy General Counsel DEONNE CONTINE, ESQ. General Counsel Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, NV 89521
FOR RESPONDENT:	PATRICIA DAEHNKE, ESQ. Collinson, Daehnke, et al. 2110 E. Flamingo Road. Suite 212 Las Vegas, NV 89119

ALSO PRESENT:
Meg Byrd, Legal Assistant

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RENO, NEVADA -- JUNE 4, 2024 -- 9:00 A.M.

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HEARING OFFICER WOODMAN: We are on the record before the Board of Medical Examiners of the State of Nevada, In the Matter of Charges and Compliant Against Annabel Elizabeth Barber M.D., Respondent, that is the Board's case number 23-11660-1.

For the benefit of Dr. Barber, I just want to tell you that there are times when I will refer to the Medical Board and their attorneys as either the "Board," sometimes I call them the "IC," that stands for the Investigative Committee of the Board who handled these cases. If you hear me say the "Board" or the "IC" or "counsel for the Board or IC," I'm obviously talking about the Board and their attorneys.

And we've got Mr. White here as counsel for the Board, representing the Board and the IC today. Ms. Daehnke is here on behalf of Dr. Barber, and Dr. Barber is here in person, for the record.

So we've got pending motions, and I'm going to take the last motion filed first,

necessarily. Last night -- I'm not even sure if it was filed until today. It looks like it was filed in this morning. The Board filed a motion to recuse me, and obviously Ms. Daehnke hasn't had the opportunity to respond to that motion.

I'm going to deny it for a couple of reasons. Number one, I certainly don't think it's timely for a number of reasons. But here's something else -- and, Ms. Daehnke, you are probably not even aware, but I have made a decision in a couple of cases, the decision is consistent between the two cases, that have nothing to do with Dr. Barber's case, concerning what I think is admissible evidence -- or excuse me -- not admissible evidence, but discoverable evidence, what I think the Board and its counsel need to do when -- in terms of discovery, and there are a couple of statutes on point, and I will probably refer to those later in the hearing when we actually get to the point where you folks are making a record.

But I just believe, based on the reading of a couple of different statutes combined, that if the Board goes forward with the case, and it's going to use anything from its investigative file in its case, and it's hard to imagine the Board not using

something from its file, otherwise what do they have to go on a case with, then under my reading of a couple of statutes, I think they've got to disclose their whole file. That doesn't mean that everything in that file is going to be admissible evidence. To the contrary, probably a whole lot that's not admissible evidence. But at least in fairness to the respondent, I think they've got to disclose it. The Board has a different interpretation of that.

There are currently two writs pending in the Washoe District Court on that issue. And I hope that the court or courts -- first of all, I think there's a motion to combine the two writs, which I think is wise, so that one court can dispose of both at the same time. I'm hoping the court will act on those expeditiously because I think that a decision from the court, whether it gets appealed or not, whatever the district court decides, I'm just hoping that we can get a decision, a final decision from the courts quickly. That will make my job and the Board's job easy.

If my interpretation of the statutes on what is discoverable from the Board's file is wrong, the court will tell me it's wrong, and that's easy. From there on out, whenever we have a discovery

issue, which I think is going to be more and more prevalent, I've got a court ruling. If the Board tells me I'm right, it'll make it a lot easier for the Board, just say, hey, regardless of our interpretation of those statutes, the court says we got to deliver our whole file.

And while I'm at it, I'm looking at NRS 622A.330, and subsection 1, which is important for the Board's position says -- oh, and by the way, I'm going to insert right here now, Ms. Daehnke, I don't know how fast of a talker you are, Dr. Barber, I don't know how fast of a talker you are if you end up testifying in this case, but let's treat our reporter right, and especially when reading, we have to remember to read in an appropriate pace.

"At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witness."

And I believe that, Ms. Daehnke, you may have just recently filed a document to that effect yesterday.

MS. DAEHNKE: An email, yes.

HEARING OFFICER WOODMAN: Okay. Then subsection 2 says:

"The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case."

Now that sentence, to me, says that the file is discoverable unless the Board is going to use something from its file in this case, and that flips it.

The rest of subsection 2 says:

"The investigative file from the case includes all communications, records, affidavits, or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee."

Then there's a subsection 3 that just isn't relevant, I don't think, to the ongoing issue.

Then I go to NRS 630.336, and if you read the very first clause in subsection 4 of that statue:

"Except as otherwise provided in subsection 5" -- so that's a signal that we got to

pay attention to what's in 5. And when we go to 5, it says:

"The formal complaint or other document filed by the board to initiate disciplinary action and all documents and information considered by the board when determining whether to impose discipline are public records."

Now, as I understand the Board's argument, they go back to subsection 1 of 622A.330 to say it's only the stuff we're going to use in the hearing that's discoverable. And I just have a basic disagreement with that.

MR. WHITE: Okay. May I just interrupt for a moment, Mr. Woodman? Are we going -- are we now into considering --

HEARING OFFICER WOODMAN: No. I'm coming --

MR. WHITE: -- her motion to --

HEARING OFFICER WOODMAN: I'm coming back to --

MR. WHITE: Her motion to --

HEARING OFFICER WOODMAN: I'm coming back to recusal.

MR. WHITE: -- get the investigative file? Okay.

HEARING OFFICER WOODMAN: Okay.

MR. WHITE: All right.

HEARING OFFICER WOODMAN: So, in any event, we have a significant disagreement on this. And, again, I'm just hoping we get a final ruling out of the court because it's just going to make my life and the Board's life easier when we deal with discovery issues.

I read the recusal motion last night. And the gist that I take from the motion is that in these discovery disputes that I'm nasty to the Board, that I'm biased, prejudiced, that I don't like the Board, and I'm trying to make them pay every chance I get. And I'll say, first of all, that I have always believed that people can be -- that people can disagree without being disagreeable.

I'm going to -- if you'll indulge me here because I'm going to take a second to tell a quick story. When was a young prosecutor in the Washoe County District Attorney's Office back in the 90s, we were on our regular criminal docket one morning, just the law and motion docket. And as it typically did, it went from whatever start time 8:30 or 9:00 in the morning right up to about the lunch hour. And one day we had a brand-new court reporter who

literally told us it was her first day as reporter on the job. And we went through the docket, it was a pretty standard, routine docket, and when the docket was over, I walked out of courtroom, the defense lawyer walked out of the courtroom and we got on the elevator and this young court reporter was already on the elevator. And defense lawyer said to me, "Are we still on for lunch on Friday?" And said, "Yeah, of course."

And the court reporter's eyes got really large, and she looked at both of us and she said, "Do you two like each other?" And we laughed and we said, "Yeah. Why would you ask that?" She said, "You've been yelling at each other all morning long. I thought you two really disliked each other."

And if I recall correctly, the defense lawyer said, "This was nothing. This was an easy morning. We didn't hardly have any disagreements this morning. You stick around, you'll really see some fun." Something to that nature.

Last week, as I was granting a motion made by the respondent, I put how I feel about discovery. I go back to due process. Due process, as we all know is notice and an opportunity to be heard. I think "notice" means that whenever you got a

governmental entity in any kind of a prosecutorial role against a person, I think "notice" means whatever the government's got, you turn it over. Again, that's the way I interrupt the statutes that I've referred to this morning. The Board has a different interpretation, which is fine. Again, I go back to the court, I hope we get a decision soon because it makes everybody's lives easier.

As far as the motion to recuse goes, again, I don't think it's timely, and it's -- I think it's -- if I were to grant it and say, hey, I can't be fair, first of all, I really truly believe I can be fair.

And, Ms. Daehnke, you don't know this, I served as a special master for more than 20 judges for something like 16 or 17 years, and on average, I heard about a thousand cases a year. I've heard a lot of cases. I think I've got pretty good experience in hearing evidence and pulling out what is salient and what ought to turn a case and filtering out the stuff that I just don't think really turns a case. People can disagree with me as to whether I do a good job or not.

I will also say that over -- I think it's been more than a decade that I've been a hearing

officer for the Board -- on no shortage of occasions, I have ruled in the Board's favor. I thought their cases were very clear and very concise and decisive, and so -- and I ruled against the Board.

In any event, I believe I can hear this case fairly, so the recusal motion is denied.

I think it would be dramatically unfair to Dr. Barber, who if I recall correctly, you've got an expert witness coming from a long way away, and all of those wheels were in motion by the time the motion was filed last night.

So I'm going to deny the recusal motion without any argument.

Now, on the pending motion to exclude evidence, Ms. Daehnke, it's your motion, and we said off the record this morning that we were going to limit arguments down to bullet points because I've got the briefing in front of me, I've read it.

Five minutes from Mr. Daehnke, five minutes for Mr. White, and then a three-minute reply by Ms. Daehnke.

MR. WHITE: May I say something at this time? Mr. Woodman, with all due respect, they -- I'm going to move to strike her motion, orally, at

this point, because you just ruled that our motion is untimely to recuse, and that's the main reason that you gave for denying our motion. You really didn't go into the substance, you told an anecdotal story, I have plenty of those too when I was a public defender for nine years, I have a friend in the DA's office -- or had friends in the DA's office that were there, and, yes, we would have our battle in the courtroom and then we would sometimes meet afterwards for whatever and hang out and talk.

Your main reason is it's untimely. Her motion was sent to us yesterday in an email at 2:20 or so. I asked for a stay of the proceedings so that I could respond in kind, and that is seven days, according to rules. I asked for at least until June 10th.

HEARING OFFICER WOODMAN: Let me just interrupt you. You're talking about her motion -- her request for discovery; correct?

MR. WHITE: Um-hum.

HEARING OFFICER WOODMAN: But we're talking about the motion that she had filed to exclude some of the evidence.

MR. WHITE: I'm sorry. Little preview of my argument, then. I'll revisit that.

HEARING OFFICER WOODMAN: Okay. I just want to make sure we're all talking about the same apples and same oranges.

MS. DAEHNKE: Your Honor, may I?

HEARING OFFICER WOODMAN: And I will say this, I haven't heard anybody say anything about it yet, but the request for discovery that was emailed yesterday is, essentially, even though that came in some hours before the recusal motion, I totally agree. It's not timely to today's proceeding as well. I mean, that's just where we are reality-wise.

So -- but I'm talking about -- and when -- let's see. For the -- for the record, the motion I'm talking about to exclude certain evidence at the hearing was filed by Ms. Daehnke, filed in by the Board on May 24th, that's what we're here to talk about right now.

MS. DAEHNKE: The motion in limine to exclude the two letters by --

HEARING OFFICER WOODMAN: Yes.

MS. DAEHNKE: Okay.

May I be heard briefly in response to what counsel just said? I know you don't --

HEARING OFFICER WOODMAN: Yes. But I

also -- before you do that, I just want to clarify.

Mr. White, substantively, yes, the timely, the timeliness, I think, would be -- for me to grant that motion would be very prejudicial to Dr. Barber because, again, they're here with witnesses, at I'm sure at significant cost, ready to go today.

MR. WHITE: We weren't -- we weren't -- I wasn't going to oppose something that wasn't written to me first. She opposed it, I asked for just a little more time around 4:14 in an email, and after having the thing for less than two hours, after having her motion for less than two hours, we didn't cause that as far as that goes, if you're talking about the motion to -- for -- not to exclude evidence but the other one.

HEARING OFFICER WOODMAN: Yeah. No. I'm just dealing with -- but for the moment, I just want to say, substantively, on the recusal I am making -- and this is always an interesting position for whether it's a judge in court or some type of administrative hearing officer -- I'm also, other than the timeliness, I'm finding that I can treat the Board fairly as a substantive matter.

And, again, maybe we will find out later on from the court in some kind of appeal to the

court or a writ that the judge doesn't think I'm fair, and I will go with any and all rulings I get from the court because that's the law. Right?

But, substantively and as far as timeliness goes, I'm denying your recusal motion.

Now, I'm not talking about the request for production yesterday. I'm talking about the motion to exclude evidence, because I think it's important to both sides.

MR. WHITE: May I add one more thing on the recusal motion?

HEARING OFFICER WOODMAN: Go ahead.

MR. WHITE: It wasn't by the word of counsel here that we were in the situation with all these writs and everything. I know that there was a writ going to -- under the case for Dr. Chacon that went to the Second Judicial District Court. And then I sat in this hearing with Mr. McCleve for a little bit, I didn't sit in the whole thing. But there wouldn't have been a timely time anyway to do a motion to recuse because it's -- you had set the deadline for motions in your order from May 24th. And so we were already beyond that because I think that hearing was to take place or did take place at least May 30th and 31st. So, yeah, it was sort of

an emergency motion to recuse.

I understand what you're saying, but I think, probably, all things were in motion anyways as far as getting her expert here from New Jersey, all that. But that really just -- those facts really just came up in the last -- at the end of last week.

HEARING OFFICER WOODMAN: And that's in the record. And for any writ coming out of this case or appeal coming out of this case, it's in the record. Because I think what I hear you saying is that the recusal is based on what I said, what I ruled in the McCleve case last week; correct?

MR. WHITE: Mostly, yes.

HEARING OFFICER WOODMAN: Okay. So it is what it is, and --

MR. WHITE: It's also based on the email you sent after I had asked for -- to stay the proceedings so that I could answer within the time that is usually allotted to answer a motion.

HEARING OFFICER WOODMAN: Right.

MR. WHITE: Not at afternoon.

HEARING OFFICER WOODMAN: Understood.

MR. WHITE: And I'll just say, and I'll quote the email from you, you had cut and pasted the

same statutes that we've been going over and over again, NRS 633.36 and 622A 230, I think, or 320, or 330. And then at the very end of it, you know -- and Ms. Daehnke was copied on this, but it says, "This position undermines faith in the system." I mean, that's kind of extrajudicial, and -- so I would say it's also based on that too, even though that may not be in the motion that was going to be part of that argument.

HEARING OFFICER WOODMAN: And again --

MR. WHITE: For the denial.

HEARING OFFICER WOODMAN: -- obviously those communications can be included for anything that goes to the court. That's the essence of my disagreement with the Board's position is, and I'll just spell it out so it's very, very clear for any court who reviews this, if a prosecuting body puts together a file in its investigation of, in this case a doctor, and then gets to pick and choose which documents -- and they go forward with the prosecution. Now, if they choose not to go forward with the prosecution, I agree, that file is a confidential file. If they chose to go forward with a prosecution, again, I think due process -- my interpretation of due process is -- and also my

interpretation of directly applicable statutes is they turn their file over. It's just what I think is fair under the United States and Nevada constitutions.

The Board has a disagreement with that interpretation, which it is absolutely entitled to have. And, again, that's why I wanted the court to rule so it makes all of our jobs easier. And when there's a disagreement in the future, we say, well, here's what the Board -- excuse me -- here's what the court said.

The other part that needs to be made clear is that the hearing officer role is to try and make the fact-finding part fair. At the end of the day, whatever decisions I make after hearing the evidence is a recommendation to the Board itself they can wholeheartedly buy off on, they wholeheartedly reject, or that they can piecemeal, we like this part of the decision but not that part, and they can do whatever they want with it. I am not the final decision-maker. I'm just here to try and make this process fair.

As far as the recusal motion goes, without talking about timeliness, substantively, I believe I can be fair. I know the Board doesn't think I can

because that's why the recusal motion was filed. And, again, I think -- it's in the record, and it is something that can be reviewed, obviously, later on, not only by the Board but by a court, and my decision is my decision both substantively and on the timeliness matter, and we're going forward from there.

MS. DAEHNKE: May I be heard, briefly?

HEARING OFFICER WOODMAN: You may.

MS. DAEHNKE: Thank you.

Mr. White was talking about several different motions, so I'm -- some of those will be left for later.

With regard to this motion to recuse that came out at 8:00 p.m. last night after a flurry of emails yesterday that we had to respond to the day before the hearing, so -- and I would note that, even by Mr. White's own statements this morning on the Chacon matter, I believe that writ was filed in March. So any grants for recusal would have been known to the IC and its counsel in March.

Also, even last week, there's no -- there would be no prohibition from Mr. White filing a motion to reuse if indeed Mr. White thought that you were bias last week when he just said you became

bias. That's two weeks ago, that should have been filed then not at 8:00 p.m. last night, I would submit.

On the substance, Your Honor, on that last-minute motion that we got last night at 8:00 p.m., I was looking, and, interestingly enough, I can find your public contract and Dr. Barber as a state employee at the University of Nevada School of Medicine, who started here at UNR as an associate professor and then got tenured, I can find her contract and I can find yours because they're public record we can't get the records for this hearing, I would just note that, from the IC.

But I looked at the contract that states, "Explain why state employees in your agency or state agencies are not able to do this work," with regard to the hearing officer. And the answer is, "Because due process needs to be afforded to the respondent by an unbiased party," such as yourself, Your Honor. And that is what exactly I find that counsel is not saying that they appointed you.

MR. WHITE: Randomly.

MS. DAEHNKE: Excuse me?

MR. WHITE: Randomly.

MS. DAEHNKE: All right. Well, randomly

appointed. Yet Dr. Barber, the respondent, obviously had nothing to do with the selection of the neutral -- of Your Honor.

What the Board is basically saying is they want a new -- they want a new hearing off- -- they don't like that random selection, and their judge shopping.

The first complaint against Dr. Barber was filed two years ago. It was dismissed by Hearing Officer Ghusn when Hearing Officer Ghusn made findings that there was a conflict with a member of the IC that determined to charge the complaint against Dr. Barber. Instead of accepting those findings, Mr. White never responded to the hearing officer's email written motion findings saying, "Please put this in findings. I'm out sick." Instead what he did was waited, sat on their hands and then dismissed that complaint, just for the record, Your Honor.

First we had Hearing Officer Ghusn. This case was then refiled, and I would note, served on Dr. Barber on the evening of Thanksgiving, Wednesday night, served on my client at home while she was preparing Thanksgiving dinner for her family, just to get the rest of stay of this, knowing that I

represented Dr. Barber and have represented Dr. Barber for years. They served my client with a second complaint that we're here for.

So you became the hearing officer, by random selection, and now the IC wants a third judge to prosecute, to state that Dr. Barber breached the standard of care in a hernia repair.

This is a lot of stuff and nothing about substance, Your Honor. I just want to make sure for the record that this is last-minute recusal was also -- how many motions were filed yesterday? Mr. White just said. First -- and we only got the email, the refusal from Mr. White yesterday morning that he was not going to produce the file as in accord with the laws and rules that Your Honor has just mentioned.

MR. WHITE: Sorry. I was answering from Sunday at four o'clock.

MS. DAEHNKE: That's --

MR. WHITE: Sunday. I luckily checked my email, but I don't usually check my email -- I don't check my emails all the time on a Sunday afternoon, but I did check for this one because I thought something could happen.

HEARING OFFICER WOODMAN: And there has been -- and it may not be officially in this record,

we can certainly take all the emails and add them to the record. There's been a flurry of late communications in this. And when I say "late," I don't mean inappropriately late, but as there usually is in a civil trial, in a criminal trial, in an administrative hearing, the closer we get to D day, the more focused everybody gets, the more little thoughts and concerns pop up, and it's common for that to happen.

MS. DAEHNKE: And Mr. White -- may I?

HEARING OFFICER WOODMAN: Hold on. I want to go back and make sure that the point is crystal clear that Mr. White brought, and I may not have made it clear because you mentioned the last little point of my email where I said "undermines confidence in the system."

It is what I genuinely believe, regardless of whether we're talking about a Medical Board hearing, a civil case, especially in, obviously not a criminal case, but it's a prosecutorial-type case, the statutes even refers to it as a prosecutor, because the doctor's license is at stake, which we know the courts have said over and over again, is a property right. When -- and again, I know the Board is going with your statutory interpretation saying

the statutes don't say let us produce our whole file. That's your position. I get it.

But to anybody on the outside looking in -- especially where I think my interpretation of the statutes is reasonable. You think yours is reasonable, it's fine -- it's like if the governmental authority, the entity that has authority to impact this person's medical license in this case or whatever other type of case we're talking about, where they get to pick and choose and say no, we're holding some information back, it just creates the appearance that why would you hold anything back? Do you have exculpatory information? Do you have something that might help them? Why would you not turn that over?

And, again, I know the Board's position is that's not it. We're just following the statute. And that's why we need a court ruling on what the statutes mean and what they don't mean, so that, again, it makes it easier for us going forward.

Now, I am sure people want to make more of a record, but we've got a hearing to make. So as to Ms. Daehnke's motion to exclude evidence, let's go five, five, and three.

MS. DAEHNKE: Your Honor, can I get my --

I thought we were going to do -- we just got an opposition to the later motion --

HEARING OFFICER WOODMAN: An opposition to your request for discovery that was sent in yesterday?

MS. DAEHNKE: Yes. I guess I would just -- I haven't read it because it was just slapped down here.

HEARING OFFICER WOODMAN: Okay. Let's not worry about that right now because anything that was going yesterday, we're just -- it's just too late to deal it with it.

MS. DAEHNKE: Thank you, Your Honor. Can I have moment?

HEARING OFFICER WOODMAN: Certainly.

I know you're looking for something, and I don't want to be unfair to you while you're looking for something, Ms. Daehnke.

MS. DAEHNKE: Yes.

HEARING OFFICER WOODMAN: One other thing I'm going to put on the record that goes back to recusal. I want make it absolutely clear on the record, for me this is nothing personal, when I shared the story about people can disagree without being disagreeable, for what it's worth,

anecdotally, in all my years of hearing cases for the Med Board, never once to this day have I ever dealt with an attorney either for the Board or defense that I wouldn't gladly go out and sit down and have lunch with and have a good conversation with, whether it's about the law or anything else. That's absolutely how I feel.

MS. CONTINE: May I just make a comment about the timing of this motion?

HEARING OFFICER WOODMAN: Certainly. And I know what you're going to say, but yes.

MS. CONTINE: I was already drafting this motion on Friday. But also on Thursday and Friday, I was filing a writ and a motion to consolidate, and I just didn't get to the motion to recuse until -- until finalizing it until yesterday. And that's why it came at eight o'clock. I had every intention, but I could not work this weekend because I had family obligations, so I was not able to get it filed until -- and we plan to renew it in every case that we have.

MR. WHITE: I'll add to that too. I did work this weekend, however, I was preparing for the hearing, and then got that motion yesterday at two o'clock and then had to kick in to do that.

Ms. Contine kindly helped me out and wrote the motion to recuse, although it does have something to do with other matters.

HEARING OFFICER WOODMAN: And I almost interrupted Ms. Daehnke to say I think a lot of -- because she referred back to the writ in Chacon from a few months ago, and I almost interrupted her to say I think a lot of their basis for their recusal motion just came up at the end of last week. I understand that.

Again, on the substantive, I absolutely think I can be fair, and I think --

MS. CONTINE: And just by way of comment, much of that came based on the last -- what? -- ten minutes of that hearing when you said you were going to recommend that the case be dismissed, that you weren't going to hear it on the merits, that you weren't going to allow testimony based on the fact that you don't think that we've provided the right information.

HEARING OFFICER WOODMAN: And --

MS. CONTINE: And so in the interest of keeping our statutory duties moving forward, there was a need at that point to make that request.

HEARING OFFICER WOODMAN: And I absolutely

recognize that because, again, I know where the Board's coming from with the statutory interpretation. And --

MR. WHITE: And in order to move cases along too.

HEARING OFFICER WOODMAN: And -- right. And when it comes to our disagreement on the discovery of the file, when we get beyond the pending motion to exclude certain evidence, I'm going to let everyone know what I think is the best decision to make in that regard for right now with the writs pending so that we can keep cases moving forward.

But that's another issue that we will address after we hear these arguments on the pending motion.

MS. CONTINE: Thank you for letting me address the timing, et cetera, and step away.

HEARING OFFICER WOODMAN: And, again, I almost interrupted her because I knew what you were going to say, and it's a reasonable explanation for why that motion came in when it did last night.

Are you ready, Mr. Daehnke?

MS. DAEHNKE: I am, Your Honor, but on timing, and I appreciate that we could probably go

back and forth multiple times, but with regard to the timing, if there was a recusal motion that was being contemplated and drafted on Friday but not remedied, we could have gotten it over -- that's very -- this is very serious.

And I just need to say, Your Honor, that I appreciate that you have stated that you can proceed without being bias, and of course I agree, an administrative -- a judge, a hearing officer actually also has a duty to sit. And I can tell from your remarks that you take that very seriously, the Board may not.

And, Your Honor, I just need to state that I actually think the motion -- I understand the disagreement, those writs have nothing to do with my client, Dr. Barber. We didn't know about the writs, the Board didn't produce the writ, the Board obviously -- even if it was last week, Your Honor, the Board should have given us a heads-up, saying, hey, our hearing officer, Hearing Officer Woodman, we think he's biased, and we are going to seek recusal.

Now, I don't know if Mr. White was contemplating a recusal motion when he filed late on March 24th, after -- at 6:30 p.m., a motion to

continue. I don't know what that motion to continue was about. I might just note for the record that we said, "Sure. We understand that you say your expert's not available, and Dr. Barber can accommodate, except for she has extreme expense."

The long weekend, four days passed, and then Tuesday afternoon the motion is withdrawn, the motion that was never filed.

So just going forward, to Mr. White's complaint about a motion being filed after March 24th at 5:00 p.m., Mr. White's motion was filed after -- that motion was filed after March 24th.

Also, Friday -- the difference between Friday and last night could be significant for Dr. Barber. Maybe we would have told Dr. Baskies, hey, don't come out here because the hearing officer is going to be recused by the Board.

And I would just note one final thing, Your Honor. We, obviously, agree that due process mandates a neutral and unbiased decision-maker, which in our opinion you are and in your opinion you are, that is one of the core requirements of a fair adjudicatory decision-maker. And -- but are also rules of judicial conduct that Ms. Contine also

cited that say "A judge shall not be swayed by public clamor or fear or criticism. A judge shall hear and decide matters assigned to the judge except when disqualification is required." There is no grounds to disqualify yourself.

Now, "While actual bias creating reasonable doubt as in impartiality of the tribunal may constitute grounds," this case, the Board has created this, the situation on its own.

MR. WHITE: That's not true.

MS. DAEHNKE: So any bias would be created solely by the Investigative Committee when it refused to comply with you, Hearing Officer Woodman's order, and argue the hearing officer has not actual authority and the Board can do what it wants, basically.

And Your Honor has appropriately made rulings on issues of law, as you're entitled to do, and this request for recusal is nothing more than blatant judge shopping for another hearing officer, who will be a third hearing officer that will just do whatever the Board wants it to do. Or if you want to say it nicer, to do -- to follow the Board's interpretation of law instead of doing what the officer wants to do.

MR. WHITE: May I address that now? Because we haven't even gotten into the motion to exclude yet, so I figure it's --

MS. DAEHNKE: I was talking about recusal.

MR. WHITE: I know.

HEARING OFFICER WOODMAN: I understand, and --

MR. WHITE: I think he already ruled on that actually though; right?

MS. DAEHNKE: Um-hum.

MR. WHITE: Mr. Woodman? Okay.

HEARING OFFICER WOODMAN: Here is what I want to do. I want to move forward. Everybody is beat up on the recusal motion and my position on it. I understand that you want to make the best record you can, but we've got to get on with the hearing.

MR. WHITE: I agree.

HEARING OFFICER WOODMAN: So --

MR. WHITE: But I take offense to be called a judge shopper. I would just like to --

HEARING OFFICER WOODMAN: And I --

MR. WHITE: -- address that if I could so maybe you can understand a little bit more -- we can clarify the record.

HEARING OFFICER WOODMAN: Can you do it in

a minute or less?

MR. WHITE: Yes.

HEARING OFFICER WOODMAN: All right.

MR. WHITE: So, there was a case for this, for Dr. Barber, same case, same facts in a different IC. Ms. Daehnke did a motion to dismiss based on an alleged -- I still say "alleged," I don't think it was -- there was a conflict of interest. And Ms. Ghusn, who was the hearing officer at that time, ruled in her favor and dismissed the case, which she doesn't have power to do. That's our stance too, she doesn't have power to dismiss the case just like that --

HEARING OFFICER WOODMAN: Let me just interrupt you --

MR. WHITE: -- without a hearing or anything.

HEARING OFFICER WOODMAN: Well, because --

MR. WHITE: No one showed up to this conference room.

HEARING OFFICER WOODMAN: What I was going to say is --

MR. WHITE: Except me.

HEARING OFFICER WOODMAN: -- in that case last week, the McCleve case, I'm making a

recommendation to the Board, but, again as I already stated, the hearing officer is far from the end arbiter, the final arbiter --

MR. WHITE: I understand.

HEARING OFFICER WOODMAN: -- of this case -- right? -- because the Board can send it right back and say, no, Woodman, you're going to hear this case, and I'll hear it.

MR. WHITE: Yeah.

And so Mr. Daehnke actually wrote that motion about ten o'clock, sent it about ten o'clock. We had talked on the phone before that. I think when she -- I -- I'm -- from what I can remember and believe, maybe, from what I was hearing, I think she had just landed in Reno, so I think we talked about seven o'clock, 7:30, something like that, and she had mentioned to me that she thought there was a conflict of interest. I disagreed with her, and she did her motion. Motion came in about ten o'clock, I think, or so on the night before the hearing.

Ms. Ghusn entertained that motion and actually dismissed. No one came here. I was asking people to come to the hearing, we can address that later, it's an appellate issue on judicial review, and we could have this hearing, hear it on the

merits, and then that could be something later on that could be dealt by a court if so, if that's where we ended up, depending on Ms. Ghusn's recommendations or the Board's findings at a board meeting, at adjudication.

Then on the next morning, about -- well, the hearing was supposed to start at like 9:00 or 9:30, I think it was 9:30, no one was here. I called -- Ms. Ghusn called a Zoom meeting, and it was all about just the motion, but there was nothing about the substantive motion. I didn't even have time to respond to it. I asked for time to respond to it, no time to respond to it.

We did an oral argument, but I could see where it was going, I said, "I'm not going to talk about substantive things as far this opposition to this motion to dismiss based on a conflict of interest." And, quite frankly, the real -- the actual remedy for that would be take to take it to the board of ethics -- the Ethics Commission, and that's where that goes. And that -- it doesn't have anything to do with what the hearing officer wants to do on the case. That should go to the Ethics Commission, and that could be something that's also done after a hearing on the merits.

So to kind to --

HEARING OFFICER WOODMAN: Let --

MR. WHITE: -- add to what was going on at that time. I mean, these last-minute motions are kind of what Ms. Daehnke likes to do.

HEARING OFFICER WOODMAN: So, let me --

MS. DAEHNKE: Your Honor, I object to that.

MR. WHITE: And also --

MS. DAEHNKE: We can go back and forth --

MR. WHITE: -- (inaudible) she created, we created this --

HEARING OFFICER WOODMAN: She can't get all of this.

MR. WHITE: I'm sorry.

She also mentioned that we -- the Board is creating this rift between yourself and the Board and Board counsel and Board staff. No. We're answering -- we're opposing motions that have been written in matters, that's what we have a duty to do, and oppose those motions.

As you've stated, we have a different stance on the statutes and what constitutes our investigative file and when it needs to be turned over, or, you know, of what needs to be turned over

based on what the difference is between discipline and when a formal complaint is filed. Those are two different things in our eyes.

HEARING OFFICER WOODMAN: And --

MR. WHITE: Everything becomes public when it goes to the Board for adjudication, not when we file a formal complaint. That is not discipline.

HEARING OFFICER WOODMAN: Well, and again, we -- I've stated, we have a 180 degree different opinion on statutory interpretation, which is fine. Let's face it, cases go all the way to the United States Supreme Court and they get a 5/4 ruling. Right?

MR. WHITE: True.

HEARING OFFICER WOODMAN: And so reasonable minds can disagree.

And, counsel, let's live by the rule today that we can disagree and not be disagreeable. Let's be respectful. And everybody can do your jobs and you can be on the opposite sides of the Earth from each other as far as how you see the case, and we can still get the job done.

Let me say clearly for the record -- and I can't overstate how genuinely sincere in saying this -- there was a prior case, I know Ms. Ghusn, I

haven't seen or talked to her in years, but I know her. I've always thought she was a smart, reasonable attorney, whatever happened in that case -- for right or for wrong, whatever happened in that case, I honestly don't care. I'm here to look this case in front of me.

And maybe someday the paper trail on this case going back to when Ms. Ghusn was here, and maybe that will matter to the Board or to a court. Again, like I said, for right or for wrong, it doesn't matter to me today. It really truly doesn't matter.

I hear things about serving the doctor personally on Thanksgiving eve, I understand why that's an emotional, why would they do that, it doesn't factor into the facts that I'm here to listen to today.

All the emotionally charged history of this case, I apologize, I don't mean to be callous, it just doesn't matter to me. I want to hear the facts that are admissible that are going to turn this case, and I want to get to that.

MR. WHITE: I have one to thing finish on too. I do take into account her expert came all the way from New Jersey. Dr. Spoerke, on that date back

in August of last year, blocked out an entire day for that.

HEARING OFFICER WOODMAN: And --

MR. WHITE: Showed up. I had to go out there and talk to him in the lobby and say, "No one showed up." No one was even here in the conference room.

MS. DAEHNKE: I --

HEARING OFFICER WOODMAN: It's a two-way street. I know how it works.

And I know you want to respond. And the record is clear that I'm going to let you, so if there's something you want to insert in response to that, then let's move on.

MS. DAEHNKE: Your Honor, I appreciate what you said. And I will, of course, abide by that directive.

However, I just need to correct, factually, this record about no one showing up. The hearing officer set a Zoom hearing at 9:00 a.m., and it was Mr. White who didn't show up for -- he got there. But I just -- I need to -- because there's not a written paper trail because the Board dismissed the first case not allowing Ms. Ghusn's order to be submitted. I'll stop now.

Also, Your Honor, I appreciate what you're saying, but Mr. White says something about everything, even when you tell him -- and I might have a tendency to do that myself. Mr. White is saying something about everything, and I need to correct some of these statements.

I appreciate you want to get to the substance, and I'll stop.

HEARING OFFICER WOODMAN: Very good. All right.

Ms. Daehnke, give me your five minutes, and I'm going to put you on the clock, but give me your five minutes on your pending motion to exclude evidence.

MS. DAEHNKE: Yes, Your Honor.

The motion to exclude -- I'll do it in shorthand fashion, given that we do have a lot of matters -- motions. So on behalf of Dr. Barber, we are seeking to exclude these statements that were obtained by the Board about care that was rendered to Patient A that are not related to whether or not Dr. Barber breached the standard of care -- breached the Medical Practice Act and standard of care.

The issue in the case is whether Dr. Barber used good medical judgment in proceeding

microscopically initially on this patient. I think we can agree to that, that' what the -- well, at least -- well, we don't know because we haven't heard from Dr. Spoerke. But that's what the Complaint alleges and that's what Dr. Barber is here to defend.

These letters -- and recognize that the court can admit hearsay -- they're not relevant to the matter at issue. They talk about things -- well, it's also time consuming, they are hearsay. And if you look at them, they really -- actually both Dr. Davis and Dr. Javed, they treated Patient A subsequent to the February surgery. Neither of them were involved in Patient A's medical care, and so their letters are hearsay.

And Dr. Barber -- I can't cross-examine these letters. I don't know what they have to say. They're strangely drafted, they really don't say much of anything, and they don't go to what the ultimate issue in this hearing is: Whether Dr. Barber breached the standard of care.

Now, I don't know why -- and also the way that they are -- and they're attached to the motion, I'm sure the court has seen them. The way they're obtained -- go -- fast forward to the IC file, we

don't know what other letters are in there. Is it the only letter from Dr. Davis or Dr. Javed? Were there drafts prepared? Were there discussions -- are there memorandums with discussions with them? Did the Board counsel say, oh, that's not what we want, send something different? There's nothing that will go to the finder of fact to be actual evidence in this case. And so they're not relevant, they're hearsay. And we don't have the rest of the file to know whether there's another letter from either of them as well.

What happened subsequent to Patient A's surgery is not relevant to whether Dr. Barber met the standard of care and performed the surgery appropriately. That's it in a nutshell.

HEARING OFFICER WOODMAN: Very good. You literally only used half of your time. Thank you for that.

And in response, Mr. White?

MR. WHITE: Thank you, Mr. Woodman.

Well, so the formal rules of evidence don't apply -- or don't apply as they do in other arenas of the law. It's much more relaxed. It's kind of paraphrasing, it's paraphrasing 233B.123. Okay? So hearsay can come in, if it's reliable.

These are reliable. I'll show that Monica Gustafson, the investigator in this case, sought to get those letters, she sent out letters. I think they're even in the -- if you've taken a look at the exhibits, you can see the letters she sent to them and the letter that was received.

They're not irrelevant. They do have to do with Patient A, and what the care went on afterwards. There are also not unduly repetitious and -- because they're just short letters, and some -- one of them, I think Dr. Davis has some medical records attached to it.

But it's also -- it's a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs. So these doctors were just asked to comment, not as respondents, but just to comment what they saw in their treatment of Patient A after his bowel was perforated by Dr. Barber.

Also, in Nassiri, I think Dr. Barber in her motion eludes to, Nassiri doesn't create like a legal standard whereby the hearing officer must prohibit evidence. It' doesn't make you the gatekeeper of evidence that comes into this hearing or any hearing, it really is an evidential standard,

legal standard for judicial review. It's more on those lines. It's not -- it doesn't make you into the gatekeeper, what should stay in and stay out.

What really is -- it's just a standard for admissibility of evidence in an administrative hearing, it cannot be considered to determine this motion because it doesn't -- that doesn't apply. In this hearing, it doesn't apply. It's further on down the line, I think, that Nassiri applies when we are talking about judicial review.

Respondent in her motion also turned briefly to NRS 48.035, which allows exclusion of evidence when the probative value is substantially outweighed by undue delay, waste of time, or needless presentation of evidence, however, also 4805 -- 48.035 3 allows evidence of another act or crime, we're not dealing with a crime, but we are dealing with another act, which is so closely related to the act. It's kind of res gestae argument -- right? -- controversy or crime charged that an ordinary witness cannot describe the act in controversy or the crime charged without referring to the other act.

Respondent admitted in her -- you'll see in the medical records, the bowel was perforated,

she did that, she knew that she did that. She abandoned his -- she had to abandon the surgery for the left inguinal hernia and had to help that patient's planned surgery. There is some relevant evidence there also, what happened afterwards, bowel was perforated, other doctors had to take care of Patient A.

HEARING OFFICER WOODMAN: You have one minute, Mr. White.

MR. WHITE: Okay. Thank you.

I think, really quickly, I'll just make a couple sentence here, I'll say a couple sentences. I think respondent also in her motion alluded to undue prejudice, but that's really up to you, Mr. Woodman. You must determine whether you have the intellectual, you know, as far as this case goes the intellectual ability to evaluate evidence and overcome your emotional or sympathetic tendencies, and that's -- I'm not sure where that comes straight out of, but I think it's -- in Armstrong, I believe.

And also there's an exception to hearsay with these letters. We have -- general rule hearsay is not -- a statement is not excluded by the hearsay rule if it is -- special circumstances under which it makes offers assurances of accuracy, not likely

to be enhanced by calling the declarant as a witness.

In other words, this was not in preparation for the hearing. This was done way back right after the investigation in this case began, I think it's in 2020. And so these doctors were not -- there's no anticipation of the hearing at that point, we didn't even know where this was going at that point, it was still in the investigative stage.

But they do offer assurances of accuracy, not likely to be enhanced by calling the declarant as a witness. They don't need to be a witness.

I think I can complete with that.

HEARING OFFICER WOODMAN: Thank you very much. All right.

Ms. Daehnke, we're going to try and keep it at three. Okay?

MS. DAEHNKE: Yes, Your Honor. Since I didn't use all my time, I might have one more minute, because I also realize that I didn't mention the diagnostics from University Medical Center that we sought to preclude, and the diagnostic films from Spring Valley Hospital as exhibits. We don't know who would authenticate those, we don't know the

relevance, we don't have the films.

HEARING OFFICER WOODMAN: And just remember, I have read the motions, so I know what they say, and I know why you want to keep them out.

MS. DAEHNKE: Thank you. That's all I wanted to say about that.

In response to Mr. White's argument about Your Honor not being the gatekeeper, I would disagree with that. That's why we're here. And it's not -- these letters were not -- they don't have any sort of hearsay genuineness exception. These letters go out from the Medical Board to doctors who say, oh no, I got a letter from the Medical Board, even though it says you are not a respondent in this case, please describe. I mean, if you look at these letters, they're months after the care and treatment. They have nothing to do with the pivotal issue.

And I disagree strongly with Mr. White's interpretation that you can't talk about one without the other. It's obvious that the standard of care and whether there's a violation of the Medical Practice Act is not looked at in hindsight, it's not looked at from the fact there was an injury or the fact that there was wound care treatment.

Your Honor, Dr. Davis and Dr. Javed were not involved in the patient's care until months after. The surgery was February 22nd, and they saw -- this is about wound care. This is about whether a patient needed wound care. There's nothing relevant about this. It is time consuming. It is prejudicial to Dr. Barber, because even though you as the hearing officer can put it aside, there's been a record created here. There's no reason for those to be produced and marked, and we don't have the ability to cross-examine these poor doctors. They want to just get a letter out to the Medical Board, and they don't say anything about standard of care, nor should they because it's not appropriate.

But the other fact of this is the Board also -- those are documents from the investigative file, we do not have the rest of the investigative file. There may have been other documents that were given to the Board from those two doctors, and should be precluded.

HEARING OFFICER WOODMAN: Very good. You still came in under three minutes.

Okay. I have said in prior cases in hearings that while this is not a court, it's an administrative hearing, just like judges in court, I

gotta call balls and strikes here. And sometimes I get it right, and sometimes I call a ball a strike or a strike a ball. And I know that. I am not perfect, don't pretend to be.

I do like to call balls and strikes so that the lawyers know where we're going and so that the record is clear. I apologize because I'm going to tell you right now, I'm leaning, right now, towards letting the evidence in, but I'm going to wait to make a final decision just to see if any evidence leading up to that evidence has any sway on whether I think I should go one way or the other.

So forgive me for not calling a ball or a strike right now. I just want to see what happens between now and then.

The reason I'm leaning towards letting it in -- and again I'm not trying to convince anybody that I'm anything special because I am not anything special, but in the thousands of cases that I have heard -- obviously not Med Board cases, I've heard plenty but not thousands of cases, but I've heard thousands of cases -- I've heard a lot hearsay and a lot of other evidence that has come in where I thought if somebody would have objected to that, I would have kept it out, but they didn't so it's

coming in. I trust myself in making a decision to sift it out.

And there are plenty of times when in my decisions and recommendations to the board I have said, "This evidence came in, and I'll tell you why it wasn't persuasive to me why I don't think it should be persuasive to the Board." Ultimately they make the decision.

But Mr. White's correct, we have the Administrative Procedure Act that says the rules of evidence are relaxed, and, Ms. Daehnke, you know that. So -- and it's just kind of like a bench trial. Right? A judge will oftentimes hear a lot more and not sift as much out through the technical rules of evidence when she or he knows that they have the ability to not be persuaded by the evidence that they think should persuade them.

I'm leaning towards admission. I'm just going to see if anything leading up to that evidence persuades me one way or the other.

Now, I want to get to the underlying issue that the Board has with me and I have with the Board on the discoverability of their entire file. We've got two writs pending so far, there may be more coming. And the Board's doing the job they think

they should do, I have no issues with that whatsoever.

Because of the pending writs -- I've been thinking about this over the weekend since we handled the McCleve case last week -- I'm trying to come up with a way that we don't just log jam all the cases that I'm hearing until we get a decision from the Board. We want to move these things forward for the Board's sake, for the sake of the respondents. And this is what I have decided to do in the interim while we're waiting to get a court ruling -- and especially the final court ruling so that will hopefully make our jobs easier in the future -- is I'm not going to exclude the Board from introducing any evidence where a respondent says that is not fair, because it seems pretty clear we're not getting the whole file. But where cross-examination of any of that evidence exposes that, well, you know, if an expert witness says, well, yeah, I did provide the Board with a report, and if that report wasn't produced, I'm just going to articulate that in whatever decision I make so that the Board is aware that -- if it comes down to concern for me. In the meantime, we can keep the cases moving forward, but make as clear a record as

possible of where I'm concerned that full disclosure of the Board's file may have made a difference in the case.

And regardless of whether anyone thinks that's a fair or appropriate way to go or not, as I've thought about this over the weekend in light of both the Chacon case and the McCleve case, I just feel like this is the wisest way to allow the cases to keep moving forward right now and still not be unfair to a respondent who is saying what are we not getting that may very well have made a difference in this case.

That is what I'm going to do. With that, --

MR. WHITE: Can I make a little record too? Just with regards to that.

You know, this is so much different than criminal law or civil law. Most of the -- most of what we get is from hospitals responding themselves, that kind of thing, so there's no hiding of anything like that. So that's what -- I'd like to say that at least. It's different. It's not -- I guess that's -- just so that -- something like that.

You know, it's hard to explain, but it's -- for instance, like you did criminal law for

a long time, Mr. Woodman, as a DA. I did it as a public defender. While -- a lot of times while my client was locked up in jail after an arrest and the police were still investigating, there was sill a lot of stuff being generated.

HEARING OFFICER WOODMAN: Yep.

MR. WHITE: A lot of statements from witnesses or reports from police and all this other stuff.

And -- but that's not what goes on -- you know, it doesn't go on here. It's kind of a closed thing. What we get, we get the records. When get a complaint, we seek out the records. And the records that are used are the ones that we use to try and prove our case, and that's where we get back into NRS 630.336, it's just the stuff prosecution's going to use for the case.

HEARING OFFICER WOODMAN: Right.

And I want to just say this again, because I have a genuine concern that the Board thinks that this is a personal thing for me, and I can't be any more sincere to say it's not. This is -- just try be fair to everybody.

I recognize this reality. The Board may not produce certain documents that it feels it

shouldn't produce under the -- under its statutory interpretation, that if we saw them all, we might read through everything you're not producing and say that stuff wouldn't have made any difference in the case at all. The only stuff that didn't get produced is just stuff that just really didn't matter that became part of their file. And the concerned I still have, that being absolutely the possible reality, is the fear of the unknown.

I had friend call me about nine o'clock last, one of the few people I still remain close friends with from high school, and I've been out of high school a good ten years by now, for sure. Called to talk to me about problems that have arisen recently in a very, very long-term marriage, and this is my best old high school buddy and his wife who I love dearly.

And there was a little bit of indiscretion, but it didn't go too far. And I told him if you don't come completely clean and tell her everything, if do that, she'll be able to process it and figure out what she wants to do. If you don't do that and if you leave her any clue, any reason whatsoever to think that she doesn't know everything, this thing will destroy your marriage

over time because the haunting of the unknown, that can't be processed.

And that's my whole concern with not a full disclosure of everything in the Board's file, is the fear of unknown. And when I -- again, I'm going to refer back to that final comment in that email, undermines confidence in the system, that's exactly what I'm talking about is: Was there a letter in there where a doctor said, no, I don't think this is malpractice?

There may very well not be any such letter, but when there's not a full disclosure of the file, it sure leaves a lot of people wondering. And when a governmental entity has the authority to impact the life of a member of our society, we just want to know that things are as absolutely as fair as they can be, and that's my whole concern from the get-go.

And, again, I understand the Board's saying we have statutes that we have to live by and if we disclose something that the statutes say we can't disclose, we could be in trouble for that.

MR. WHITE: Exactly.

HEARING OFFICER WOODMAN: And I get that position, and, to me, that's not an unreasonable

position, it's just a different position from my position.

As I've said over and over again, we can disagree, 5/4 decisions in the supreme court. Right? And let's just not be disagreeable.

MS. DAEHNKE: I agree with that, Your Honor. On Dr. Barber's behalf, though, of course, this is a sensitive due process situation, whether the rules of evidence are relaxed or not.

HEARING OFFICER WOODMAN: And I get that. And I think even though you haven't been party to the decisions where the Board and I butted heads, you understand that I have the same concerns.

But going forward, like I said, cross-examination may expose some basis to my concerns. We'll see. I'm just going to do my best.

With that, does both counsel want to make an opening statement?

MS. DAEHNKE: Your Honor, let me --

MR. WHITE: Yes, I do.

MS. DAEHNKE: I will, yes, Your Honor.

Just so the record is clear -- I'm not sure if it was Meg that dropped this opposition off. The court is really reserving ruling on our motion to exclude the contents of the IC that was not

produced or -- essentially. Is that what my understanding is? But I can renew a motion subject to what's revealed during cross-examination of the Board's case.

HEARING OFFICER WOODMAN: Yes, I consider the motion, essentially, still pending. Yes.

MS. DAEHNKE: It's still in play.

HEARING OFFICER WOODMAN: Yes.

MS. DAEHNKE: And I just need to make -- for the record, I have not had a chance to review the Board's opposition. And understanding that we've all been -- but it was just given to me now, so I don't know the contents of this thick document.

HEARING OFFICER WOODMAN: All right. We will burn that bridge when we get to it.

MS. DAEHNKE: And I also need to take a comfort break.

HEARING OFFICER WOODMAN: Did you need a break?

MS. DAEHNKE: Just quickly, please.

HEARING OFFICER WOODMAN: We'll take five, and our court reporter will not complain.

THE REPORTER: I will not.

(Recess from 10:20 a.m. to 10:34 a.m.)

HEARING OFFICER WOODMAN: Okay. We are

back on the record In the Matter of Charges and Complaint against Annabel Elizabeth Barber, M.D., Respondent, that's case 23-110660-1. We have spent a good chunk of the morning on legal issues, and now we will take opening statements.

And, Mr. White, on behalf of the Board and the IC, you've got the burden, so you get to go first.

OPENING STATEMENT

MR. WHITE: Thank you, Mr. Woodman.

I'm Don White, Senior Deputy General Counsel on behalf of the Investigative Committee or the "IC" is what we will be calling it a lot today. I would like to thank Hearing Officer Woodman, Ms. Court Reporter, opposing counsel, and Dr. Barber for appearing and participating in this important proceeding.

This hearing is for the Investigative Committee to present evidence to determine if Dr. Barber violated two counts in the Complaint that the Investigative Committee filed on November 17th, 2023.

The Complaint contains Count I, malpractice, which is defined as the failure of a physician in treating a patient to use the

reasonable care, skill, or knowledge ordinarily used under similar circumstances, and that's pursuant to NRS 630.301, subsection 4, and NAC 630.040.

And also Count II, which is failure to maintain proper medical records, pursuant NRS 630.3062, sub 1, sub A.

Dr. Barber has been licensed to practice medicine in the State of Nevada since July 1st, 1997. Throughout this hearing, the evidence will show, as we move forward, the Board investigator, Monica Gustafson, she's a senior investigator, compiled nearly all of the documents contained in the exhibit binder, of which everyone has a copy. Ms. Gustafson mailed Dr. Barber requests and orders for medical records related to Patient A, as she always does. She also mailed respondent an allegation letter, to which respondent responded. She will testify as the authenticity of the documents she received as she investigated this case.

Next, our only other witness at this time, is Dr. Nicholas Spoerke. He will testify that -- he will testify regarding -- he will testify that Dr. Barber's recordkeeping regarding Patient A were improper. Also Dr. Spoerke will testify that based

on his experience, his review of documents in the case, and his expert opinion that Dr. Barber committed malpractice in the treatment of Patient A.

This case began on -- in or about December, 2017. Patient A went to see Dr. Barber complaining of a left inguinal hernia. Patient A returned to see Dr. Barber in February of 2018 for surgery. Dr. Barber attempted, unsuccessfully -- as the evidence will show, unsuccessfully a laparoscopic surgery on the right side.

Respondent then attempted to unsuccessfully do a laparoscopic surgery on the left side, then attempted laparoscopic surgery in the midline, at that time perforated Patient A's bowel, and then repaired the bowel, which left his -- and that caused the planned surgery to be abandoned at that point, and so repairing his bowel left his hernia unrepaired.

As can be seen from some of the evidence that's there already, there was some aftercare by Dr. Barber after that, after the 22nd of February, which is the date of the surgery in 2018. And then from some other doctors also.

Dr. Spoerke will testify that Dr. Barber should have done an open hernia surgery, and maybe

that the first attempted laparoscopy might have been forgivable. However, after the first attempt at laparoscopic surgery, without being able to see Patient A's inguinal hernia through his vast scar tissue, respondent should have abandoned laparoscopy and done open surgery.

And this is because, as you'll hear, that Patient A was born with a -- he was born with short bowel, I think, or short gut syndrome, and then also had a few surgeries too on top of that. It caused adhesions. You'll learn that it caused some adhesions, especially in the midline because that's where the other surgeries were. And so trying to get in there with a laparoscope, at least according to what the IC believes, was not a good decision, and should have been abandoned at that time, at least, and gone in and done open surgery. And it probably would have -- could have avoided or probably would have avoided the perforation of Patient A's bowels too, because those things could not be seen over the vast scar tissue.

The testimony and evidence that will be presented today will establish by a preponderance of the evidence that Dr. Barber -- between today and tomorrow, that Dr. Barber committed malpractice and

failed to maintain proper medical records with regards to Patient A. Both counts, if established, are violations of the Medical Practice Act.

On behalf of the Investigative Committee, we ask the Board to consider the record that will be presented here and render the appropriate findings and discipline.

Thank you.

HEARING OFFICER WOODMAN: Thank you. I don't very often ask questions during opening statements, as you know, Mr. White, because you and I have done bunch of these, but the question that popped to mind as I listened to your statement is: Is there evidence that Dr. Barber either knew or should have known of the patient's condition that would say, oh, you're going to just have to do an open surgery, your scope isn't going to work?

MR. WHITE: There -- yes. Yes.

There's evidence that I think differing, obviously, reasonable minds -- we've been talking about that -- reasonable minds will differ. Dr. Spoerke will testify that there was enough evidence, based on his -- the way he was born, and then the subsequent surgeries that he had to endure that open surgery would have been the better route to go. And

it's in her medical records, so she was at least aware of that.

I would say that, you know, we're going to find out that Dr. Barber decided to go a different route.

HEARING OFFICER WOODMAN: All right. Very good. Thank you.

All right. Ms. Daehnke?

MS. DAEHNKE: Thank you, Your Honor.

MR. WHITE: Oh, did we invoke the rule of exclusion on the record?

HEARING OFFICER WOODMAN: I don't think we did. The rule -- we talked about it off the record, so for the record, the rule of exclusion is invoked.

MS. DAEHNKE: Except as to experts.

MR. WHITE: No. Everyone. My expert's sitting outside.

MS. DAEHNKE: Well, that's fine. I would -- no.

HEARING OFFICER WOODMAN: I usually -- I haven't heard an argument that's persuaded me yet to allow experts to listen in when the rule is invoked.

MS. DAEHNKE: All right. Fair.

But the practice, I mean, it would save time if an expert is here to hear the other expert's

criticism, given that we don't have any reports or deposition or anything of that nature.

HEARING OFFICER WOODMAN: And I get that. And you know where I stand on that.

MS. DAEHNKE: Yes.

HEARING OFFICER WOODMAN: But the rule's going to be the rule, so -- and obviously it's just going to mean you're going to have to spend more time going through what you want to go through to cover everything that came in in the Board's expert testimony.

MS. DAEHNKE: That's fair enough.

MR. WHITE: May I just chime in for a second? And, likewise, we don't have their reports either from their experts.

MS. DAEHNKE: Well, excuse me, from our experts?

MR. WHITE: Right.

MS. DAEHNKE: Oh, our experts didn't provide -- didn't prepare reports because you didn't give us your reports, so there's nothing -- since we're in a rebuttal of the case, we don't have reports. We need your reports is what we need.

HEARING OFFICER WOODMAN: All right. Your statement, Ms. Daehnke?

MS. DAEHNKE: Yes, Your Honor. I'm just looking for something very quickly because of something that Mr. White just said, we want to make sure that the record is correct.

All right. Do you mind if I stand?

HEARING OFFICER WOODMAN: No, I do not. You know you don't have to, but I don't -- and I understand, I have a hard time not standing when I'm talking, but you do what you want to do.

MS. DAEHNKE: Thank you.

OPENING STATEMENT

MS. DAEHNKE: Hearing Officer Woodman, counsel, parties present, thank you on behalf of Dr. Barber, and thank you for being here. And of course, most importantly, our court reporter. And I am trying to speak slowly however, my pronunciation may not be as good as I would like for your transcribing because I'm tired from all the motions that we've had.

On behalf of Dr. Barber, I am honored to represent Dr. Barber in this proceeding. She's a board-certified surgeon, who has been in the community for years, as Mr. White mentioned, since 1997. And Dr. Barber actually was a professor at University of Nevada Reno School of Medicine, she

was an associate there and got tenured there before she joined -- when the school did -- became Kerkorian School of Medicine. She is, as mentioned, a state employee, and she serves the State of Nevada instead of a more lucrative, private practice, and she teaches. She teaches residents, she teaches fellows. She also serves as the representative of doctors to the American College of Surgeons, she is the governor from Nevada. And she's the only representative, so she represents all the surgeons in the state, board of governors at the American College of Surgeons.

She has done countless repairs of hernias over her career of more than 30 years. We like to say "more than 30 years" now that we're about same, just more than 30, about 30 years.

She has done so many surgical left inguinal hernia, right inguinal hernia, she's done them laparoscopically, she's done them open, she has -- she is recognized -- people come to Dr. Barber to fix repairs that have failed by others, Dr. Barber is often called on in an emergency basis. She also serves call at the hospitals in Las Vegas. She is -- she is called into the patients who have a need for the most

exquisite surgical techniques, and she is known for that. She is known for that at the school of medicine.

Therefore, I would submit that the evidence will be that Dr. Barber not only did not breach the standard of care or violate the Medical Practice Act in any fashion in her care and treatment of Patient A even though the allegation is that she failed to use good medical judgment and decision-making by going in laparoscopically. And interestingly, Mr. White said something to the effect of reasonable minds may differ, well, we haven't heard from Dr. Spoerke, so I don't know really what he has to say, I don't see a report, we don't know what medical literature is referred in the Complaint in the charging allegations because we haven't seen that either; however, if you operate from the reasonable minds can differ, and you look at whatever Dr. Spoerke is going to tell us -- it will be interesting hear that today -- and compare it with Dr. Baskies' also four years of experience in surgeon -- general surgery, if reasonable minds can differ and there's a question as to who is more reasonable, the Board has the burden of proof.

And so that mind, you can't just simply

say, oh, Spoerke says this, Baskies says this, it is a draw, the Board wins. The Board doesn't win, the Board loses.

So we'll have two board-certified, highly qualified surgeons testify, that's Dr. Barber and Dr. Arnold Baskies, he is coming over from back East, again, he had come over -- no, excuse me -- he didn't come over the last time the case was dismissed. He had booked his ticket, so we have that expense. Dr. Baskies will testify that Dr. Barber used good medical decision-making and, in fact, going in laparoscopically was the right choice for Dr. Barber, based upon all of her years of experience with laparoscopic surgeries, specifically laparoscopic hernia repairs.

It's not disputed that the standard of care as whether the patient should have a laparoscopic or open repair is key to the experience of the physician in doing laparoscopic surgery. Dr. Barber has that experience, she made good medical decision -- she used good medical judgment in evaluating the patient. As Mr. White, said Dr. Barber saw the patient, the patient was seen. Dr. Barber evaluated, Dr. Barber did know the patient's history, yes, in answer to Hearing

Officer, she did. And she took that into evaluation.

I would submit that not only has Dr. Barber met the standard of care and not violated the Medical Practice Act, she did exactly what was right in this situation, preoperatively, during the surgery, and although there is no allegation in the Complaint that it charges Dr. Barber, that there was anything done inappropriately or violation of the Medical Practice Act subsequently. We submit that Dr. Barber also met the standard of care in her care and treatment of Patient A afterwards. She was very attentive to him, offering --

MR. WHITE: Objection. Just one second. Please don't use the patient's name.

HEARING OFFICER WOODMAN: Yes. So patient A.

MR. WHITE: Can we strike that, please?

HEARING OFFICER WOODMAN: Yes. That will be stricken.

MR. WHITE: That's the first time I've heard it, but if it was said before that, we need to strike all references.

HEARING OFFICER WOODMAN: I don't think it was.

MS. DAEHNKE: Certainly Patient A is fine.

MR. WHITE: Thanks.

MS. DAEHNKE: Will be then -- since that is confidential, Patient A's name is all over of the motions filed by both the Board and respondent, all over the medical records, and to the extent that this is going to be filed -- possibly filed the court or -- and it's a public record, how do we accommodate that?

HEARING OFFICER WOODMAN: There will be a redaction.

MR. WHITE: It's actually 622A, I think. I can't remember which one it is, it's 622A actually doesn't -- it allows us not to have to submit medical records to the public copy of what goes to the Board at adjudication.

HEARING OFFICER WOODMAN: I think there's redaction.

MS. BYRD: I can respond because we -- I respond as a legal assistant to medical -- or requests, public record requests. We redact any patient information, and we redact any particular medical record numbers, social security numbers, anything that specifically identifies patients when we have public records requests.

HEARING OFFICER WOODMAN: And so in hearings we just always refer to them as "Patient A." Some cases, we have Patient A, B, C, D, E.

MS. DAEHNKE: Of course. And I appreciate that, Hearing Officer. That just came up about the redaction, and that's what I was thinking about when Ms. Byrd just mentioned because this is rife with his name.

HEARING OFFICER WOODMAN: Right. And we just do our part on the record. And it oftentimes squeaks out a time or two, but we just strike it from the record and do our best to stay with Patient A.

MS. DAEHNKE: Thank you. And I will ask Dr. Baskies to use the Patient A, and Dr. Barber will as well, although I think it's harder for Dr. Barber.

HEARING OFFICER WOODMAN: It is. You gotta force yourself to do it, but we do.

MS. DAEHNKE: Yes, it is. Thank you, Hearing Officer.

So just in response to Mr. White's opening, Dr. Baskies will testify that Dr. Barber did not breach the standard of care, in fact she did meet the standard of care, did not violate the

Medical Practice Act. She did use -- the appropriate approach was used, and the appropriate repairs were done, and he will talk about why.

Also with regard to medical recordkeeping, that's a very vague complaint, but Dr. Baskies has reviewed Dr. Barber's recordkeeping, and he believes that the recordkeeping is fine and does not violate the Medical Practice Act and should not certainly subject Dr. Barber to any discipline with that.

HEARING OFFICER WOODMAN: Very good. Thank you, Ms. Daehnke.

All right. With that, who is the first witness for the Board?

MR. WHITE: Monica Gustafson, Senior Investigator.

THE REPORTER: Just so I understand correctly, anytime that gentleman's name was mentioned anywhere in the transcript, it's to be replaced with "Patient A"?

HEARING OFFICER WOODMAN: Yes, ma'am.

Good morning, Ms. Gustafson.

THE WITNESS: Good morning.

HEARING OFFICER WOODMAN: Ms. Gustafson, I'm Charles Woodman, and I'm the hearing officer in this case. And before we can get your testimony, I

need you to raise your right hand and our reporter will swear you in.

(The oath was administered.)

THE WITNESS: I do.

HEARING OFFICER WOODMAN: Very good.

Mr. White, your witness.

MR. WHITE: Thank you.

DIRECT EXAMINATION

BY MR. WHITE:

Q. Ms. Gustafson --

MS. DAEHNKE: I'm sorry. I Patricia Daehnke, and I represent Dr. Annabel Barber.

THE WITNESS: Hi. Nice to meet you.

MS. DAEHNKE: I think we met at the Medical Board in Vegas.

THE WITNESS: Yeah.

MS. DAEHNKE: Thank you. Sorry, Don.

MR. WHITE: That's okay.

BY MR. WHITE:

Q. Ms. Gustafson, I'd like you to -- at this point, could you introduce yourself to the court reporter and everybody in the room and spell your first and last name, please?

A. Sure. My name is Monica Gustafson. The spelling of my name is M-O-N-I-C-A,

G-U-S-T-A-F-S-O-N. I'm a senior investigator here.

Q. Where do you work?

A. At the Nevada State Board of Medical Examiners.

Q. And in what capacity do you work for Nevada State Board of Medical Examiners?

A. I investigate complaints that come in to the Board.

Q. Do you have a title?

A. I'm Senior Investigator.

Q. How long have you worked at the Nevada State Board of Medical Examiners?

A. Seventeen and a half years.

Q. How long have you been the Senior Investigator?

A. I've been the Senior Investigator for about -- I don't have the exact date, probably about eight years.

Q. Do you understand what we're here today for, that we're to present evidence so that the Board can determine if Dr. Barber violated the Medical Practice Act?

A. Yes.

Q. Okay. Now, are you the investigator who was assigned to this case as --

A. Yes.
Q. -- with regards to Dr. Barber?
A. Yes. Um-hum.
Q. And as part of your investigation for this case, were you required to obtain medical records?
A. I was, yes. Correct.
Q. And as part of the investigation for this case, were you required to serve orders and requests and letters, allegation letters, things like that?
A. Yes. Yes.
Q. I'm going to direct you toward Exhibit 1. I want you to take a look at that for a moment.
A. Okay.
Q. Look up when you're finished.
Are you familiar with Exhibit 1?
A. I am.
Q. Okay. I'm going to go through them one by one, maybe -- just a couple of the things here are kind of different from the others.
What is the first document you see on pages 1 and 2?
A. That is the allegation letter that I wrote for the client.
Q. Okay. And who is that addressed to?
A. It is addressed to Annabel Barber, M.D.

Q. And you signed, I believe. Did you sign it?
A. I did.
Q. That's your signature?
A. Yes, that is my signature.
Q. Okay. And following that on pages 3 and 4, what do we see there?
A. This is the order to produce medical records that was sent to Dr. Barber.
Q. Okay.
MS. DAEHNKE: Counsel, could you -- we have multiple copies of things. Do you -- could you refer to the Bates stamp number, if you don't mind?
MR. WHITE: NSBME 3 and 4.
MS. DAEHNKE: Thank you.
BY MR. WHITE:
Q. Do you send out an order to produce medical -- well, actually let me start --
Do you send out an allegation letter in just about every single case that you work on?
A. Yes.
Q. And what about order to produce medical records?
A. If it pertains to a medical case. Sometimes there's cases with behavior, but this

one's a medical case, so yes.

Q. So, patient care?

A. Patient care, um-hum.

Q. And then what follows, with regards to Exhibit 1 which goes from page 5 to 48, NSBME 5 to 48?

A. Page 5 is the response from Dr. Annabel Barber. Page 6 is the custodian of records affidavit that is notarized and signed, and the rest of those pages that you referenced are medical records that were sent in by Dr. Barber.

Q. Okay. And the letter that you referred to -- or the response that you referred to on page 5, is that addressed to you?

A. Yes, it is.

Q. Okay. And looks to be signed by Dr. Barber; is that correct?

A. That's correct.

Q. And then you mentioned that there's a custodian of records on page 6?

A. Um-hum.

Q. All right. And then is this -- are these the records -- did you -- did you receive that custodian of records certificate?

A. Yes, I did. It came with her response.

Q. Okay. And then were the records attached to that --

A. Yes.

Q. -- that we see here?

A. Um-hum.

Q. Okay.

MR. WHITE: I'd move to admit Exhibit 1.

HEARING OFFICER WOODMAN: Any objection, Ms. Daehnke?

MS. DAEHNKE: I have no objection.

HEARING OFFICER WOODMAN: 1 is admitted.

(IC's Exhibit 1 is admitted.)

BY MR. WHITE:

Q. I'd like you to turn to Exhibit 2 now, please.

A. Yes.

MR. WHITE: Just one second. Indulgence.

BY MR. WHITE:

Q. What do you -- have you had a chance to look through it?

A. I just did, yeah.

Q. Okay. And going one by one, on NSBME page 49 -- oh, yeah, page 49 -- let me see -- what is that that we see there?

A. That is a request for records that was

sent to Dr. John S. Davis.

Q. Are you familiar with that document?

A. I am.

Q. Was it -- was it a letter that you sent out?

A. It is a letter I sent out, yes.

Q. What date did you send that out?

A. October 28th, 2019.

Q. And this is -- this is a letter not to respondent, so what do you call this when you send a letter to someone else?

A. It's a non-respondent letter. It's a request for records and a statement of their treatment plan.

Q. Okay. And why would you do that in a case such as this?

A. In this case, this gentleman was another treating physician for the patient. So often, I get records from other treating physicians to go with the timeline to see how they were treated.

Q. And it looks like you signed the letter at the bottom to Dr. Davis?

A. Correct.

Q. That's your signature?

A. That is my signature.

Q. Okay. And then on page NSBME 50 of Exhibit 2, what do you see there?

A. This is Dr. John S. Davis's statement of his treatment plan for the patient.

Q. And when we talk about patient, we're obviously not going to use his name, but it's Patient A?

A. Patient A, that's correct.

Q. Okay. And is that a letter addressed to you?

A. Yes, it is.

Q. And does it appear to be signed by Dr. John S. Davis?

A. Yes, it does.

Q. Okay. And so in putting these together, you sent a letter to him on October 28th, 2019, and when did he -- it looks like -- when did he send his letter back to you?

A. I received his letter on December 24th, 2019.

Q. Okay. And following that letter -- and I'm referring to pages NSBME 51 through 79 --

A. Do you want me to answer?

Q. Yeah. What are we seeing there?

A. On 51, NSBME 51, that is a certificate of

custodian of records provided by John S. Davis, M.D.

Q. And it looks like it was notarized too, subscribed and sworn; correct?

A. Yes.

Q. And then between pages 52 and 79, where those attached -- are those the records from Dr. Davis that were attached to the custodian of records?

A. Yes, these are Dr. Davis's records.

MR. WHITE: I move to admit Exhibit 2.

HEARING OFFICER WOODMAN: Ms. Daehnke?

MS. DAEHNKE: I object. This is hearsay. There's no guarantee of genuineness. I don't object on the authenticity that it appears to be authentic, but, however, the medical records themselves are hearsay. There's also statements in the medical records that are not made for purposes of treatment or diagnosis that are hearsay. And this document would lack foundation absent the physician who treated Patient A.

So I object on those reasons.

HEARING OFFICER WOODMAN: And, Mr. White, will Dr. Davis be testifying in the hearing?

MR. WHITE: He will not.

HEARING OFFICER WOODMAN: All right.

MR. WHITE: I'll just renew my argument before, which I think there's a presumption of truthfulness, I guess, in these documents. I don't think -- I got the language wrong but it's in the motion -- or our opposition to their motion to exclude.

HEARING OFFICER WOODMAN: Was Dr. -- were there any other doctors that treated Patient A after Dr. Barber to address whatever happen in Dr. Barber's treatment?

MR. WHITE: Yeah, there was also a Dr. Javed. That's the next exhibit.

HEARING OFFICER WOODMAN: Okay.

MR. WHITE: Beyond that, I mean, there were plenty of people treating because he was in the hospital for a little bit too.

HEARING OFFICER WOODMAN: Right. And I know there was --

MR. WHITE: So I couldn't answer your question completely. I don't have all those names.

HEARING OFFICER WOODMAN: Let me check one thing here.

MR. WHITE: Or at least I didn't compile a list of all those names. They're in here somewhere or they're in -- yeah.

HEARING OFFICER WOODMAN: So I'm going to admit their medical records. And, again, they may prove important to me, they may prove to be hearsay that just doesn't factor in. We'll see what the rest of the evidence tells me.

(IC's Exhibit 2 was admitted.)

MS. DAEHNKE: I'm sorry, Hearing Officer. Admit to subject to?

HEARING OFFICER WOODMAN: Subject to wait and what I determine to be credibility after I've heard everything.

MS. DAEHNKE: And relevance.

HEARING OFFICER WOODMAN: Exactly. I may find them completely relevant and significant to the case; I might find them completely irrelevant.

MS. DAEHNKE: Thank you.

HEARING OFFICER WOODMAN: But I am going to admit them, especially in light of the fact that they pertain to Patient A, they purport to pertain to follow-up treatment of Patient A following Dr. Barber's treatment of Patient A, and we've got that wonderful general medical records exception to the hearsay rule.

MS. DAEHNKE: Thank you, Your Honor.

Just also to be clear too -- I think you

got this -- my objection is not just the medical records as being hearsay, because there is a difference of opinion, but it's to statements made and conclusions drawn in the medical records that there's no foundation, no ability to cross-examine him.

HEARING OFFICER WOODMAN: And I absolutely get that. And that will definitely factor in to what these records ultimately mean to me or not.

MS. DAEHNKE: Thank you, Your Honor.

BY MR. WHITE:

Q. May I refer you to Exhibit 3 now, please.

A. Yes.

Q. Okay. So have you had a chance to look at it?

A. Yes.

Q. Okay. And are you familiar with documents here in Exhibit 3?

A. Yes.

Q. And are they -- what is -- as far as NSBME page 80, what is that?

A. That is a second request for treatment -- a statement of treatment plan and records for Dr. Lubna Javed.

Q. For clarification, is this another

non-respondent letter?

A. Yes. Correct.

Q. Okay. And you addressed it to -- how did you say his name?

A. Lub-na Ja-ved.

Q. And you addressed it to him, and it was sent what date?

A. It was sent on August 24th, 2020.

Q. And it is signed by you at the bottom?

A. Yes.

Q. Did you receive -- is 81 -- what are we seeing there, page 81?

A. Page 81 is a response to the second request letter, the treatment plan for the Patient A.

Q. Okay. And it is addressed to you?

A. It is address today me, yes.

Q. Is it -- it appears to be signed by Dr. Javed; is that correct?

A. Yes.

Q. Then what is on page -- maybe these are a little bit of order, I think.

What is page 82 then?

A. Page 82 is the original letter that was sent, the request letter for the non-respondent.

Q. Okay. What's the date on that one?
A. That one is October 28th, 2019.
Q. Okay. And just so we're clear on the record, going back to page 80, what was the date on the second request?
A. The second request was August 24th, 2020.
Q. About ten months later?
A. Yes.
Q. Okay. Then page 83?
A. Page 83, that was the original response from Dr. Lubna, but it did not inform me of the treatment plan for the patient.
Q. Okay.
A. It was just stating that the records could be found at Spring Valley Hospital.
Q. All right.
MR. WHITE: I'd move to admit Exhibit 3.
HEARING OFFICER WOODMAN: Ms. Daehnke?
MS. DAEHNKE: Same objections as to Exhibit 2, Your Honor, would you like me to repeat them or just incorporate?
HEARING OFFICER WOODMAN: No. I know exactly what the -- I was going to anticipate the same objection.
And I'm going to admit 3 under the same

provisos, that is ultimately the rest of the evidence in this case will help me to know what, if any, parts of 2 and 3 should weigh in and how much.

(IC's Exhibit 3 was admitted.)

BY MR. WHITE:

Q. And, Ms. Gustafson --

MS. DAEHNKE: Your Honor -- I'm sorry, Don -- just with regard to this particular exhibit, Your Honor, NSBME 80 through 83, with regard to Lubna Javed, I just note that there are not any records --

HEARING OFFICER WOODMAN: Right.

MS. DAEHNKE: -- produced by this doctor, nor really anything at all.

HEARING OFFICER WOODMAN: Right. So what we have, really, is correspondence.

MR. WHITE: That's it. Yeah.

MS. DAEHNKE: So, again, even more of the relevance objection. Thank you, Your Honor.

BY MR. WHITE:

Q. And I'd like to draw your attention to Exhibit 4 now.

All right. Page NSBME 84, what do we see there?

A. This is a request for medical records from Las Vegas Surgery Center.

Q. With regard to?
A. To Patient A.
Q. And when did this -- when did you send this out?
A. October 28th, 2019.
Q. Did you sign it at the bottom?
A. I did sign it, yes.
Q. And page 85, what do we see there?
A. This is --
HEARING OFFICER WOODMAN: Are page 84 and 85 not the same document?
MR. WHITE: They're almost the same.
HEARING OFFICER WOODMAN: I keep looking for something to distinguish them.
MR. WHITE: They are the same.
THE WITNESS: Um-hum. One justs has a stamp that reads when we received it.
BY MR. WHITE:
Q. Okay. Do sometimes --
MS. DAEHNKE: Sorry. Are you talking about 84 or are we talking the handwritten received, is that the stamp not -- or is there a stamp?
MR. WHITE: Yes.
HEARING OFFICER WOODMAN: There's a received stamp on 85, whereas there's the

handwriting on the bottom right of 84.

MR. WHITE: I'll tie that together.

BY MR. WHITE:

Q. So on 84, what do we see at the bottom right?

A. That is me verifying that I did receive the medical records and the custodian of records on 11/21/2019 from the Las Vegas Surgery Center.

Q. Then on 85, do custodian of records, people that are the custodian of records, do they sometimes send back your letter to you?

A. Yes.

Q. As sort of a --

A. Yes.

Q. -- heading page?

A. Yes.

Q. Is that what happened here?

A. That's what happened here, yes.

Q. And is that why there's a stamp on that one?

A. Correct. So this one would be from my side of the file, and this is what they sent me.

Q. Okay. And then on page 86, what do we see there?

A. That is the notarized custodian of records

from Las Vegas Surgery Center.

Q. Okay. And then was everything from page 87 to page 132, are those the records that were attached by the custodian of records when they responded to you?

A. Yes.

Q. Okay.

MR. WHITE: I'd move to admit Exhibit 4.

HEARING OFFICER WOODMAN: And, Ms. Daehnke, Exhibit 3, we find out, really doesn't have any records, just correspondence.

But same objection as to 2, Exhibit 2?

MS. DAEHNKE: Yes, Your Honor.

HEARING OFFICER WOODMAN: All right. I note that.

And for a same reasons that I admitted 2, I'm going to admit 4.

(IC's Exhibit 4 was admitted.)

MS. DAEHNKE: Oh. I thought you said Exhibit 2. I have no objection to Exhibit 4, except for any -- I don't have an objection to these medical records that are marked as Exhibit 4 from Las Vegas Surgery Center, except to any hearsay statements that are contained therein.

HEARING OFFICER WOODMAN: Right. And I

know that's part of your objection 2, and it will absolutely be a real consideration, again, as I look at what is in them and as I take that into context with all the other evidence.

MS. DAEHNKE: Thank you, Your Honor.

BY MR. WHITE:

Q. Now turning to Exhibit 5, did you ask -- well, first of all, take a look at it please, and lift your head up and look at me when you're done.

What do we see there?

A. This is the curriculum vitae for Dr. Nicholas Spoerke, who is our peer reviewer.

Q. And what did he -- and that encompasses all the pages here from 133 to 136?

A. Correct. Yes.

Q. Did you collect that as part of your investigation in this matter?

A. Yes.

Q. Okay. Is that -- do you do that on every case where we have a peer reviewer?

A. Yes.

MR. WHITE: I'm not going to move for that yet. We'll do that with Dr. Spoerke.

That's all I have. Pass that witness.

HEARING OFFICER WOODMAN: Very good.

Ms. Daehnke, cross?

MS. DAEHNKE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. DAEHNKE:

Q. Ms. Gustafson, hello.

A. Hello.

Q. I'm going to ask you some questions.

What's your official title with the Board?

A. I am the senior investigator for the Medical Board.

Q. What -- before -- when did you become Senior Investigator?

A. Approximately eight years ago.

Q. Eight years --

A. Approximately. I'd have to look at the date. I can't remember the exact date.

Q. Were you the senior investigator on the file when this -- I presume you were the senior investigator on this file back when the first complaint was filed; is that correct?

A. Correct.

Q. And is part of your role as a senior investigator and obtaining and gathering the information that you talked about, what else do you do besides what Mr. White asked you about?

For instance, who do you send letters to?

A. I sent letters to the respondent, to any other doctor that may be named in the complaint, any doctor that I feel might have information that can tell us the timeline of the injury past, like, after the patient saw the particular doctor or prior.

Q. Okay. What else?

A. If I need to interview anyone, I would go down and interview them or call them on the phone if it's necessary. I would write reports, investigative reports if I needed on specific phone calls.

Q. What else -- you would write reports on the phone calls. What else would you write reports on?

A. I would also do allegation letters. I'd write a report if I felt like there was information that was needed and I maybe needed to ask permission to get more information to my chief.

Q. So like a memo to your chief saying I found this, I need that, may I do this?

A. Yes. Um-hum.

Q. So interviews, telephone calls. What other -- any other kind of investigation?

A. I would read the entire complaint and

write my allegation or summary on what I read, because all of my allegation letters come specifically from the complaint.

Q. When you're talking about that complaint, you're talking about the publicly filed complaint in the matter, you review those for the allegations?

A. They're not all publicly -- it -- there's -- we get complaints from all different various places. We get citizen complaints, we get complaints that come in from courts.

Q. Okay. So when you're referring to reviewing the complaint, is the document that you're referring to allegation letter?

A. Oh, you're trying to understand.

Q. No, no, no, I'm not trying to understand. I think I understand fully the difference between the documents. I think it's just a different name because we used to say "complaint letters," the letters that are sent out that, essentially, can come from citizens, patients, or Board.

That's the complaint you're discussing; right?

A. When we get in -- when I'm assigned the case, whatever is written in that case file that I'm assigned and I read it, that's the complaint. And

then I write my allegation letter based on what I just read.

Q. And who -- where do you get that file that you just described you're reviewing in order to send out the allegation letter?

A. It's assigned by our Chief of Investigations.

Q. Is that Ernesto Diaz?

A. Correct.

Q. And was he the chief at the time that this case was initiated?

A. No.

Q. Who was?

A. Actually, that was Pamela Castagnola, C-A-S-T-A-G-N-O-L-A.

Q. Okay. And so in this case, if I understand what you're saying, and in all cases, you get a file from the Chief of Investigations.

A. Chief.

Q. Just chief. All right.

And so what documents would be contained in that file that you're reviewing?

A. Anything that was sent in by --

MR. WHITE: Objection as to form.

MS. DAEHNKE: You can answer.

MR. WHITE: No. Objection.

MS. DAEHNKE: Do you need to rule on the objection? Sorry. It's to form.

HEARING OFFICER WOODMAN: Well --

MR. WHITE: And it's also -- it's -- now we're starting to get close to what could be considered attorney-client privilege because we have -- the IC is our client. We're also getting into -- possibly -- or actually privileged information and also, again, the investigative file, which is confidential.

HEARING OFFICER WOODMAN: Sharpen your question as much you can, and then I'll let you know whether I think that the witness should answer or not.

BY MS. DAEHNKE:

Q. What documents are contained in the file that you just discussed reviewing in order to send the allegation letter to Dr. Barber in this case?

MR. WHITE: Objection. Again, it's the investigation file.

HEARING OFFICER WOODMAN: And so this is where -- again, this goes back to so much of what we talked about before the evidence began in terms of my difference of opinion with the Board.

I want you to answer the question. Your counsel --

MR. WHITE: I'm instructing her not to.

HEARING OFFICER WOODMAN: -- may direct you not to answer the question, and then that will be a factor that I look at.

Right now, your question is just: What is in the file?

MS. DAEHNKE: Correct.

HEARING OFFICER WOODMAN: And I'm going to make a more specific rule.

If you have any notes in the file that were made as result of communications that you had, either with the Board itself or with the Board's attorneys, I don't want you to give those answers. But in terms of other documents that would not be privileged or work product, I do want you to answer that as far as what is in the file.

MR. WHITE: Well, I will object that Ms. Gustafson is not a lawyer, she's not going to understand what's privileged and what's not at this point with regards to the question because it's a very open-ended question, very general question.

The question as I heard it was what's in the file, which kind prompts the allegation letter,

what's in the file. That is way too much -- it's just very open-ended and too general. And it's not something that Ms. Gustafson can sort through. She's not an attorney.

HEARING OFFICER WOODMAN: Well, so, if we took a break so you could have a consultation with her to talk about what you believe to be properly privileged documents, attorney-client privileged and/or true work product, would that make you comfortable in not directing her not to answer?

MR. WHITE: Well, no. And also I'm going to object to relevancy if this not relevant to prompted -- we have the allegation letter. Everything is in there.

She already told that she uses the complaint wherever she gets it from. It could be other agencies, it could be a court, could a patient, could be a patient's family. Lots of different things. That she sort of boils that down into an allegation letter.

The rest of what was happening -- we're just getting into -- we're getting way too close to what could be attorney-client privilege, and I'm going to instruct her not to answer that. I don't think it would be helpful at this point. And I

think it's irrelevant.

HEARING OFFICER WOODMAN: Okay. So I'm overruling the relevance objection.

But I'll go back to my question: If you had a minute, a few minutes to consult with her so you could direct her what not to testify about that could be properly privileged attorney-client and/or properly categorized as work product, then would you be comfortable allowing her to answer the question?

MR. WHITE: No. Because I don't know -- I mean, I don't do her job. She's an investigator. I don't -- our jobs are separate. She's an investigator. I don't -- I don't know every single thing that she does in the investigation.

HEARING OFFICER WOODMAN: Have you seen the entire investigation file?

MR. WHITE: Probably not. I don't see -- I don't see -- no, I don't see everything.

HEARING OFFICER WOODMAN: All right. So you're directing her not to answer?

MR. WHITE: Right.

HEARING OFFICER WOODMAN: All right.

MR. WHITE: And unless Ms. Daehnke wants to ask specific questions "are there," "is this in there," then I would -- could, obviously, have the

opportunity to object. If she wants to know if there's like notes to the IC that she's had or she's seen, well, then obviously I'm going to object to that.

But she's on a little bit of a fishing expedition, I think, right now, respectfully.

HEARING OFFICER WOODMAN: Well, then --

MR. WHITE: I understand what she's doing, but it's just -- again I know you've overruled it, but it's not relevant to this case at all.

HEARING OFFICER WOODMAN: All right. So we have for the record a question that I've overruled the relevance objection, and you've turned down the opportunity to meet with your client to clarify with her what is appropriately attorney-client privilege, what's appropriately classified as non-discoverable work product, so that'll factor into the record.

And, Ms. Daehnke, if you do want to ask questions about what types of documents are in there, we can take those one by one.

MS. DAEHNKE: Thank you, Your Honor. That's what I was getting to, and I understand the court's ruling. And I do not intend to breach attorney-client, however, the witness has now been

instructed to answer three times, and even given the opportunity to talk to counsel.

Although I would note that the fact that Mr. White doesn't know if he's seen the IC file --

MR. WHITE: It's also outside the scope. And I actually just thought of this. It's actually outside the scope of my direct.

There's no -- I mean, I know that evidence rules are relaxed, but it's way outside the scope. I didn't ask her what's in the -- I didn't ask anything like that.

We have our documents that we produced to prosecute the case, so we go on.

HEARING OFFICER WOODMAN: But here's the thing: She called her as witness in her case. And if she addressed those issues now, it's a saving of time. It goes to economy of this hearing.

And so typically -- and you'll remember from past cases, I will allow cross of the Board's witnesses to go outside the scope so that we save the time of having them call this witness in their own case.

MS. DAEHNKE: Thank you, Your Honor. I was also following up on Ms. Gustafson's direct testimony about the fact that she had materials in

the file that she used to review to form the allegation letters.

BY MS. DAEHNKE:

Q. What types of documents, generally, are in these files, please?

MR. WHITE: Objection.

THE WITNESS: I'm not comfortable --

MR. WHITE: Objection. I just objected to general, and I was told that she was going to ask more specific questions that I could object to individually along the way. And now we just have what's in the file again.

MS. DAEHNKE: Well, counsel doesn't know what's in the file because he doesn't know if he's even bothered to review it, Your Honor. And so if I can ask Ms. Gustafson -- now she's not comfortable.

She gave direct testimony that said that she had materials in the file that she would review in order form the allegation letter. She also testified -- and with respect to the witness -- that she reviews the complaint.

In my world, the complaint is the formal complaint. The allegation -- we've been -- the letters are not complaints. We used to call them "complaint letters," now they're allegation letters.

I wanted to make sure what we were talking about, so I just wanted to follow up on what the witness was talking about when she testified. I'm not going outside the scope of direct, I'm following up on what Ms. Gustafson's said.

HEARING OFFICER WOODMAN: All right. So ask the most specific question that you can for the moment. Let's just get the -- figure out a way to get beyond this impasse, and then Mr. White will make objections as he deems appropriate, I'll make rulings, and we'll see if we get answers.

MS. DAEHNKE: Okay.

BY MS. DAEHNKE:

Q. In this case, what records did you review, what were you referring to when you testified that you reviewed records in the file in order to prepare and sending the allegation letter to Dr. Barber?

A. I'm not comfortable answering that.

HEARING OFFICER WOODMAN: I'm going to direct you to answer.

MR. WHITE: Objection.

THE WITNESS: I'm not comfortable answering that at this point.

MR. WHITE: Objection. Again, it's -- that's part of the investigative file. This is the

thing --

HEARING OFFICER WOODMAN: This goes to --

MR. WHITE: This is kind of we need to do -- this is what we need the rulings on the writs for.

HEARING OFFICER WOODMAN: I understand. And we don't have them yet.

MR. WHITE: I know.

HEARING OFFICER WOODMAN: And, again, my job is to call balls and strikes here.

MR. WHITE: I suggested we stay the proceedings until we get a ruling on that, but I was shot down on email.

MS. DAEHNKE: Actually, you directed the Hearing Officer to stay the case. There was no request.

And also, just for the record, and I know that you all know this, none of those writs have anything to do with the substance of Dr. Barber's medical license that you have now, second time, brought to hearing in this case and now refusing to --

MR. WHITE: Sorry. Are you referring to me directly or --

MS. DAEHNKE: Excuse me. For the IC, the

Board, however you would like to be. I apologize, Mr. White.

The writs, I understand the legal issue. We just learned about it yesterday. I don't even -- we tried to find them after we learned about them. We can't get to Washoe -- we're not parties to the action. I don't even think the lawyers who were on the Chacon matter and the McCleve matter are parties to the action.

So I understand. However, we're here, and Dr. Barber's license has been under investigation by this Board since 2019. It is now 2024. And this would -- I don't know -- I mean, if this witness can't testify, then --

HEARING OFFICER WOODMAN: And we're here so that we can move toward closure on Dr. Barber's situation. And we've got a witness who I've told her to answer, she won't answer. Again, it'll factor in.

Ask your next question.

MS. DAEHNKE: Okay.

MR. WHITE: May I, just on one little thing, Mr. Woodman. Did I direct you to do anything through the email yesterday?

HEARING OFFICER WOODMAN: I would have to

go back and look at the email again. I wasn't concerned about it, other than the fact that when I checked back in a reply all and learned from Ms. Daehnke that they have an expert witness who is traveling the country to be here, I thought we're not going to prejudice that.

I will say, whether it matters or not, it probably doesn't, I didn't read anything that offended me.

But be that what it may or may not matter, go ahead, Ms. Daehnke, just keep asking the most specific questions that you can ask.

MS. DAEHNKE: I will, Your Honor. And thank you. Your Honor, has thicker skin than I do, and perhaps it was the hour and multiplicity of emails, but it offended me.

BY MS. DAEHNKE:

Q. Ms. Gustafson, I'm sorry you said you're not comfortable answering my last question.

Can you tell me then -- all right. You did say that you would make telephone calls to doctors who were involved in the case and in the care and treatment of this Patient A?

A. No.

Q. You did not make telephone calls to any

doctors in 2019 involving the case of Patient A?

A. No. Because you asked me what my role was as an investigator and what I do on the various cases.

I wasn't specifically stating it for Patient A.

Q. Do you recall --

A. It was in general.

Q. -- whether you made any telephone calls regarding Patient A?

A. I'm not going on answer that question either.

MR. WHITE: Objection. I instruct her not to answer for possible attorney-client privilege and information.

MS. DAEHNKE: Let me state the question again. It's whether the witness made any telephone calls to any other doctors who are involved in the care and treatment of Patient A or subsequent care and treatment.

HEARING OFFICER WOODMAN: And I'll allow that question.

Did you call any other doctors?

THE WITNESS: I'm not going to answer that question because that's part of the --

MR. WHITE: Same objection.

THE WITNESS: -- investigative file. I'm not going to answer any of those.

BY MS. DAEHNKE:

Q. Just so we're clear, it's not that you do or do not remember, you just don't want to answer -- I mean, with respect, that you're not going to answer?

A. I'm not going answer that question that you just said to me.

MR. WHITE: Would it be helpful if we submitted this as a -- and I'll tell you what it is in a second. This is an answer to a frequently asked question on our website about understanding the investigative process. We can submit that as an exhibit right now. It could be exhibit 8.

And then everybody would have -- all be on the same page, and this doesn't include anything that could be construed as confidential or attorney-client privilege. It's out there in the public.

HEARING OFFICER WOODMAN: Well, you can --

MR. WHITE: And I think it would answer the questions. Because she's asking general questions, so this a general answer.

HEARING OFFICER WOODMAN: You can offer it as an exhibit, and she can respond to whether --

MS. DAEHNKE: I don't know what the purpose of the exhibit is. I'm asking this witness --

MR. WHITE: I just explained. It's --

MS. DAEHNKE: And if Mr. White could let me at least finish a sentence and put almost a period on it before he interrupts me.

HEARING OFFICER WOODMAN: Let's not interrupt each other. Number one, it's not appropriate, and, number two, it makes our reporter's job all the more difficult.

We will do this: Over our lunch break, you can take a look at that and let me know whether you think it's helpful or not. And you can make objections you want to it.

MS. DAEHNKE: Thank you, Your Honor. I've reviewed it previously, but I'll take a look at it again. I don't think it's really relevant to this witness. I'm trying to get the testimony from the witness.

BY MS. DAEHNKE:

Q. All right. And I know this is uncomfortable. I'm sorry. It's just not

comfortable. I can appreciate that.

Did you -- in this file, does this contain letters from any other doctors that you sent non-respondent letters to?

MR. WHITE: Objection. Investigative file.

THE WITNESS: I'm not going to answer that.

HEARING OFFICER WOODMAN: All right. We've got the record.

BY MS. DAEHNKE:

Q. And just so we're clear that you're not going to answer, it's not that you don't recall or you remember -- you don't recall, it's that you're not going to answer?

A. I'm not comfortable answering that.

MR. WHITE: I believe she's taking my advice to not disclose something that might be in the investigative file, which we still have a stance that it's confidential.

HEARING OFFICER WOODMAN: It's clear on the record.

BY MS. DAEHNKE:

Q. Under the code, the investigative file for the case includes all communications, records,

affidavits, or reports or created as a part of the investigation of the case, whether or not acquired through a subpoena related to investigation of the licensee.

Do you agree with that, that that's the contents of the file for --

A. Yes.

Q. Okay. So in this case, what communications do you have in the file related to Dr. Barber?

MR. WHITE: Objection.

BY MS. DAEHNKE:

Q. Excluding any attorney-client --

MR. WHITE: No. It's still confidential under the investigative file. You just referred to -- sorry.

Ms. Daehnke just referred to the definition of what an investigative file is.

MS. DAEHNKE: Um-hum.

MR. WHITE: Again, our stance is that we do not have to turn over the investigative file except for what we're going to use in a hearing. That is all here.

And that's where we differ.

HEARING OFFICER WOODMAN: Absolutely.

MR. WHITE: And also differ obviously again -- to beat a dead horse, but we differ on what discipline is. Discipline is when it gets to the Board, that is what discipline -- they say in the statute that becomes a public record. It's this (indicating.) The Board does not get anything else. The Board gets exactly what we see here for today, including a transcript from when the hearing is finished, your recommendations, and that's pretty much the whole -- their universe.

And so, again, I'm going to advise her not to answer that as it gets into what we consider the investigative file and what we consider not disclosable.

HEARING OFFICER WOODMAN: Again, it just goes to exactly the disagreement I have with the Board.

You're directing her not to answer, even though she's not going to answer anyway, and so it's in the record.

BY MS. DAEHNKE:

Q. All right. You testified, though, as part of your job that you would send non-respondent letters out to physicians and other health care providers who treated the patient in question.

And you're not going to respond as to whether or not there were any statements from any other doctors other than the two that the Board has marked as exhibits in this case; is that correct?

MR. WHITE: Objection.

THE WITNESS: Yes.

BY MS. DAEHNKE:

Q. So you're not saying that there are no other records from any other doctors that you sought as non-respondent information, you just are not going to answer; is that correct?

MR. WHITE: Objection.

THE WITNESS: I'm not comfortable.

MR. WHITE: Objection. It's -- again, you're asking her to --

Ms. Daehnke's asking her to disclose what could be privileged information and the confidential investigative file.

HEARING OFFICER WOODMAN: All right. And a ruling at this point is almost useless because we know she's directed to answer and she's not going to it anyway.

BY MS. DAEHNKE:

Q. What you identified for Mr. White on direct, Exhibit 5, the CV of Dr. Spoerke; is that

correct?

A. What was the question again?

Q. I'm just asking you, you identified that as the CV or the resume, curriculum vitae of Dr. Nicholas Spoerke?

A. Correct.

Q. And you identified him as one of your peer reviewers?

A. Yes.

Q. How many other cases has Dr. Spoerke peer reviewed for the board?

MR. WHITE: Objection.

THE WITNESS: I cannot answer that.

MR. WHITE: That's also investigation. That's even getting into investigation of possibly other cases.

MS. DAEHNKE: It's asking for a number. If she knows, she knows -- I believe the witness said she didn't know.

THE WITNESS: I'm not comfortable answering that.

MS. DAEHNKE: Oh, all right.

HEARING OFFICER WOODMAN: Mr. White, just --

MR. WHITE: And it's not relevant either.

How is it relevant whether Dr. Spoerke's doing other investigations -- or other peer reviews?

MS. DAEHNKE: She's said she's not going to answer. It's relevant -- I'm just trying to test -- all we have from this doctor is this CV (indicating) that's pretty light anyway, and was probably produced five years ago.

I want to know what Dr. Spoerke does.

HEARING OFFICER WOODMAN: Mr. --

MR. WHITE: I will respond to that with she will have her chance to cross-examine Dr. Spoerke. He's one of our witnesses.

HEARING OFFICER WOODMAN: Fair enough.

You can save that for Dr. Spoerke.

MS. DAEHNKE: Well -- thank you.

BY MS. DAEHNKE:

Q. What else in the file do you have regarding Dr. Spoerke, for instance, what about an expert review?

MR. WHITE: Objection. I'm just going to start saying "investigative file -- confidential investigative file."

MS. DAEHNKE: And I'm going to keep asking because my doctor has a right to due process.

HEARING OFFICER WOODMAN: Here's --

MR. WHITE: Due process has not been --

HEARING OFFICER WOODMAN: This is --

MR. WHITE: We could argue that right now, actually.

HEARING OFFICER WOODMAN: Listen up. The question --

MR. WHITE: Due process has not been violated. Ever.

MS. DAEHNKE: Are you ever just going to stop? I mean, why don't we let the Hearing Officer talk.

HEARING OFFICER WOODMAN: Listen up. As I understand the question, it was just -- what was your question again?

MS. DAEHNKE: What else do you have in the file from Dr. Spoerke, do you have an expert report.

HEARING OFFICER WOODMAN: So right there, whether an expert report exists or not, without getting into the substance of the report, if it does exist, I don't know how that can be a question that you don't answer, whether or not there's a report.

And again, it goes to leaving the respondent and anyone else in the world who cares wondering what is being hidden. And it's -- again, it's the fear of the unknown that leaves everybody

concerned when there's some type government intervention in the life of our people.

So, are you directing her not to answer the question: Is there a report?

MR. WHITE: I didn't hear that. I'm sorry.

Yeah, you can answer if there's a report.

BY MS. DAEHNKE:

Q. An expert witness report by Dr. Spoerke?

A. There is a report.

Q. Do you know the date of report?

A. I don't.

MR. WHITE: No. And now that's it. No, we're not doing the date.

MS. DAEHNKE: Excuse me?

MR. WHITE: You just asked if there is a report. There's a report.

MS. DAEHNKE: The date of the report, we don't --

MR. WHITE: He has --

MS. DAEHNKE: You're instructing her not to answer on the date -- just so I'm clear.

MR. WHITE: Now you're getting back into the investigative file.

THE WITNESS: Um-hum.

HEARING OFFICER WOODMAN: It's in the record.

MS. DAEHNKE: So it's the same objection that it's confidential?

HEARING OFFICER WOODMAN: Yes. He's essentially saying that when he tells us his objection is the investigative file, that it's the Board's position that it's not discoverable.

MS. DAEHNKE: That's shorthand for everything?

HEARING OFFICER WOODMAN: Yes.

MS. DAEHNKE: Okay. So we're sort of incorporating everything? Just so I'm clear.

HEARING OFFICER WOODMAN: Yes.

BY MS. DAEHNKE:

Q. Do you have any medical articles produced by Dr. Spoerke contained in the file?

MR. WHITE: That's --

THE WITNESS: Not comfortable answering.

MR. WHITE: No. It's -- objection. Investigative file.

HEARING OFFICER WOODMAN: And are you asking for medical literature?

MS. DAEHNKE: I am.

HEARING OFFICER WOODMAN: All right.

MS. DAEHNKE: And the reason -- not just generally but specifically in the Complaint, specifically the thrust of the allegation against Dr. Barber -- I want to make sure that I have it correctly --

MR. WHITE: I'm going to --

MS. DAEHNKE: -- is that Dr. Spoerke states, paragraph 15, page 3 of 5, that --

MR. WHITE: It's the Complaint you're reading?

MS. DAEHNKE: Yeah. Page 5.

MR. WHITE: I'll refer you to Dr. Spoerke.

MS. DAEHNKE: May I continue?

HEARING OFFICER WOODMAN: Please.

MS. DAEHNKE: Thank you.

So paragraph 15, the allegation against Dr. Barber is essentially that she failed to use proper medical judgment in her surgery. But then the last sentence is relevant in that it -- this says that the laparoscopic approach is contra indicated by medical literature, just going to that without reading the whole paragraph.

And so I would like to know what medical literature is contained in the investigative file that supported the decision to file this complaint.

HEARING OFFICER WOODMAN: And, Mr. White, do you object to that? Because that's -- it appears to me right now to be a critical part of your case?

MR. WHITE: Publication -- he lists his publications here that he -- if she wants to know that he's written anything else, here's his publications in his CV, page 135.

HEARING OFFICER WOODMAN: But are you saying that he's only relying on his own publications?

MR. WHITE: Oh no. I don't know.

MS. DAEHNKE: Okay. That wasn't my question at all. I'm not really particularly interested, at least at this point, in his publications. I didn't see any that were relevant.

But what I am asking about is this is the Complaint, it mirrors the first Complaint against Dr. Barber. The second Complaint, which is what we're here for, is my understand, paragraph 15 states that the allegations against Dr. Barber for violating the Medical Practice Act is that her approach was contra indicated by medical literature, and I would like to know what medical literature is referred in the Complaint that's contained in the IC file.

HEARING OFFICER WOODMAN: And --
MR. WHITE: Well, we can ask him too.
MS. DAEHNKE: I am asking this witness.
MR. WHITE: Or I can -- okay.
HEARING OFFICER WOODMAN: And are you objecting to this witness answering that question?
MR. WHITE: Oh yes. Yeah.
HEARING OFFICER WOODMAN: So the objection's overruled. If you're making this allegation, it's only fair to point to the medical literature you're referring to.
MR. WHITE: He will. He can.
HEARING OFFICER WOODMAN: But that's providing discovery by a direct examination, which is pretty prejudicial in terms of not allowing people to research articles that would disagree with whatever literature he was looking at.
So, in any event, Ms. Gustafson, you can answer the question if you know what medical literature the Board is referring to that was contra indicated by the procedure.
THE WITNESS: Not comfortable answering that question.
HEARING OFFICER WOODMAN: It's in the record.

MS. DAEHNKE: And for the record, when the witness says she's not comfortable, which again I understand that means that she is taking her -- the advice of counsel for the IC and not answering the question. But what --

MR. WHITE: Correct.

MS. DAEHNKE: I need to make this record.

MR. WHITE: Correct.

HEARING OFFICER WOODMAN: It has to be because she --

MR. WHITE: Right. Investigative file again.

HEARING OFFICER WOODMAN: -- is not an attorney, so she's going off of advice of counsel.

MR. WHITE: Confidential investigative file.

MS. DAEHNKE: I need to ask just for a moment -- excuse me, Ms. Gustafson -- just again for purposes of the record, when Mr. White is saying "confidential investigative file," I'm not absolutely certain of his position with respect to the fact that they're picking and choosing parts of the investigative file and not disclosing the others that are public record, I don't understand that argument. Is there anything else other than what we

chatted about in the emails?

MR. WHITE: This is a question to Ms. Gustafson?

MS. DAEHNKE: No, it's not. And I said "Excuse me, Ms. Gustafson."

I need to make this record just so that it's clear about what's happening here because the witness is uncomfortable, you're not letting her answer questions, and you're not letting me explore the foundation for the Board's Complaint against my client.

And so when you state "confidential IC file," despite the fact that we're now at the hearing -- because yesterday we weren't at the hearing so you had introduced these documents. Now you've introduced the documents, and you're still saying that even though I've introduced a portion of the IC file, I don't have to produce the portions of the file that I don't want to because it's confidential.

So to me, now that we're here, and you've introduced those records, I'm struggling to understand what your position is.

HEARING OFFICER WOODMAN: Do you want to respond?

MR. WHITE: Oh, absolutely.

I think Ms. Daehnke has a -- she misinterprets and misreads what public records are when it comes to a formal hearing versus a formal complaint versus a complaint from the public or somewhere else.

Those -- that is a -- those are steps taken and, again, like I said before, they don't become public record until the Board is going to make a decision on discipline. There is this (indicting) and the transcript that will take place today and tomorrow and your recommendations. That's what becomes public record, not public record.

HEARING OFFICER WOODMAN: And, again, it's just our basic, organic disagreement.

MR. WHITE: Um-hum. Yes.

MS. DAEHNKE: All right. And I have always counseled my young lawyers never to say "with due respect," but with due respect to counsel, I still don't understand that argument, but I just want to make sure that's what you're -- that now that you have introduced a portion of the file, you're still saying that the rest of the file you that you haven't -- you've decided not to produce -- or use as an exhibit -- is confidential, even though

now we're in the hearing and a witness testified and it's been admitted into evidence, you're still refusing to produce the rest of the IC file?

MR. WHITE: Let's -- do we want to look at the statute again, would that be helpful for everyone?

HEARING OFFICER WOODMAN: No.

MS. DAEHNKE: That would not be helpful for me at all.

MR. WHITE: Okay.

MS. DAEHNKE: Neither would this (indicating). I've already saw that years ago.

HEARING OFFICER WOODMAN: Go ahead.

MS. DAEHNKE: Thank you.

HEARING OFFICER WOODMAN: I'm going to interject here. It's 12:02, it's been going on a couple hours since our reporter had a break. Tell me -- I know you don't have a crystal ball, but the rest of your cross-examination of Ms. Gustafson, time anticipation?

MS. DAEHNKE: If she's not going to answer any questions and Mr. White is going to instruct her not to answer all of my questions, it will be short. If she is allowed to answer my questions, it will be longer. Are we determining whether we should take a

take break now?

HEARING OFFICER WOODMAN: Not necessarily saying we take a break now, just if we wanted to get through Ms. Gustafson, approximately how much longer do you think?

MS. DAEHNKE: Twenty or thirty minutes.

HEARING OFFICER WOODMAN: All right. Let's --

MR. WHITE: Are we going to be able to get Dr. Spoerke on the stand? I'm actually concerned about that because we've been going for quite a while.

HEARING OFFICER WOODMAN: What time do you have him set up for?

MR. WHITE: Ten o'clock.

MS. DAEHNKE: Well, that was unrealistic given all the motions that we've had.

MR. WHITE: That's your opinion. Thank you.

HEARING OFFICER WOODMAN: So -- why don't we do this. And I apologize to you, Ms. Daehnke, because this is the least fair to you. But it'll give counsel and Ms. Gustafson some time to chat. We're going to break for lunch. When we come back from lunch, we'll put on Dr. Spoerke. And -- but of

course we're going to come back and let Ms. Daehnke finish her examination of Ms. Gustafson after Dr. Spoerke.

I -- like most people, I don't like to keep experts, especially medical experts, hanging around in light of the expense, but -- and I don't know what questions Ms. Daehnke has for Ms. Gustafson. I have a sense that a whole of them aren't going to be answered. And so it just is what it is. It's our reality, and we move forward and do the best we can.

It is 12:05, let's be in here, ready to ask questions of Dr. Spoerke at 1:15.

Off the record.

(Lunch recess from 12:05 p.m. to 1:17 p.m.)

HEARING OFFICER WOODMAN: We are back on the record In The Matter of Charges and Complaint against Annabel Elizabeth Barber, M.D., Respondent. And again that is case number 21-111660-1.

Dr. Barber is with us with her attorney, Ms. Daehnke. Mr. White's here on behalf of the Board. And we are reconvening for the afternoon session of evidence. And Ms. Daehnke has let me know that she has an oral motion.

MS. DAEHNKE: I do, Your Honor, and thank you.

I just -- I have another question. I'm looking up at the video screen right now, it shows the Las Vegas hearing room, which I recognize well. In the corner, it looks like there's another room, and I'm just wondering where those people are remotely attending from? Because my understanding from discussions -- I'm not necessarily objecting, I'm just asking the question. My understanding with counsel over the last year about what can be remote and what can't, I'm just wondering where those persons are.

MR. WHITE: Lower right?

MS. DAEHNKE: Yeah.

MR. WHITE: That's us.

MS. DAEHNKE: Who are you referring to -- that's us. Sorry.

I thought someone was referring to someone earlier in attendance. Is there no one --

MR. WHITE: Patient A is in attendance, I believe. I have never seen him, so I can't confirm that.

MS. DAEHNKE: That's what I was -- I can't -- all right.

HEARING OFFICER WOODMAN: It looks like there is somebody sitting at a table, and our little picture box of --

MS. DAEHNKE: Oh. That's what I was referring to. Is that Patient A?

MR. WHITE: I've actually never been down there. You probably have. This is the -- the camera is facing that direction where the gallery usually sits. Sometimes respondents, when they come in to talk to the Board, is at the white table there.

And then there's another camera over there, if you turn it back this way, I guess we could see that person a little better.

MS. DAEHNKE: I'm just wondering. I get that, but right there is someone that's not us. It actually looks like a female person.

HEARING OFFICER WOODMAN: I can't tell. All I know is because of the public nature of these hearings, we've got to allow them to listen in.

MS. DAEHNKE: And I understand that. However, there has been an exclusionary rule.

HEARING OFFICER WOODMAN: Yes.

MS. DAEHNKE: And so to the extent that that person may be a witness, I think that both

Mr. White I would like to know the identity of that person who we can't see. It does not look like --

HEARING OFFICER WOODMAN: Well, they can hear us, obviously.

This is the hearing officer, and I am addressing whoever is in the conference room down in the Las Vegas office, and we can see slight back of a head of somebody. Can you identify yourself for us, please, audibly?

MR. WHITE: And I would say if it's -- hold on -- if it's Patient A -- if it's Patient A, which I believe it is, we can have him identify as Patient A.

HEARING OFFICER WOODMAN: The man in the blue shirt with the hat, are you the patient in this case?

PATIENT A: Yes, I am.

HEARING OFFICER WOODMAN: Okay. We don't want to know your name. That's fine.

And, ma'am, with the sunglasses on her head, tell us who are, ma'am.

MS. SCHMIDT: Dana Schmidt. I'm a investigator here in the Las Vegas office.

HEARING OFFICER WOODMAN: Okay.

And you don't intend on calling her as a

witness?

MR. WHITE: No.

HEARING OFFICER WOODMAN: Okay.

Ms. Schmidt, is there anybody else that's present there that we can see?

MS. SCHMIDT: There's no one else, no, sir.

HEARING OFFICER WOODMAN: All right. Then do you have -- will your next -- your expert be testifying from the Vegas Office?

MR. WHITE: No. He's here.

HEARING OFFICER WOODMAN: You don't plan on anybody testifying from down there?

MR. WHITE: No.

HEARING OFFICER WOODMAN: Okay. Very good.

Thank you, folks. Appreciate it.

MS. DAEHNKE: Thank you.

HEARING OFFICER WOODMAN: That was a good clarification. I hadn't even noticed.

MS. DAEHNKE: To make our record, in case this --

HEARING OFFICER WOODMAN: Sure.

MS. DAEHNKE: Thank you, Hearing Officer, and thank you, Don, for taking the time to find that

out.

I do have an oral motion based upon Ms. Gustafson's testimony earlier this morning. I realize that we interrupted her testimony.

And on behalf of respondent, Dr. Barber, we move that Dr. Spoerke be excluded as a witness in this matter as Ms. Gustafson has testified there were items in the investigative file that were not included, not produced to Dr. Barber, which would include an expert opinion report and possibly other memorandums summarizing his opinion or documents and the like. Those documents might include a telephone call, a written report.

Also any medical literature that he specifically relied upon, the Complaint says that it's based upon medical literature. That medical literature was not provided and, presumptively, Dr. Spoerke, being the foundation for the charging Complaint, his opinion would be important and necessary for Dr. Barber to see in advance of this hearing, why her license is seeking to be restricted.

And so on that grounds, the code -- well, as we've been talking about the code so I have to talk about all the code, but NRS 622A.330 2 states

that the investigative file is not discovery unless the prosecutor intends to present materials from the investigative file as evidence in support of the case. We've discussed that. I'm just trying to get my NRSs out for the record. NRS 622A.330 2 states that the investigative file includes all communications, records, affidavits, reports acquired or created as part of the investigation in this case. And then NRS 622A.080 defines records as files, books, documents, papers, information or data in any form.

Therefore, that would include any form that Dr. Spoerke's opinions take, Dr. Spoerke's opinions, which include data in any form or intended to be presented by the prosecutor in support of this case, and any records related to his opinions must be disclosed.

Therefore -- and furthermore, 634.653 provides 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. 4653 requires the IC to provide a summary of the testimony of each proposed witness. The IC did not provide a summary of the testimony of Dr. Spoerke.

Dr. Spoerke's testimony is not rebuttal evidence. Dr. Baskies' is. Therefore, his opinions were required to be produced. They were not.

Therefore, under NRS 634.653, his opinions may not be introduced if they have not shown good cause as to why his opinions have not been disclosed as they are records, they are data in any form, and Dr. Barber has requested production of that information.

It's fundamental that administrative bodies must give notice to the defending party of the, quote, issues on which the decision will turn and the factual materials on which the agency relies for the decision so that he or she may rebut it. And that's Dutchess Business Service v. Nevada State Board of Pharmacy, 124 Nev. 701.

We've heard that those materials exist in the file, they were not turned over. The basis for -- Ms. Gustafson testified that he was the peer reviewer in this case, so there's no doubt the only information that was provided to Dr. Barber as about Dr. Spoerke was his CV. There were no -- although Mr. White said, oh, I can produce his CV, he has articles that he's written, I'm not particularly interested in articles that Dr. Spoerke has written

unless he relies upon his own treatises and publications to support his opinion. And in that matter, then they should have been produced.

But it's clear that -- although, Your Honor, a hearing officer does not need to strictly adhere to the rules of evidence, you must still ensure due process of the law, and that's clear, but NRS 622A.370.

Dr. Spoerke will testify about materials contained in the investigative file, therefore, the Board has failed to comply with NRS 622A.330 1 and NRS 622A.330 2. NRS 233B.123 states, "Irrelevant or unduly repetitious evidence must be excluded." There is no -- the opinions of Dr. Spoerke should be excluded because they are irrelevant, immaterial or not the type commonly relied upon as they have not been disclosed. We haven't had an opportunity to test them. We don't know what they're based upon. They're probative value is thus substantially outweighed by the danger of unfair prejudice to Dr. Barber.

Even if relevant, when relevant testimony is outweighed by the prejudicial value of the testimony when a moving party shows that an error is prejudicial, error's not harmless, and that's under

the Wyatt case.

So, Dr. Spoerke's testimony is entirely prejudicial. It has been disclosed, therefore it should be disclosed -- excluded as a reasonably and prudent person would not rely on an undisclosed, trial-by-ambush testimony in the course of their affairs.

HEARING OFFICER WOODMAN: Very good.

Mr. White, I suppose you want to respond.

MR. WHITE: Yes. Thank you.

First of all, 622A.330, we've had this discussion before, that if -- you gotta read them together, 1 and 2.

"If at any time after being served with the charging document, the licensee may file" --

HEARING OFFICER WOODMAN: Hold on.

MR. WHITE: Slow down?

THE REPORTER: "Charging document," anything after that I didn't catch.

MR. WHITE: "The licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case, any list of proposed of witnesses."

So, really, what it's doing is just kind of cutting short the process of the prehearing conference statement and giving out those witnesses with a synopsis and also the exhibits that are intended to be used. So it cuts off NAC 634 65, just makes it a little earlier if somebody were to request documents according to NRS 622A.330, subsection 1.

Subsection 2 says:

"The investigative file for the a case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case."

So, again, we're not presenting materials, we're not presenting -- we have some materials, obviously, that we have chosen to present as relevant to this case.

Other ones are part of the investigative file that don't get presented -- or are not presented and are not part of this case as the prosecution.

Again, the Board will not see it either. The Board doesn't get an extra, you know, bunch of evidence to make their decision. They get the same thing we have here, including your recommendations

and the transcript of these proceedings.

So, unless the prosecutor intends to present materials from the investigative file as evidence in support of its case, materials, so materials are tangible documents. There's no reason to have Dr. Spoerke's testimony. He can testify as to what he knows as somebody who has been doing this for quite a while. There's no reason to exclude his testimony based on a report that is part of the investigative file that we do not turn over as part of our -- we're not using those materials as part of this case.

He's going to be sitting here in front of everyone, laid bear as a witness, and she has -- Dr. Barber has an opportunity to cross-examine Dr. Spoerke.

HEARING OFFICER WOODMAN: Okay. And --

MR. WHITE: As to -- hold on. Sorry. As to the allegation that we didn't provide a synopsis or anything that we should do in NAC 634 --I'm looking at our prehearing conference statement, which was filed on May 1st, our prehearing conference, I believe, was May 2nd. It shows, number C -- letter C, our witnesses, our list of witnesses, Nicholas Spoerke, and also what -- the

synopsis of what he will testify on pages 2 of 4 of our prehearing conference statement.

HEARING OFFICER WOODMAN: And I was -- that's where I just turned to right now.

MS. DAEHNKE: From respondent's position, that says nothing, and it doesn't state his opinion.

MR. WHITE: Okay. Well, did you read it yet?

MS. DAEHNKE: I read it multiple times and tried to find any helpful information there.

"Dr. Spoerke is a board-certified general and critical care surgeon. He is licensed to practice medicine in the State of Nevada. Dr. Spoerke 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."

That doesn't say anything.

HEARING OFFICER WOODMAN: Okay.

MS. DAEHNKE: And plus our position, again, is that the Board has an affirmative duty to produce this. And then, of course, does have another additional duty, once they're picking and choosing stuff from the file, they don't get to keep back the substance, including any other expert

reports. And Ms. Gustafson testified that there's an expert report in there and that he's a reviewer. And so now we know that that's in there.

And so I move to preclude Dr. Spoerke's opinion, based on those arguments, and that Mr. White has made and I've made and that the Hearing Officer's been made aware of.

HEARING OFFICER WOODMAN: All right.

MR. WHITE: Again, it's the definition of materials, the definition of when it becomes a public record. It's the definition of investigative file. The definition of -- if there was -- if the -- if the legislature didn't intend on keeping some of this confidential, why would they list everything here that the -- for the definition of the investigative file? Because it's confidential. That's what we need to know. What is confidential? The investigative file. What's in that? Oh, okay, let's look. It's the case includes all communications, records, affidavits or reports acquired or created as part of the investigation in this case, whether or not acquired through a subpoena related to the investigation of the license. That is 622A.330, subsection 2.

Why would there even be a statute this is

long explaining -- defining if -- why don't they just say, Medical Board, you gotta turn over everything. Whatever you get, turn it over.

HEARING OFFICER WOODMAN: So I've heard enough. I'm going to make my ruling. It's consistent with what I said before we got into evidence this morning.

I -- my interpretation of these statutes when you combine 622A.330 with 630.336, to me it seems clear that if you're going to use anything from your file, you gotta give them your file. I know that's not the Board's position, obviously. We're at an impasse there. That's what we're waiting to hear from the court.

But as I said, in order keep my --

MR. WHITE: What? I'm sorry.

HEARING OFFICER WOODMAN: Just listen.

MR. WHITE: Okay.

HEARING OFFICER WOODMAN: In order to keep my cases moving forward rather than just create a log jam while we're waiting for those writs to be decided, I'm going to let the testimony in, but to the extent that I think a refusal to turn over, for example, Dr. Spoerke's report, which we know there is one, to the extent that I think that prejudiced

Dr. Barber's defense, I'm going to spell that out for the Board. And we all know, like I said, the Board can wholeheartedly accept what I say, they can wholeheartedly reject what I say, they can pick pieces that they like and keep those and get rid of the rest. I'm not the final decision-maker.

I'm the person who is supposed to try and keep this process fair. And I have a strong disagreement with the Board, and the Board has a strong disagreement with me over what is the definition of fair. But I'm not going to let that disagreement keep us from moving forward.

I will call them as I see them. We know that Dr. Spoerke created a report. With over 30 years of practicing law, the idea that that report would be held back is repugnant to my sense of fairness, but we're going to hear from him, and I'm going to spell it out like I see it when this thing's all over.

Let's -- and obviously the motion and the objection to his testimony is well recorded, and it may or may not do some good at some point in the future, depending on what happens with the writs.

MR. WHITE: Mr. Woodman, you and I have always got along, we've been doing hearings for

quite a while.

I would just object to your framing of this, of the Board, framing them as unfair. You've said that twice, repugnant to fairness, and that you don't think it's fair, that we might be -- accusing us, basically, or at least your position is that we're holding things back.

So I would at least like to make the record clear that I object to that framing of how you feel about the Board.

HEARING OFFICER WOODMAN: And dually noted. I say it because I think its unfair. And I don't say that with any animus toward the Board. I don't. The Board's doing what it thinks it ought to do. I get that.

Again, I'm just calling them like I see them. And when we get a final decision from a court, whether it's the District Court or a higher court, it really, I think, is going to make my job a lot easier because it's either black or it's white, hopefully, based on the decision that we get, and I'm hoping that decision comes out sooner than later.

MS. DAEHNKE: Respectfully, Your Honor, I appreciate what you're saying, and I appreciate that

you believe this is the right way to go.

I just need to add that Dr. Barber is now caught in the crosshairs of statutory interpretation between you, the Hearing Officer who has been appointed to make rulings on all such matters, and Board counsel. And despite the fact that we didn't know about any writs, of course, and that's really not Dr. Barber's -- she's here to defend her license and her standard of care, so this creates a somewhat untenable position for Dr. Barber, recognizing that you've spelled this out, but what is Dr. Barber's remedy once a witness who we haven't had an opportunity to test their opinions, what's her remedy then? I'm throwing that out because I really don't know.

She's already had to appear for prosecution by the Board twice in Reno, get her experts out here, get me out here. And I know we've said that, and I know that everyone's well aware of this.

But, really, the reason that this -- that we are where we are is because of writs that the Board has filed? I mean, that's a little bit suspect.

MR. WHITE: Well -- can I -- the writs

that are in response to rulings on those cases, obviously, that didn't go in favor of the Board, and that's not just, you know -- or in favor of the interpretation that the Board has. And the Board's feeling is that if they were to turn over everything that's in the investigative file, they're violating a lot of statutes.

HEARING OFFICER WOODMAN: And that's --

MR. WHITE: (Inaudible) duty of confidentiality, duty of attorney-client privilege. And so that is the response. It's a response, again, that wasn't caused by the Board. I just want to make that clear.

HEARING OFFICER WOODMAN: And I --

MR. WHITE: And also I wanted to state this. Sorry, Mr. Woodman.

That was the reason for the motion to recuse also that we tried to do this morning and filed this morning that Ms. Contine wrote. It's -- if -- it's such -- it's unsettled statutory interpretation, and you heard from Ms. Daehnke that she's caught in the crossfire, Dr. Barber, well, I mean, that's why, I mean, that's exactly one of the reasons we were doing a motion to recuse because that -- maybe somebody else needs to look at this.

That's the only thing.

HEARING OFFICER WOODMAN: I get it.

Now -- I was going to say something and I decided not to say it. Because I think if you got a different hearing officer who agreed with me, we'd be in the same boat. Right?

MS. DAEHNKE: Yes.

HEARING OFFICER WOODMAN: The fact that another hearing officer may find what I find isn't going to change the Board's position until you get a court order. And I'm sure --

MR. WHITE: That was it too. Until we get a court order, let's, you know ...

HEARING OFFICER WOODMAN: If -- but, again, that just creates a log jam with every case I've got. And that isn't right, it's not fair to the doctors, it's, frankly, not fair to the Board to just put everything on indefinite hold.

So, I'm sure everybody wants to add more to the record. We're not going to. We're either going to get Dr. Spoerke on the witness stand now or we'll find another witness who wants to testify.

MR. WHITE: He's ready.

HEARING OFFICER WOODMAN: Good afternoon, sir. You are Dr. Spoerke, is that the proper

pronunciation, sir?

THE WITNESS: Correct. Yes.

HEARING OFFICER WOODMAN: I'm Charles Woodman, I'm the Hearing Officer in this case. We have here Mr. Daehnke, who is counsel for Dr. Barber. And you probably know Mr. White.

THE WITNESS: Correct.

HEARING OFFICER WOODMAN: All right. Sir, before we start with your testimony, I have to have you raise your right hand and our reporter will swear you in.

(The oath was administered.)

THE WITNESS: I do.

HEARING OFFICER WOODMAN: All right. Very good.

Mr. White, when you're ready. And, Mr. White, as the day has worn on, your speed has increased, so be kind to our court reporter.

MR. WHITE: Duly noted.

DIRECT EXAMINATION

BY MR. WHITE:

Q. You've kind of already been introduced, but would you please say your first and last name and spell it for the record.

A. Sure. Nicholas Spoerke, N-I-C-H-O-L-A-S,

and the last name is spelled S-P-O-E-R-K-E.

Q. Are you a doctor?

A. Yes.

Q. Are you licensed in Nevada?

A. Yes.

Q. How long have you been licensed in the State of Nevada?

A. Since 2012.

Q. And what kind of medicine do you practice?

A. I practice general surgery, acute care surgery, trama. I'm a certified in critical care.

Q. If you want to turn to -- I'll get there in a second, but if you want to turn to Exhibit 5, we'll be there in a little bit.

What year did you graduate from medical school?

A. 2005.

Q. And did you do a residency?

A. Yes.

Q. Where did you do that?

A. Oregon Health Sciences University, Portland, Oregon.

Q. What year did you complete residency?

A. 2011.

Q. And did you have a specialty when you were

in residency?

A. No. But I did a fellowship from 2011 to 2012, surgical critical care. And I did a year of research between my third and fourth of general surgery residency. So normal general surgery residency is five years. Mine was seven because I did a year of research and fellowship.

Q. Seven years instead of five?

A. Correct.

Q. During your fellowship?

A. Residency is five years. I did a year of research and a year of fellowship, so my entire post-medical school training was seven years.

Q. Was that also at Oregon Health Sciences?

A. Yes.

Q. And that was -- what is your fellowship in again?

A. It's in surgical critical care. It's more commonly known as a trauma fellowship, but it's technically a surgical critical care fellowship.

Q. Okay. I'm going to direct your attention now to Exhibit 5. Please take a look at it for the moment, look up when you're finished reading it to yourself.

A. The whole thing?

Q. Just take a look -- yeah.
A. Okay. Yeah.
Q. What -- are you familiar with that document?
A. Yes.
Q. And what is that?
A. That's my CV from last year.
Q. Okay. Is it complete and accurate to the best of your knowledge?
A. Not presently.
Q. Is there anything you would like to add?
A. No.
Q. Okay. So what's inaccurate about it?
A. My ATLN certification and my ACLS certification are expired. They are no longer required at our hospital.
Q. Okay.
A. And I don't know if it still says on there -- it says "Medical Director, Surgical Critical Care," that has expired. I'm past that. On the second page of the CV it says "Medical Director, Surgical Critical Care," I did that for five years. I'm no longer that medical director.
Q. Okay. What page are you referring to on --

A. It's NSBME 135, second page of my CV. 2017 to present. I'm no longer the medical director.

Q. Okay. At Renown. Okay.

HEARING OFFICER WOODMAN: And, Dr. Spoerke, like a lot of doctors, you talk on the fast side. In fairness to our reporter, try and methodically slow it down a little bit. The most guilty party in this room is sitting right behind you, but I just like to try to keep her hands and wrists from getting too beat up. Thank you.

BY MR. WHITE:

Q. Did you write this CV?

A. Yes.

Q. And now that you've made some corrections on the record, do you feel that it's an accurate depiction of what -- of your education and experience, et cetera?

A. Yes.

MR. WHITE: I move to admit Exhibit 5.

HEARING OFFICER WOODMAN: Ms. Daehnke?

MS. DAEHNKE: Well, it's hearsay, but no objection.

HEARING OFFICER WOODMAN: It will be admitted.

(IC's Exhibit 5 was admitted.)

HEARING OFFICER WOODMAN: I just have this question, Doctor, USMLE, what does that stand for?

THE WITNESS: United States Medical Licensing and Examiners, I think. Just standard licensing body for all of those.

HEARING OFFICER WOODMAN: It's toward the bottom of the first page.

THE WITNESS: Yeah, it's a little bit outdated when you compare it to current educations, because I don't think they take those steps anymore. But we used to -- that was the name of the test we took in medical school to get into -- apply for residency programs.

HEARING OFFICER WOODMAN: Okay. Thanks very much.

MR. WHITE: I'd also like to address it's not hearsay, it's not an out-of-court statement for the truth of the matter. I'm just laying a foundation for his CV.

MS. DAEHNKE: It is. A resume is hearsay.

HEARING OFFICER WOODMAN: For the rationale that he is here to testify about it and be questioned on it, I'm going to overrule any hearsay objection.

BY MR. WHITE:

Q. Dr. Spoerke, are you still practicing?

A. Yes.

Q. Okay. And where do you practice?

A. Western Surgical Group.

Q. And do you have a specialty there?

A. Yes.

Q. What is it?

A. Acute care surgery, surgical critical care, and trauma.

Q. Okay. Can you explain what those mean as opposed to maybe a general surgery?

A. Yeah. Those are all fields within general surgery. Acute care surgery tends to be hospital based and deals with exactly it says, acute emergencies, and that varies, all kinds of general surgery, hernias, lung infections, gallbladders, cancer. It's quite broad. Generally, those patients are more emergent.

Trama is trama, so patient's injury in any traumatic mechanism, whether that's motor vehicle, motorcycle, slip and fall or all kinds of things.

And then surgical critical care is the intensive care unit, comprehensive ICU care of the patient, of those types of patients in the hospital.

Q. Have you done any laparoscopic inguinal surgeries like the one this case?

A. Yes.

Q. Okay. How many, about? You can estimate.

A. Probably -- quite a few. Probably five to ten.

Q. Laparoscopic?

A. Correct.

Q. Why is that?

A. I haven't it found to be -- well, a couple of reasons. In the acute setting, there's a number of limitations to the procedure, and I personally have not found it to be as effective as open hernia repair.

Q. So, open surgery?

A. Correct.

Q. Would you say laparoscopic surgery is common for a hernia repair?

A. Yes.

Q. I think you kind of answered my question already, but have you done open inguinal hernia surgeries?

A. Yes. Quite a number.

Q. Do you have an estimate?

A. Probably least a hundred over the last

12 years.

Q. Is that a common surgery for hernia also?

A. Yes.

Q. Have you also done bowel repair surgeries?

A. Yes.

Q. And you have an estimate, do you know how many?

A. I've done a lot of bowel repair surgeries through trama and acute care surgery, so I would say hundreds over the last 12 years.

Q. You said before that your specialties are a sub of general surgery, so you still consider yourself a general surgeon also?

A. Yes.

Q. And how long have you been doing that?

A. Twelve years. I guess, technically, it would be 12 years on September 10th, so it's almost 12 years.

Q. And is that the same for your critical care specialty?

A. Yes.

Q. About 12 years?

A. Yes.

Q. I'm going to direct you to IC's Exhibit 4, specifically page NSBME 108, with what Dr. Barber

diagnosed Patient A.

A. Left inguinal hernia acquired in number two, and acquired short bowel syndrome.

Q. What page are you looking at there?

A. NSBME 111.

MS. DAEHNKE: I'm sorry. Just for the record, Doctor, are you looking at a Bates stamp?

HEARING OFFICER WOODMAN: 108.

MR. WHITE: Now it's 111.

MS. DAEHNKE: Thank you.

BY MR. WHITE:

Q. And do you also see on there there's assessment plan?

A. Yes.

Q. Okay. And I think it's like the last one there before it was electronically signed by Dr. Barber. It says something there, "will start Juven," what is that?

A. Juven is a nutritional supplement.

HEARING OFFICER WOODMAN: I'm sorry. Mr. White, where is that?

MR. WHITE: 111.

HEARING OFFICER WOODMAN: I see it.

BY MR. WHITE:

Q. It's a nutritional supplement?

A. Yes.
Q. What is it used for?
A. I can't give you all of the reasons for people that are placed on Juven because there's a lot of reasons, but --
Q. What did Dr. Barber write here?
A. It says, "Will start Juven for short bowel to maximize healing." Which to me means that previous diagnosis of acquired short bowel syndrome, that the Juven was prescribed or administered or recommended based on that diagnosis of acquired short bowel syndrome.
Q. Okay. And was 12/27/2018, which is this date at the top of the page, was that the day of the surgery?
A. No.
Q. Okay. So would there be a reason for -- like pre-operative to prescribe Juven?
A. There might be. It's hard to tell, though, with the information that's given to us why it was indicated.
Q. There's just not enough information there, is that what you're saying?
A. Correct.
Q. Now, in these records from that initial

encounter on 12/27/2018, is there anything that kind of draws your attention to regards to Patient A's medical history?

A. Well, the medical history specifically, no. But the surgical history, which is often the root of the same, yes.

Q. Okay. And where do you see surgical history?

A. On page NSBME 109, on the page that says "Surgical History," it's listed.

Q. Okay, what, if anything, there draws your attention?

A. The hernia repair right does not raise opinion concern. The omphalocele repair which required multiple surgeries and the small intestine surgery, which at about 30 years of age, two-thirds removed, those two, the omphalocele and the small intestines were really what raised concern in this patient.

Q. What kind of concerns?

A. Specifically repairing the hernia usually often requires -- laparoscopically repairing a hernia often requires intraabdominal or intraperitoneal access to get at the hernia. And these two operations, specifically, are likely to

cause scar tissue in the abdomen, making the laparoscopic repair difficult.

Q. And could you explain to us what --

A. Omphalocele?

Q. Omphalocele?

A. Yeah.

Q. What is that?

A. That's where layers of the -- the muscular layers of the abdomen don't come together at birth, so the baby is born with a very large hernia with the bowel extruding, and it requires, usually, a staged approach over a period of weeks or months to get the abdominal wall to expand and the bowel to fit inside and then the midline, the muscle layer is then closed usually by a pediatric surgeon.

Q. Okay. And could that -- even at that young age, could that start the beginning of scar tissue?

A. Yes.

Q. And, again, you had said that some of that scar tissue makes it tough to -- does it make tough to see, to be able to see with a laparoscope?

A. It does. The scar tissue we talk about, it usually occurs in between structures in the peritoneal cavity, so bowel to bowel, bowel to

abdominal wall, bowel to liver, for instance.

And so normally in a patient who has not had abdominal surgery or multiple infections, there's not a lot of scar tissue that is connecting the various structures, and they are free to move pretty free. After you have surgery, in a very unpredictable fashion, people develop these bands of tissue and adhesions of the structures to each other so that when you attempt to insufflate the abdomen laparoscopically, often there's scar tissue and bowel and other abdominal organs obscuring your view of the structure you're trying to see.

Q. Is it because they're not free to move, so they're attached one another?

A. Yeah. Yes.

Q. What about -- is there times when you would put C02 in there to maybe make it a bigger working space and see things?

A. Yes. It's standard practice once you gain entry into the peritoneal cavity to instill carbon dioxide, 10 and 15 millimeters mercury pressure, in order to expand the abdomen wall outward and move the bowel downwards so that you have a working space to complete your tasks.

Q. And in a patient such as this, with the

amount of scar tissue, would that CO2 be effective or would it still just be attached to one another?

A. The CO2 is generally less effective when there are adhesions in the front of the abdominal wall to any of the organs. So if there are adhesions to the colon -- from the colon to the abdominal wall of the small bowel abdominal wall, wall, et cetera, when insufflating, there are now bands of tissue that are tenting up the organs and often obscuring your ability to see.

Q. Actually pulling on the organs?

A. They do, yeah, pull the organs.

Q. You said "tenting."

A. As we insufflate the abdomen, the anterior abdominal wall goes up with the gas, kind of like a balloon, and if it's not attached to anything, then you have a great working space. If it's attached to the bowel and spots, it can't go up to give you a working space. It's limited by multiple bands of scar tissue that simply obscure your ability to work and see.

Q. Are you able to tell from these medical records if CO2 was administered for this?

A. I would have look at the operative note.

Q. I will -- I think that's NSBME 115.

A. Based on the information I was given, the operative note does not indicate that CO2 is insufflated into the abdomen.

Q. There's a referral in here to, I think, short gut syndrome or -- what is that?

A. Short gut syndrome which is also called "short bowel syndrome," is a consolation of usually nutritional deficiencies that result of a patient having too little small bowel.

So when we eat or food, we chew it and break it down into very small pieces, and as those pieces pass through our stomach and into the intestine, they're absorbed into the blood stream and lymphatics so that we're able to absorb our food.

You can imagine if you remove enough of the absorptive cells in the gut, you can no longer absorb enough food to survive. So you can put it in your mouth, but you're not able to extract the nutrients out of what you eat. And that occurs from a variety of causes and can give you a variety of nutritional deficiencies.

And so short gut syndrome generally means you don't have enough small bowel or bowel in general to maintain perfect nutritional homeostasis

because of the lack of bowel.

Q. Okay.

A. As part of that, depending on what section of bowel is remaining, that's why you can have a variety of different nutritional deficiencies. There are certain parts of the bowel that only absorbed fat, soluble vitamins for instances, and so if that's missing, then you develop deficiencies in those vitamins. That's just an example.

But you can have poor overall absorption of too few nutrients or you can have specific vitamins and key features to living that are not absorbed through the gut.

Q. Okay. And if you know you have a patient that has short bowel or short gut syndrome from having just a lot loss of a bowel, would that be something that would concern you in doing an inguinal surgery?

A. Not -- it could for two reasons. One, I would want to make sure that they have, nutritionally, that they are able to heal the surgical procedure they were about to undergo. And more importantly, I would like to know why they acquired short gut syndrome because most likely usually in the United States in 2024, that's from

some sort surgical -- large surgical procedure earlier their life, whether that's genital or subsequent to that.

Q. Okay. From what you see in the records, can you determine here whether it was -- actually let me ask you this first.

What other way can you acquire short bowel?

A. The other way, it's not from a very large surgical option, is neonates, new born children sometimes develop it when they get -- they get a different subset of abdominal catastrophes. They can be born with multiple severe abnormalities to their bowel that cause it to not function. It still usually involves a surgeon, but you can be born with short gut syndrome simply because of the way the bowel didn't form. Those are the main ways.

You can get it other ways. There are other ways to defuntionalize the absorptive capacity of your small intestine, infections, et cetera, but the most common way that we see in this country in these days is almost always a large surgical procedure in the past.

Q. Ask you to turn to page 109. Below where it says, "Small intestine surgery," and it says,

"occurred around 30 years ago of age 230 removed," would you know what that removed means?

A. I would, yes. I would assume as it's written that two-thirds of small bowel was removed at the time of surgery.

Q. Okay. Now can that be something that would cause short bowel?

A. Yes.

Q. And would it be more of a concern if it was surgical -- surgical resulting -- a surgery resulting in small bowel versus what you had talked about where an infant might have it, would that be more concern as far as going in laparoscopically?

A. No. Because both of those processes generally result in a very large amount of intraabdominal scar tissue.

So, if you have short gut syndrome from an abdominal catastrophe as an infant, you're likely to have -- you're just as likely to have significant scar tissue as somebody who had a large surgery prior. But both of them are associated with a large amount of intraabdominal scaring.

Q. We've gone over -- I think there's two ways that we're talking about here as far as doing inguinal-type hernia surgery. We have laparoscopy,

open.

Is there any other ways of doing this?

A. No. Well, you can do it robotically, but they're all variations. Those are the two main decisions, open repair versus laparoscopic repair.

Q. Okay. Just quickly, maybe say how they differ?

A. An open repair involves usually general anesthetic or something similar. You make an incision, inguinal area over the bulge, you dissect down through the muscle layers until you find the bulge, you isolate the structures, such as the round, then you're able to reduce the hernia back into the abdominal cavity. And then they're almost all done with mesh into 2024, or for a last 40 years, they're almost been done with mesh. You then sew the piece of mesh under -- well, on top of the layers to help the hernia repair hold. And then you close the wound. And that's it for an open repair.

A laparoscopic repair there are multiple different versions of it. You can do total extraperitoneal, we can do transabdominal. But the approaches generally involve a similar type of anesthetic. And then if you do a peritoneal

approach doing a laparoscopy, so being a laparoscopic access to the abdomen, insufflating the abdomen with carbon dioxide, and then where you're able to see the hernia, it's dissected free from, pulled back from the inside, and once the hernia's reduced into the intraabdominal position, usually a piece of mesh is unrolled from the inside, tacked into place, and then if everything looks good, the CO2 is removed and that's the end of the operation.

Q. Thank you for saying that in layperson terms.

Would open surgery require more healing time, generally?

A. Healing time? I'm not sure what you mean.

Q. Okay. Let's see here.

Let me have you turn to page 5, which is in Exhibit 1, about the third paragraph down, it says, "Based upon his CAT scan which I reviewed prior to surgery with him, I felt that a laparoscopic surgery will be less painful with shortened healing time."

Is that something that is considered with laparoscopic?

A. It can be on some operations, yes.

Q. Okay. With a left inguinal hernia surgery

too?

A. I think so. Yeah. We think that a laparoscopic operation is probably easier on the patients. I can't really say that there's less healing time, but we do think that patients recover more quickly after laparoscopic surgery.

Q. Okay. I think -- sorry if I already asked this.

Would that diagnosis that you see of short bowel syndrome, would that affect your decision to use a laparoscope?

A. It might. If you're going back to the reason for the short bowel syndrome and then relating back to their prior surgical history.

Q. Which surgery did Patient A have in this case between laparoscopic and open?

A. Well, the patient had attempted laparoscopic repair and no ultimate repair of the left inguinal hernia, but attempted laparoscopic which was converted to a mini laparotomy.

Q. If you can, briefly explain the steps from your review of these records that -- what the steps that respondent took to try to -- to attempt a repair of Patient A's hernia?

A. Is it okay if I look at the operative

note?

Q. Yes. It's 115 in Exhibit 5.

A. It sounds, from the operative note --

Q. I'm sorry. I said Exhibit 5, it's Exhibit 4.

A. Well, what I have to go off of as far as my understanding of the operative conduct is the operative note, which is what I'm referring to for my information here.

It sounds like once the patient was asleep there was two attempts to enter the peritoneal cavity with a five millimeter optiview trocar. And without success, there was then an attempt to try and enter the abdomen safely in the midline of the abdomen. And when that was done, it appeared that there was an injury to the small bowel. And so a mini laparotomy was made, which is just a way of saying a small incision in the abdomen was made. This was converted to an open-type operation to repair -- to evaluate and repair the injury to the small bowel. The small bowel was grasped and --

Q. We'll get into to that. Okay?

A. Sorry. You have to also understand it's difficult to tell exactly what happened based on the dication because it is incomplete.

Q. Are you -- thank you.

Are you able to tell if Dr. Barber went in from the right side unsuccessfully, then from the left side unsuccessfully, and then midline, or is it just one side and went to the midline? If you can tell.

A. There is no indication as to which side was attempted first. You can't tell.

It could be inferred -- you gotta be careful inferring too much. It could be inferred because the marking was infiltrated in the subcutaneous tissue on the patient's right side, that the right side was attempted first, but it's not actually stated.

Q. Would that be something you would normally include in your medical records, your operative note?

MS. DAEHNKE: Object. Vague.

BY MR. WHITE:

Q. Would you include the site of your attempts at fixing a left inguinal hernia --

A. Yes.

Q. -- in your notes?

A. Every laparoscopic procedure that we do, we indicate where the port was placed. So I would,

yes.

HEARING OFFICER WOODMAN: Where the what was placed?

THE WITNESS: The port. What we're talking about is this plastic tube, it's rigid, that goes through the abdominal wall into the peritoneal cavity, and then we can use them to put instruments in and out of the procedure.

Q. And that's for laparoscopic?

A. Correct.

Q. Okay. While we're on this page, do you see there's some blanks there?

A. Yes.

Q. Just kind of some blank lines. You've been a doctor for 12 years now, what do you attribute that to?

A. The blank lines, in my understanding, are when this transcribed document -- it's dictated into a dictation system, and if the transcriptionist can't understand what was said in the dictation, they leave it blank.

In this case, it looks like the transcriptionist actually put the time signature on there in case somebody wanted to go back and figure out what was said, and time signature is indicated

next to both of the blanks on page 115.

Q. And whose responsibility is it to complete that note?

A. The physician's.

Q. And this -- would you consider this complete?

A. No.

Q. I want to go back to -- we don't know exactly how many times laparoscopic surgery was attempted in this case. We're not sure if it's -- two or three, I guess at least; right?

A. Correct. It sounds like a total of three.

Q. Okay. So had you gone in laparoscopically on a patient such as this and saw what you saw, there's hardly any visualization, what would you have done?

MS. DAEHNKE: Objection. Lacks foundation.

MR. WHITE: Okay. Hold on.

BY MR. WHITE:

Q. On page 115 that we're still on, about a third of the way down that paragraph, do you see where it says, "A five millimeter"?

A. Yes.

Q. Could you read that to us?

A. "A five millimeter, optiview trocar was advanced to the abdominal cavity; however, no visualization could be seen and previous trocar was removed and identical procedure was done."

Q. Okay. What does "no visualization" mean in layperson's terms?

A. That means that when we put the camera in to see if we could see the operative site, there was too much scar tissue to safely be able to visualize the anatomy.

Q. Okay. And then at the end of that sentence, it says, "and identical procedure was done."

At that point, would you have gone to do an identical procedure if you can't see anything because of the amount of scar tissue?

A. No.

Q. What would you have done at that point?

MS. DAEHNKE: Object. Foundation. Based both the witnesses' experience and the medical records, it's hypothetical.

HEARING OFFICER WOODMAN: Do you want to respond to the objection?

MR. WHITE: I didn't hear her objection.

HEARING OFFICER WOODMAN: Foundation;

right?

MS. DAEHNKE: There's no foundation based upon the witness's experience, and based upon the description in the medical records, it's a hypothetical and it's speculative.

HEARING OFFICER WOODMAN: You can lay a little bit more foundation.

MR. WHITE: Yeah, well, I think I already did. His CV, just talking to him at the very beginning asking the question, he said hundreds of hernia surgeries.

MS. DAEHNKE: I object and move to strike that misrepresentation of witness' testimony as to done hundreds of.

HEARING OFFICER WOODMAN: As to the specifics on this procedure, though, you could dip a little bit more foundational.

BY MR. WHITE:

Q. How many open -- how many open and inguinal hernia surgeries have you done?

MS. DAEHNKE: Objection. Asked and answered.

HEARING OFFICER WOODMAN: Well, and I know the answer.

MR. WHITE: Can she have it both ways

because she wants --

MS. DAEHNKE: Well --

HEARING OFFICER WOODMAN: He's done hundreds of those.

MS. DAEHNKE: He said he's done a hundred over 12 years. That's -- yeah.

HEARING OFFICER WOODMAN: But only a few by the scope.

MS. DAEHNKE: Five.

BY MR. WHITE:

Q. But you have done -- have you done any laparoscopic surgeries?

A. I do a lot of laparoscopic surgeries.

Q. Not just on a hernia?

A. Correct.

Q. Do you ever run into the same kind of issue that we see in this case where there's scar tissue giving you no visualization?

A. Not infrequently.

Q. And what do you do at that point?

HEARING OFFICER WOODMAN: Did you say frequently or infrequently?

THE WITNESS: Infrequently. We are commonly asked to do laparoscopic procedures on patients who have previous abdominal surgery and

have intraabdominal scar tissue.

HEARING OFFICER WOODMAN: Thank you.

BY MR. WHITE:

Q. And if you run into a point where you have no visualization, as was written in her operative report, Dr. Barber's operative report, what do you do then?

A. If you think that you're not going to be able to do the operation laparoscopically, you convert to an open operation. If you find a very small amount of scar tissue, sometimes you can get around it and get it out of the way so that you can do your job safely.

Q. But I guess -- would you write no visualization if you had just a small amount of scar tissue?

A. No.

Q. In your experience and your education and all your experience as a doctor, should the laparoscopic surgery -- at what point should laparoscopic surgery been abandoned in this case and gone on to open surgery?

A. That is a little bit of surgeon preference and comfortability, and you can see in this case that it was a laparoscopic versus open. And so the

thought going into this is there may be some scar tissue and we may need to do an open operation if you can't see. That is very common for us to do that. As we gain more information through the course of the operation, that usually helps us decide do we go open or do we remain laparoscopic.

And in this case, it was at increased risk to do it laparoscopically initially, and then upon finding no visualization on one side increases the risk further. Finding no visualization on the other side further increases the risk. And then a subsequent attempt at midline entry resulted in mal injury.

Q. Okay. And that was part of my question too, next.

Where do most -- where does most of the scar tissue manifest itself? Is it left side, right side, or midline?

A. It can be quite variable depending on what happened. For instance, if somebody has diverticulitis in their pelvis and they now have a lot of upper abdominal adhesions. But the most common place to find adhesions after two large midline operations in the midline.

Q. And just like patient A?

A. Yes. In our experience.

And you can't predict where it's going to be. Part of the problem is that that entry into the peritoneum is blind in most of these laparoscopic procedures, including this one. And so if there's -- you want in the place where there's least likely to be scar tissue.

And I think both of those were attempted, and then the midline was attempted after that where there was still more scar tissue.

Q. And in your opinion, was -- did going into the midline laparoscopically, did that -- was that a high risk to cause possibly bowel perforation?

A. Yes.

Q. And is that what ultimately caused this bowel perforation?

A. Yes.

MR. WHITE: Indulgence.

BY MR. WHITE:

Q. And is it your opinion, after reviewing these records of the surgery, laparoscopically on the date in question, is it your opinion that it was malpractice to continue down the road of laparoscopic surgery?

A. Yes.

Q. And, I guess, rather than trying an open surgery?

A. Yes.

Q. I'd like to kind of draw your attention more now to the bowel perforation.

A. Okay.

Q. Is this uncommon -- is a bowel perforation uncommon in a surgery, a laparoscopic surgery of the left inguinal hernia?

A. Yes.

Q. It is uncommon?

A. Yes.

Q. It is one of the known complications?

A. Yes.

Q. And so was there an increased risk of bowel perforation in this -- sorry. Strike that.

Was there an increase in bowel perforation with patient A with regards to his medical history?

MS. DAEHNKE: Object to the form.

HEARING OFFICER WOODMAN: I didn't really understand that question very well either. Will you please restate your question.

BY MR. WHITE:

Q. Base on Patient A's medical history, was there a higher risk of bowel perforation for this

surgery?

A. Than average?

Q. Yes.

A. Yes, there is a higher average risk for bowel perforation.

Q. Why is that?

A. Two prior laparotomies and acquired short gut syndrome.

Q. Would that risk have been reduced somewhat in an open surgery versus laparoscopic?

A. Yes.

Q. Why is that?

A. Bowel injury can still occur during an open operation as well. But there are -- an open operation doesn't involve any blind access to any cavities, so you can see everything that you're doing. That's probably the main difference is that you can see everything in an open operation than laparoscopic, at least during the initial entry, you can't see what you're doing. And you can't see -- if there's scar tissue there that you don't see, you will injure it laparoscopically. If there's scar tissue that you don't see, you are unlikely to encounter it at all.

Q. That brings up another question.

If -- how long would a laparoscopic surgery take on a left inguinal hernia from the midline, just generally?

A. Depending on the surgery and the patient, 30 to 90 minutes generally.

Q. Okay. Do we have any indication here in the records how long it was until that bowel was perforated? I'd refer you back to page 115.

A. No, there's no indication as to the amount of time elapsed.

I suppose the only way to find it is if you look at the anesthesia record and it's documented what time that was done, then you can match up the times. But it's not easily discoverable with what we have in front of us here.

Q. Okay. How did respondent repair Patient A's bowel?

A. I'm not sure. I can't tell from what was dictated in the operative note exactly how it was repaired.

But it was repaired with some sort of staple with an endo GIA stapling device and with 3-0 microsutures. But the endo device tells me what it was closed with; it does not tell me how it was closed.

Q. Okay. And does it tell you in here the size of the injury?

A. No.

Q. Would that be something you would write down?

A. Yes. It's generally clinically relevant.

Q. And so you said you cannot tell -- you can tell the staple but you're now sure how?

A. Correct.

Q. And when you say you can't understand -- or can tell from these records how, why is that?

A. Part of it is because it's incomplete, part of it is because it is not sound English, sentences don't make sense, and some of it is simply because it's not described how the repair was done.

Q. Okay. Does it include if she -- if Dr. Barber checked for narrowing of the bowel after stapling?

A. It's not stated as to whether a workup was done here.

Q. Is that something you would do?

A. Generally, yes.

Q. And does that happen often after you've repaired a bowel.

A. It can, yes. Especially depending on the

size of the bowel injury, the location of the bowel injury, and the method that it was repaired.

Q. And when do you check that?

A. It's checked immediately, post-operatively, in the operating room. As soon as you're done with the stapling and you check for, basically, see the caliber of the lumen that's remaining.

Q. And that's with your own eyes?

A. With your eyes and your fingers.

Q. And there's no indication in these records that that was done; correct?

A. Correct.

Q. And what other things would you use in a description of a bowel injury?

MS. DAEHNKE: Objection. Vague, ambiguous, irrelevant, foundation.

HEARING OFFICER WOODMAN: I'm going to overrule that. I think it's a fair enough question.

MR. WHITE: I can be more specific.

HEARING OFFICER WOODMAN: Go ahead.

THE WITNESS: There's some very clinically relevant things that we need to describe about injuries to the bowel. Included on those things are what the reason for the bowel injury is so the

relative velocity of the injury instrument, if it was an instrument or a bullet, the part of bowel, whether your duodenum, jejunum, ilium, colon, which part of the colon, which part of the bowel, meaning there's a mesenteric and an anti mesenteric order to the bowel. The mesenteric side involving the blood supply and being important because if you fix an injury to the bowel, but the mesentery's been injured, the bowel is still going to die.

So size, mesenteric versus anti mesenteric, which part of the bowel was injured, its proximity to other things are the things we usually describe.

And the reason that the size is important is because, you can imagine, the bowel is a tube because it is, and the tube is there for a cylinder. If you remove half the cylinder and close the hole, then you narrow the bowel. Alternatively, if you have a large defect in the wall, you can close it in other ways that do not result in narrowing the bowel.

These are all tricks of the trade in general surgery.

Q. You were describing the difference in if you have like a tube and you remove half of it,

you're going to have kind of -- would you have to go in and -- almost like slice -- right? -- to take out that part.

A. Yeah. If you do that and you think it's too narrow and it's not going to be able to accommodate food coming through, then you usually in that scenario, you just remove that piece and start over. You would trade a new anastomosis between two healthy pieces of bowel --

Q. Okay.

A. -- into a narrowing problem.

Q. And is there anything in here that indicates anastomosis like you just said?

A. No.

Q. There's no reference to that at all?

A. Correct.

Q. What is anastomosis?

A. Is when you either sew or staple two pieces of bowel together to create one functional piece of bowel.

Q. And then so based on your education, experience, you've repaired bowels, do you -- is it your opinion that this was malpractice in the repair of this bowel?

MS. DAEHNKE: I object. That wasn't

charged in the Complaint. It's inappropriate. There's no charge of that. Of course, I'll -- if the doctor says no, which he should, then I will withdraw my objection.

HEARING OFFICER WOODMAN: Mr. White, if that's not charged in the Complaint, how is that question relevant?

MR. WHITE: Well, just malpractice overall was charged. And there's -- obviously it's relevant because whole -- the bowel was injured. It's admitted to in the records, it's admitted to in her response to the Board.

HEARING OFFICER WOODMAN: Give me one moment here.

Okay. The way -- the allegations I'm reading in the Complaint, I will allow the question.

MS. DAEHNKE: And I would renew my objection because it's not charged.

MR. WHITE: Well, it is.

MS. DAEHNKE: It's not charged. It's not. Read me where it is.

MR. WHITE: It's right here. "Attempted to gain access through midline incision which injured the bowel during the incision."

HEARING OFFICER WOODMAN: There's no way

she can get that.

MS. DAEHNKE: There's no -- yeah, sorry Madam Court Reporter.

MR. WHITE: Sorry.

MS. DAEHNKE: There's never been an allegation that the repair of the bowel was -- well, probably so because so, I mean --

HEARING OFFICER WOODMAN: Here's is why I want to let you know why I'm allowing the question. The general allegations before you get to Count I are very -- are pretty general here. And then the charge of malpractice in Count I, paragraphs 12 through 16, also pretty general.

And so without any litigation to narrow those allegations down, I'm going to allow this particular question, but, again, I'll take in the general context of the big picture.

You can ask this question.

BY MR. WHITE:

Q. Using all your experience, education, and your review of this, was this bowel repaired properly or was it malpractice?

A. I can't say from the information that I'm given that it is malpractice, this one specifically.

But I think in total, all of the series of

events that occurred that constitute malpractice here is to be included, which is a little bit weird.

But taken out of context, no. And with the information I'm given, no. But overall, looking at entire case, yes, this is part of the malpractice allegation claim. Yes.

Q. I'm going to draw your attention to the records. We have alleged a records violation as to -- that Dr. Barber's records were legible and complete. Actually the whole statute is: Failure to maintain timely, legible, accurate, and complete medical records.

So, we've gone over it a little bit already. I think we can stick with page 115 for a little bit of this. I'd turn your attention to that if you're still there.

We had talked out before that there was some blanks left; right?

A. Yes.

Q. And those are the responsibility of the doctor?

A. Yes.

Q. Okay. And so would you say that those -- by looking at this, page 115 this operative report, would you say that this is complete?

A. No.
Q. Would you say it's accurate?
A. No.
Q. Would you say it's legible?
A. Borderline. Legible, I can read it, comprehendible so I can read the words, but some of them don't make sense when placed next to each other.
Q. Okay. Turn you attention to page 87, which is also still in Exhibit 4.
What -- do you see where it says -- it's about three-quarters a way down the page, "unilateral inguinal hernia"?
A. Um-hum.
Q. Okay. And then next to it, "without obstruction or gangrene"?
HEARING OFFICER WOODMAN: Mr. White, will you again redirect me to where you are on that page.
MR. WHITE: About three-quarters of the way down.
HEARING OFFICER WOODMAN: I gotcha.
BY MR. WHITE:
Q. Can you see that page?
A. Yes.
Q. Are these pages, are these written by --

are these -- do you know from looking at this if Dr. Barber was entering this?

A. It does not look as though she did, no.

Q. She wouldn't be entering this?

A. No.

Q. Okay. Even though it says her name there, primary diagnosis; right?

A. Correct. She wouldn't have filled this out.

Q. I'd like you to turn to page -- let's see. Well, first to page 107, and so what are we looking at here?

A. It appears to me that this is the history and physician operative note from the Las Vegas Surgery Center on the day Patient A had his procedure.

Q. Okay. And so would this be something -- who would be taking these notes?

A. The physician.

Q. Okay. And does this appear to be legible?

A. Yes.

Q. Okay.

A. Marginally, but, yes, I can make it out.

Q. Is there anything -- as far as this goes, is there anything else that probably should be

included in here? If you can read the right side, I guess that might help.

A. So the section at the upper right is usually reserved for a brief, immediate post-operative note.

Q. Oh, it's a post-operative?

A. Yeah. Just that section.

And then the section below it is for orders. The history and physical section on this one form is just the left column.

Q. Now, it says there, if you look at "abdomen" on the left side, and it says -- you can see -- I can definitely read that, it says, "Left inguinal" -- it looks like it says, "Left inguinal hernia."

A. Yes.

Q. And what is checked off there?

A. WLN.

Q. What does that stand for?

A. Within normal limits.

Q. And does -- is that saying that this patient had an abdomen that was within normal limits?

A. That's what it implies. Within normal limits, plus a left inguinal hernia.

Q. Tell us if that -- would you write that "within normal limits," if you saw Patient A?

A. No.

Q. Why not?

A. Because I can assume that he had very large, extensive abdominal wall scarring that would be surgically significant.

Q. How about between that page and maybe even going into page 108, which is the initial visit, do we have a good -- do we have a pretty detailed description of the hernia anywhere? Kind of looking at the whole thing here, from 107 to 108, even 109 and 110 and 111.

A. The descriptions of the hernia are found on page 111, six lines down, it says "abdomen wall soft, bowel sounds are normal. He exhibits no distention, and there is no tenderness, there is no rebound and no guarding. A hernia is present."

Q. And in all your experience and education using that, do you think just saying "a hernia is present" is enough detail for this patient?

A. No.

Q. Do you see anywhere in here that there's a description of his prior surgeries and scarring?

A. No. The descriptions, there are no

descriptions of them. There's simple naming of them. In the history of present illness, "HPI" on page 1 of 8, it says, "He was born with an omphalocele and had a larger reconstruction as a newborn. He has subsequently had an alarmingly amount of his small bowel removed from his SBO," which is a small bowel obstruction.

Q. What else would you have included in his history as far as the --

MS. DAEHNKE: I'm sorry. I have to --

MR. WHITE: I have to finish.

MS. DAEHNKE: Okay. Finish, then.

BY MR. WHITE:

Q. What else would you have included in the description of prior surgeries and scarring?

A. Well, it can be difficult to -- what we're really looking for in an ideal scenario is the operative reports and the records from the previous surgeries so we, as surgeons, can understand what happened, and therefore adjust the likelihoods that we encounter, scar tissue, et cetera.

In cases like this, it's basically impossible get the records from when he was a newborn and 30 years ago. And so that's often all you all have to go on is the patient's history.

And so beyond that, beyond probably a resource exhaustive search to find those records, it's probably not possible to -- to find out anything else about what happened from the other two operations.

I will say that if there's a diagnosis of acquired short gut syndrome and a prescription or a recommendation to start Juven, but I don't see any assessment in here of the patient's potential nutritional deficiencies at all, short gut is not addressed really at all during the visit, it's just there's a prescription for it at the end.

Q. Would -- I guess what -- how would you get that information? Would you get it from the patient themselves?

A. Generally it would involve -- yeah, with a lengthy interview with the patient and then some nutritional markers, which is usually in the form of blood work, where we can mark -- we can assess their nutritional status before we institute a nutritional plan, which at times it's usually quite costly for the patient. And then generally you can follow those things through some sort of nutritional markers while they're on that treatment to make sure that they're getting benefit from it.

Q. Would that be something you would note in the record too?
A. Yes.
Q. If you were inquiring about nutritional deficiency?
A. Yes.
Q. So based on your education, experience, and your review of these records and what we just talked about and what you've testified to, would you say that the records are -- that this was a failure to maintain proper medical records and that they're not legible, accurate, complete, so on?
A. Yes, I would agree with that statement.
Q. Thank you.
MR. WHITE: Pass the witness.
HEARING OFFICER WOODMAN: Very good.
Let's take a break and give our reporter a breather, and then we'll come back for cross. It's 2:52, let's be ready to go at three o'clock.
(Recess from 2:52 to 3:00 p.m.)
HEARING OFFICER WOODMAN: It's three o'clock. Ms. Daehnke, are you ready to go?

CROSS-EXAMINATION

BY MS. DAEHNKE:
Q. Dr. Spoerke, I'm going to ask you some

questions about your background.

You were the peer reviewer in this case for the Medical Board. How many times have you acted as a peer reviewer for the Medical Board?

A. I don't know exactly.

Q. Would you say it's more than ten?

A. Probably around ten.

Q. Over how many years?

A. I think about the last 11 or 12 years. I think. These are just rough estimates.

Q. About ten?

A. About 10, yeah.

Q. Fair enough. And general surgery issues?

A. Correct.

Q. Anything different from that?

A. There's been some specific surgical critical care cases, but no involvement within the realm of general surgery.

Q. When you describe your practice, as I understood it, critical care and emergency surgery and trauma, is that accurate?

A. Um-hum.

Q. Can you describe that versus a general surgery practice, like what's different?

A. Yeah, I can. So we -- acute care

surgeons, limited out-patient office, so we generally take care of patients that show up to the emergency room or when we're called by another physician and asked to take care of. The problems we deal with are acute. So things that are dangerous or discomforting that have occurred acutely, and so as surgeons, we're called in consultation to evaluate, diagnose, and treat those responses.

In addition, I do surgical critical care which is intensive care unit based, and that is comprehensive care of somewhere between 10 to 25 critically ill patients.

And then the other hat that I wear as a trauma surgeon is just that, it's a trauma surgeon. You're on call and respond to emergency trauma activations in the emergency room, and then you provide care and coordinate care for those trauma patients once they're hospitalized.

Q. Okay. And so -- and that's what I understood.

You really don't see patients --

A. Sorry. I wasn't really quite finished.

Q. Oh, I'm sorry. Please go ahead.

A. The other -- that is how I currently

practice. For the first number of years that I was in Reno, I did practice in those three realms, although there was not an acute care surgery program.

So I had a private practice general surgery business where I saw outpatients, referred a variety of surgical complaints, and developed diagnoses and treatment plans and carried out those treatment plans on those patients.

And that kind of practice went on from 2012 until around 2018. So I did have a private practice for about six years.

Q. And you've been in practice for how many years?

A. Twelve.

Q. You testified earlier that in those 12 years of practice, you have only performed five to ten laparoscopic hernia repairs; correct?

A. No. I testified that I have performed five to ten laparoscopic hernia repairs.

Q. What I just said.

A. No. You said in the last five to ten years. Let me just say what I'm getting at.

Q. No. Let me ask a question and then you can answer it. How's that? How about we go about

it that way, Doctor?

MR. WHITE: Objection. Argumentative.

MS. DAEHNKE: Thank you.

BY MS. DAEHNKE:

Q. Doctor, I appreciate this not where you live, it's not where Dr. Barber lives. You would both rather be in surgery, I imagine.

What I heard you testify to this morning -- and I believe the Hearing Officer heard my question this way too -- is that you had done five to ten laparoscopic hernia repairs; is that accurate?

A. That's correct.

Q. Okay. Thank you. All right. And so you've had a private practice.

And why you wanted to fill me back in and not stop me from going on is that you did more of a private general practice, and now you're more in trama and acute care and ICU; correct?

A. Yes. I just wanted to accurately answer the question.

Q. Certainly. I appreciate that.

What did you review in formulating your opinions that Dr. Barber had breached the standard of care, what did you review? Tell me what the

foundation for your opinions is?

A. Foundation for my opinions?

Q. Yes.

A. Most of the foundation of my opinions are having completed a general surgery residency in the United States, being board-certified in general surgery and surgical critical care and trauma. And those are how most of our opinions are formed.

Q. When you're -- I'm sorry. Repeat what you said?

A. Those are how most of our surgical judgments are formed in general surgery, through our training.

Q. Sure. You mean in the moment when you're making surgical decisions as to what to do in surgery based upon your training and your experience?

A. Correct.

Q. Okay. And so you agree that Dr. Barber would be the best judge of -- because you don't know what judgment and decisions she was making when she was operating on Patient A; correct?

A. What's the question? Sorry.

Q. I was asking you a little different question, but you answered about your training and,

so -- well, here. Strike that.

Let me ask you this, do you agree with this statement: In experienced hands, laparoscopic repair results in a quicker return to work and reduced post-operative pain?

A. No. And, again, it's because of the way it's phrased, not because of the actual statement itself.

Q. Do you agree with it in principle?

A. It can result in decreased pain and faster time back to work. It does not -- that's the problem with semantics there. It does not result in that. It can result in that.

Q. Okay.

MR. WHITE: Are you referring to a Bates stamp?

MS. DAEHNKE: No.

MR. WHITE: Okay.

MS. DAEHNKE: No.

BY MS. DAEHNKE:

Q. Do you agree with this statement: Patients with bilateral groin hernias and patients with recurrent hernias after prior interior mesh repair should be offered a laparoscopic approach?

MR. WHITE: Objection. Relevance. I

don't even -- it's not even in the records, I don't think.

BY MS. DAEHNKE:

Q. Do you agree with that statement?

MR. WHITE: We're just throwing out scenarios.

MS. DAEHNKE: Yeah, just like you were.

MR. WHITE: No. I was doing it in return --

MS. DAEHNKE: No.

MR. WHITE: -- but they were relevant to this.

MS. DAEHNKE: Well, they were relevant in your view. I'm asking a question as to whether he agrees with this.

HEARING OFFICER WOODMAN: Lay a little foundation for me, would you?

MS. DAEHNKE: Sure. Well, that's true. That might be the point. Well, this might lay the foundation.

BY MS. DAEHNKE:

Q. Do you agree with this statement: An array of factors contributes to deciding which operative technique is the best approach to managing a patient presenting with an inguinal hernia?

MR. WHITE: Objection. Same.

MS. DAEHNKE: Okay.

BY MS. DAEHNKE:

Q. And I think you actually testified to that on direct when Mr. White was asking you about you said it depends.

A. That's correct.

Q. That under the circumstances, given the judgment of the surgeon, that open can be appropriate and laparoscopic can be appropriate?

A. Correct.

Q. That's what I heard you say. Thank you, Doctor.

And then do you agree with this: Published data vary due to the heterogeneity of techniques compared patient's presentations and surgeon expertise.

Do you agree with that?

A. No. And the reason is because "published data" is a very broad term. There's all kinds of published data that would refute anything you can say.

You would have to be more specific that it is established surgical practice or something else, but published data is very vague, and I can't agree

with that.

Q. Sure. Okay. That's fair.

What about surgical expertise, does that play into, Doctor, including judgment?

A. Yes.

MR. WHITE: It's vague.

BY MS. DAEHNKE:

Q. And that's important in this case, would you not agree?

A. Can you define "expertise"?

Q. Sure. How about this case specifically, the number of laparoscopic hernia repairs that Dr. Barber has performed up to the time of Patient A's surgery, would that be important?

A. It might be.

Q. Is it something you considered?

A. No.

Q. Why not?

A. I'm trying to take the facts of the case based on the information that I'm given, and included in that was not any information and an extensive background on Dr. Barber.

Q. And that's fair. You can only form your opinion from the records you're given and the background.

What records were you given?

A. I would have to defer to Don here, and he can provide you with the records I was given.

Q. So I'm asking you, Doctor, as to what records you were given. Well, when were you first given records, how's that?

A. Again, I'd have to refer back to those said records.

THE WITNESS: Do you have those for me?

MR. WHITE: I --

BY MS. DAEHNKE:

Q. No, Doctor, you're here to testify against my client, Dr. Barber, who is a board-certified member of the American College, and you're saying that she has committed malpractice, so I think that maybe you would be prepared to tell me what you reviewed --

MR. WHITE: Well, I'm going to object.

MS. DAEHNKE: Let me finish.

MR. WHITE: Argumentative.

BY MS. DAEHNKE:

Q. Just what you --

MR. WHITE: Objection. Argumentive.

MS. DAEHNKE: I'm not done with --

MR. WHITE: It's not even a question.

MS. DAEHNKE: I'm not done.

HEARING OFFICER WOODMAN: Let her finish. And if you think that our reporter can get all of that.

MS. DAEHNKE: Sorry about that.

HEARING OFFICER WOODMAN: So nobody speaks until the person speaking is finished speaking. Finished speaking.

MS. DAEHNKE: Thank you.

Sorry, Madam Court Reporter.

BY MS. DAEHNKE:

Q. So, Doctor, I know this is not your forum, you'd rather be with your patients or in surgery. However, I am not obligated to tell you when you got -- and I don't know when you were retained to review this case or when you were referred to the case as a peer reviewer. I don't know what records you were given.

Are you telling me you don't know what records you were given and you don't know when you were first contacted?

MR. WHITE: Objection. Relevance. Because -- well, first of all, it was at least these records that have been produced, having to do with the surgery as far as the Complaint went. So we

know he reviewed these records that are here today. So it's irrelevant what other records he reviewed because he's not even testifying to it anyway.

HEARING OFFICER WOODMAN: Well, I disagree with that, so overruled.

You can answer the question, Doctor.

THE WITNESS: Can you help me understand so I can give a better answer, what part are you asking?

BY MS. DAEHNKE:

Q. You have some records in front of you, Doctor. What other records were you given to review to formulate your opinion in this matter?

A. The records -- without being able to give you the specifics in the records, generally speaking, I was given the pre-operative clinic notes, the operative notes, and the post-operative care and all the subsequent complication care.

That includes notes from the pre-operative office, the surgery center, and then another hospital for the subsequent events that occurred to the patient. And that's operative notes, it's all the medical records from those procedures.

Q. Okay.

A. From those facilities, excuse me.

Generally speaking.

Q. And there's a reason I'm asking you this, not to torture you. So just medical records?

A. I was given Dr. Barber's reply letter, her -- then given a variety of other instruction paperwork from the Nevada State Board of Medical Examiners.

But generally speaking, the pith of what I was given was the medical records and the reply letter from Dr. Barber regarding this patient's involvement with Dr. Barber from start to finish, and then the subsequent, additional hospital records from the second hospital.

Q. And you agree those three months later, the wound care and stuff, that's not something that you used to evaluate the medical judgment and decision-making during the surgery; correct?

A. Correct.

Q. What -- you said something and I'm sorry. I was trying to understand. You said in addition to instructions and papers from the Medical Board and something else.

Besides medical records, what else were you given?

A. As I said, Dr. Barber's letter. Off the

top of my head, that's all I can remember, there may be some more things, but for the most part, the pertinent medical records for this patient.

Q. And I'm wondering, so you didn't see the anesthesia record?

A. No, I did see it.

Q. Okay. I'm sorry. I thought you had indicated in your testimony that you did.

A. An anesthesia record is part of hospital records. That's what I said. I reviewed the medical records, which includes all of the things that are included in the medical records.

Q. Okay. In response to questions from Mr. White, I though you said that you didn't -- hadn't seen the anesthesia record?

A. I said if you would like --

Q. It's in that.

A. I was trying to say if you wanted to discover that piece of information you may be able to discover it from the anesthesia record.

Q. Right. Okay.

A. It's here on page 126.

Q. Yeah, I reviewed thoroughly. Thank you. I just -- my misunderstanding of what you said was entirely different.

Did you prepare a report for the Board in this case?

MR. WHITE: Objection.

THE WITNESS: Yes.

BY MS. DAEHNKE:

Q. Yes. Okay.

When did you prepare the report?

MR. WHITE: Objection. Relevance.

HEARING OFFICER WOODMAN: Okay. Hold on, there's an objection.

MR. WHITE: I'm going to say that I object again on -- what we're here for today, as a sidebar, again, the proceedings, the IC procedures are confidential, the investigative file is confidential.

MS. DAEHNKE: Excuse me. I don't want -- I'm so sorry. Patient A took a picture of the screen. I'm not comfortable with this. I know it's public. It's just -- it wouldn't be allowed in a courtroom, I don't -- I don't think you saw that, Hearing Officer. I'm not comfortable with that, just noted for the record.

HEARING OFFICER WOODMAN: And for what it's worth, until I had to deal with that specifically in a hearing, I told people they had to

take their camera down, and then I found authority on it that said they can come in and video record the whole thing. We had to let them put their camera back.

MS. DAEHNKE: And, Judge -- and I'm sorry, Doctor.

I had to investigate that too because I was very surprised they let CVN in record a couple of my trials from moment no moment. But the public was not allowed to video tape or photograph any of my cases. That CVN, trials, great trials.

HEARING OFFICER WOODMAN: Was it with the Medical Board or in court? In Med Board, there's a statute.

MR. WHITE: Was it -- this is a public hearing.

MS. DAEHNKE: Well, trials are public too. I mean, I understand there's Open Meeting Law. And I doubt CVN trial would come in -- well, they might. All right. Well --

HEARING OFFICER WOODMAN: I had to reverse -- later the same day, I had to reverse an order that I had made earlier in the day.

And I know it seems, maybe seems a little contrary to what we would expect when we literally

had to let them put up the video camera and let them tape the whole proceeding, but --

MS. DAEHNKE: All right. That's fair.

HEARING OFFICER WOODMAN: -- where did we leave off?

MR. WHITE: I objected.

MS. DAEHNKE: Yeah.

MR. WHITE: I was objecting to -- based on everything I've been saying all morning and all afternoon -- the confidentiality of the investigative file, the IC proceedings are confidential. I mean, all this stuff is getting down to into confidential areas, and which we are waiting -- again, we're waiting for a ruling from Second Judicial District Court sometime.

HEARING OFFICER WOODMAN: But your specific question, I think, was did he prepare a report --

MS. DAEHNKE: And he said yes.

HEARING OFFICER WOODMAN: -- and when did he prepare a report.

Do you know the answer to that question, Doctor?

THE WITNESS: Not specifically, no.

BY MS. DAEHNKE:

Q. Do you have the month and year?

MR. WHITE: I'm sorry.

THE WITNESS: I can look it up if you'd like.

BY MS. DAEHNKE:

Q. That would be great.

MR. WHITE: I didn't hear the question that you asked, Ms. Woodman. I'm sorry.

HEARING OFFICER WOODMAN: Well, it was -- I was restating the question she had asked.

After he said he had prepared a report, she asked when, and that's where we got sidetracked with the objection. And she's following up to see if he knows the month and year that he prepared the report.

MR. WHITE: Okay. Again, objection. Relevance.

And it's -- I know you're allowing these, Mr. Woodman, but it's going right down to what we're talking about. This is all stuff that happened before the Complaint was filed even, and it's not part of -- it's part of the investigative file and it's not part of what we're using to prosecute the case.

HEARING OFFICER WOODMAN: I know.

MR. WHITE: And there's not materials. You only heard his testimony on direct. I think we need to stay within the scope somewhere, somewhat close to the scope of direct, because this is just all irrelevant.

I mean, what does it matter when he submitted his report?

HEARING OFFICER WOODMAN: Well, it --

MS. DAEHNKE: It matters to my client, Dr. Barber. That's why.

MR. WHITE: You can cross-examine him.

MS. DAEHNKE: I am cross-examining him, and you're obstructing it.

HEARING OFFICER WOODMAN: And it --

MR. WHITE: I'm not obstructing.

MS. DAEHNKE: You are. It's a simple question. I'm sorry.

HEARING OFFICER WOODMAN: It could go to when was the last time he looked at the report. If he prepared the report years ago, which is possible in light of the dates pertinent in this case, when did he last look at, how fresh in his mind is it.

MR. WHITE: Why is that relevant? Because he's answered all the questions that have to do with

this matter.

HEARING OFFICER WOODMAN: Okay.

MS. DAEHNKE: This is outrageous.

MR. WHITE: And you can cross-examine him on it.

MS. DAEHNKE: Thank you. I am asking him a question. The judge has not asked him a question.

HEARING OFFICER WOODMAN: What's the --

MS. DAEHNKE: And you're speaking in order to coach the witness.

HEARING OFFICER WOODMAN: Okay. All right. Hey, you know what, I'm going to direct you two, no more talking to each other. Talk to me now.

MS. DAEHNKE: I'm -- thank you.

HEARING OFFICER WOODMAN: What's the best you can do on when you prepared your report? And I understand, you may be not be able to do very well depending on how long it was. I get that.

THE WITNESS: I -- I think it was sometime in 2022. The last time I looked at it was in August of 2023, as I prepared for initial trial.

HEARING OFFICER WOODMAN: Okay.

MS. DAEHNKE: Thank you.

BY MS. DAEHNKE:

Q. I'm so sorry. I missed that.

The last time was August of 2023, and the time before that was?

A. I think sometime in 2022, when the case originally came to me.

Q. And so you were reviewing that expert report when you were preparing for trial the first time, and the case got dismissed anyway, so we had to go home?

A. Yes.

Q. Okay. And so what conversations did you have with Mr. White about your --

MR. WHITE: Objection.

BY MS. DAEHNKE:

Q. -- expert report?

MR. WHITE: He's -- this is now getting into IC confidential -- no.

HEARING OFFICER WOODMAN: So --

MS. DAEHNKE: You're -- he is -- I'm sorry, Your Honor. This witness is a witness. I'm entitled to know this, it's not attorney-client protected. He can't instruct the doctor not to testify like he did the last witness.

HEARING OFFICER WOODMAN: How would it be privileged, Mr. --

MR. WHITE: And relevance.

HEARING OFFICER WOODMAN: Well, I think it is relevant, so how would it be privileged?

MR. WHITE: It's still part of the IC's investigation.

HEARING OFFICER WOODMAN: So -- hang on a second.

MR. WHITE: Conversations. Part of conversations -- well, I'll go back to it.

HEARING OFFICER WOODMAN: Hold on. I will speak next. In 630.336 --

THE WITNESS: The report that I sent --

MR. WHITE: No question yet.

THE WITNESS: I'm sorry. I'm still working on the previous question.

MR. WHITE: Oh, okay.

THE WITNESS: And I have the answer to it. I sent in my report to Monica Gustafson on 8/31/2021, initial report.

HEARING OFFICER WOODMAN: So 622A.330, says -- this is subparagraph 2:

"The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support the case."

Now, for me, the plain reading of that

sentence from subsection 2 is that if the prosecutor intends to present -- and I think they used the word "prosecutor" is important to all of our situation, unless the prosecutor intends to present materials from the investigative file as evidence in support of the case.

So if the prosecutor intends to present any material from the investigative file --

MR. WHITE: We didn't present those materials.

HEARING OFFICER WOODMAN: Then you don't have a case.

MS. DAEHNKE: Right.

HEARING OFFICER WOODMAN: And let -- we have to go on and read the rest of subparagraph 2:

"The investigative file for the case includes all communications, records, affidavits, or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee."

So --

MR. WHITE: We're right back where we've been all morning.

HEARING OFFICER WOODMAN: Right. And

you've --

MR. WHITE: And I'm going to instruct him not to answer that because --

HEARING OFFICER WOODMAN: And you can, but it's going to be noted in the record, and --

MR. WHITE: Okay.

HEARING OFFICER WOODMAN: -- it's going factor --

MR. WHITE: But also see --

HEARING OFFICER WOODMAN: -- my decision.

MR. WHITE: But also see 336, Mr. Woodman. 630.336, "Except as otherwise provided in 239 0115, the following may be kept confidential." This is subsection 3 A:

"Any statement, evidence, credential, or other proof submitted in support of or to verify the contents of an application. Any report concerning the fitness of any person to receive or hold a license to practice medicine, perfusion, or respiratory care."

And C:

"Any communication between the Board and any of its committees or panels" -- that's the IC and the Board -- "and the Board or its staff, investigators, experts, committees, panels, hearing

officers, advisory members, or consultants and counsel for the Board."

That is confidential, and I'm going to have to instruct him not to answer that question because it would be violating this confidentiality, duty of confidentiality we have as the Medical Board.

HEARING OFFICER WOODMAN: And it says that those may be kept confidential, but we have a set of conflicting statutes that go directly contrary to it.

And here's -- when I had to litigate the issue of attorney-client privilege, just one of the privileges over the years that I had to do some really specific litigation on, I remember that a summary of it is this:

The law is supposed to be about getting to truth, whatever kind of a case you're in. Privilege throws up hurdles to getting to the truth. So we always have to construe privilege as narrowly as we can to protect the reason for the privilege, whichever privilege we're talking about, and around that, get to everything that we can get to help reveal the truth.

And I remember, I was dealing with

attorney-client privilege, and the fact a client met with a specific attorney, how much they paid that attorney, how many times they met, the dates they met, none of that is protected by attorney-client privilege. I was actually -- this was years ago when I was much a younger lawyer -- surprised to find out that the only thing that was protected by attorney-client privilege is when the client says I need you help with problem X, and the lawyer gives his or her opinions or problem X.

So you're --

MR. WHITE: Can I --

HEARING OFFICER WOODMAN: You're referring and relying on a statute that says these things may be kept confidential, and we've got contrary statutes that say they're not confidential, they're public under the circumstances that I believe apply here.

I've beat this thing to death. We've all beat it to death. I'm allowing the question and you can instruct the witness not to answer, but, again, it's just all going to come out in how I decide the case and what I send to the Board.

MR. WHITE: Well, let me base my reasoning on why I'm instructing him not to answer because it

is all tied together, we have investigators, we have an Investigative Committee. The Investigative Committee is my client. Things are talked about. This is all before a complaint, a formal complaint is filed.

So all those things invoke attorney-client privilege, not saying it does, but it could invoke attorney-client privilege because now giving up things, again, that could be attorney-client privilege. The IC has not waived it. It's their privilege to waive or not. They're not here to waive their privilege, and I don't think they would. They would not waive that privilege.

As far as confidentiality, 336, yes, again may be kept confidential. Well, who's allowed to do that? Who interprets that? The Board does. May be confidential, well, we're going to keep it confidential because it's -- we can by statute, and it's a lot of stuff that could be -- we have a duty of confidentiality to a lot of people as a state agency.

HEARING OFFICER WOODMAN: Who is the duty to?

MS. DAEHNKE: Right.

MR. WHITE: A lot of people, actually. If

you want the policy, probably a lot of people. Doctors and the licensees and the patients who make the complaints. It could chill the affect of them wanting to make complaints anymore if they're constantly exposed. Lots of people that we should keep that confidential.

We had this discussion in that case we've been talking about when we were down in Las Vegas. If you remember, they wanted to get into why -- how many times this investigator had investigated the certain doctor. And it was like, well, you know, those things are not -- those things are not all -- they go very -- sometimes they don't go very far.

If you saw a history of every single investigation into some of the doctors because due process really weeds a lot of that stuff out. And if you saw every investigation, if it was made public, every investigation into every doctor, even the ones that just didn't go anywhere, there's a duty of confidentiality there. There's a duty of confidentiality on letters of concern. We don't mention the names. If you've ever been to one of our board meetings, we talk about the number of letters of concern that go out. It's never told who get a letter of concern.

HEARING OFFICER WOODMAN: And as I have said --

MR. WHITE: Their file remains confidential.

HEARING OFFICER WOODMAN: -- I don't know if I've said it in this case, but I'll say it now: If the IC determines not to file a case, then you've got huge confidentiality protections. When they make the case public, I think the statutes say their file is public.

Again, that doesn't mean that there aren't some privileged communications in there that privilege will still protect, but communications with an expert witness, there could possibly be some work product protections in there, but generally speaking that, in my humble opinion based on all my years of practice, I think it's fair game.

We're going to stop the argument. I know you want to argue. I want you go back and ask your question again.

And, Doctor, I believe Mr. White's going to direct you not to respond. I'm going to -- depending on the question she asks, I may very well tell you you need to respond. And you get to decide whether you want to answer or not, whether you want

to listen to the person here who is supposed to be directing this process, say what happens and what doesn't happen, or the Board's attorney.

Go ahead with your question.

MS. DAEHNKE: I will ask the question. Just one little thing.

All of the discussion that was had about those other cases and letters of concern, I just object. I understand that there's other things, but there's a lot of time being taken up by Mr. White talking about the Chacon and McCleve case, which -- here's my point: Those cases, I reviewed them, or as much as I could because the writs aren't public and I guess weren't served on those lawyers, those are completely different cases. From my review of Chacon, that was sort of a violation that needed to be investigated, and then looking into other doctors' files. The McCleve was different too. That's not exactly here. Although I understand there's a dispute over the interpretation of law.

My question, last question was I had asked did you have conversations with Mr. White about your expert report before the last hearing. The doctor said yes. And I said, "What conversations with Mr. White?"

MR. WHITE: Work product. Objection.

HEARING OFFICER WOODMAN: Well --

THE WITNESS: I don't remember specifically, anyways, so I'm not sure -- before -- you're asking before I filed the report or before the hearing in this case?

BY MS. DAEHNKE:

Q. Before the last hearing, what discussions did have with Mr. White?

A. I don't remember before --

MR. WHITE: Relevance. Before the last hearing?

THE WITNESS: Maybe it was August of 2023. I don't specifically remember everything we talked about.

BY MS. DAEHNKE:

Q. So you told us that you gave the report over to the Board in August of 2023; correct?

A. No. I sent in my expert report the date of August of 2021. And then the last time I reviewed my report was in August of 2023, before the original trial date.

Q. Sure, as you were getting ready for the hearing.

And what discussion did you have with

Mr. White?

MR. WHITE: Objection. Work product.

THE WITNESS: I don't --

MR. WHITE: I'm instructing you not to answer.

HEARING OFFICER WOODMAN: I don't think discussions are work product. Work product, as I understand the law are part -- and part of what makes work product is stuff put down on paper, can be electronic, obviously, but I don't think discussions qualify as work product.

I'm going to overrule. You can direct him not to answer if you want.

And then, Doctor, I leave it to you to decide who to listen to, me or Mr. White.

MR. WHITE: I'm going to say this: Without waiving any other future questions like this or objection -- without waiving objection to this, go ahead. But I'm not waiving this for any future hearings or even future questions like in this hearing.

Go ahead and answer.

THE WITNESS: I don't remember the details of the conversations I had before that last hearing.

BY MS. DAEHNKE:

Q. Okay. And what conversations did you have with Mr. White today?

A. Today?

Q. Yeah.

A. I talked to Mr. White about some casual things in the break room, and then conduct of the hearing that we're having here is basically the summary of my interactions with Don today.

Q. Okay. When did you speak to Mr. White about this hearing before today, when was the last time before today?

A. Yesterday.

Q. Okay. And did you meet in person or by telephone?

A. By telephone.

Q. Did you have your expert report in front of you?

A. No.

Q. Okay. Where is your expert report?

MR. WHITE: Objection.

BY MS. DAEHNKE:

Q. Do you have a copy of it?

MR. WHITE: Objection. Objection.

BY MS. DAEHNKE:

Q. Do you have a copy --

MR. WHITE: That is his work product. This is IC's --

MS. DAEHNKE: It's work product? His expert report that he prepared is work product?

MR. WHITE: No. No. For -- was for -- it's his work product for the IC, my client.

MS. DAEHNKE: What?

MR. WHITE: You don't -- it's part of the investigative file. Again, it all came in before we filed a formal complaint. We don't use that material.

BY MS. DAEHNKE:

Q. Do you have a copy of it?

A. No, not in front of me.

Q. Do you have one at home?

MR. WHITE: Objection.

THE WITNESS: I don't know if --

MR. WHITE: Objection. Relevancy.

THE WITNESS: -- I have one at home.

MR. WHITE: And again relevancy. What is -- really, Mr. Woodman, what is relevant about this?

MS. DAEHNKE: Wow. If it's not obvious to Mr. White that it's relevant --

MR. WHITE: That's not --
MS. DAEHNKE: -- (inaudible) he can explain.
MR. WHITE: Please tell her --
HEARING OFFICER WOODMAN: Okay.
MR. WHITE: -- that's not a response to an objection.
HEARING OFFICER WOODMAN: Go ahead.
MS. DAEHNKE: It's absolutely relevant because I'm entitled to know what his opinions were, whether they've changed, what they may be based on, how that opinion -- how that report was prepared, if he had two or three reports, if there was anything that he needed to alter in the report, what materials he would have reviewed to change his opinion.
I know nothing --
MR. WHITE: This is a speaking --
MS. DAEHNKE: Excuse me.
MR. WHITE: This is a speaking --
MS. DAEHNKE: I'm responding.
MR. WHITE: This is a speaking response.
MS. DAEHNKE: Yes.
MR. WHITE: It's not saying it's relevant.
MS. DAEHNKE: I apologize, Hearing

Officer, and I'm sorry to respond to Mr. White.

I was responding to the relevancy objection by way there's probably 25 reasons why it's relevant, and I was trying to explain that.

If I haven't articulated that well enough, it's relevant because the report contains the stated violations that this is expert found or didn't find with Dr. Barber. And her license is being subject to discipline, it's absolutely relevant.

HEARING OFFICER WOODMAN: I'm going to overrule the objection. You can ask the question again.

You asked does he know where his report is.

BY MS. DAEHNKE:

Q. Do you have a copy of your report?

A. I think there is a copy of my report at home on my computer. Again, as I stated, the last time I looked at the report --

MR. WHITE: Objection. I'm going to ask him not to answer these questions again.

MS. DAEHNKE: Are you asking or instructing him?

MR. WHITE: I'm instructing him not answer these questions because it is all a part of the IC.

It's, again, it's confidential, it's confidential according to NRS 630.336, 622A.330, it is part of the investigative file.

Answering these questions -- because I know where this is going. I know she's going to ask for the report and you don't get the report. It's part of the investigative file.

HEARING OFFICER WOODMAN: And --

MR. WHITE: It's not being turned over.

HEARING OFFICER WOODMAN: So you have an ongoing objection.

MR. WHITE: Yes.

HEARING OFFICER WOODMAN: And I'm not going to waste anymore time on these arguments.

So every time she asks a question, if you want to direct him not to answer, that's all you say, because I'm noting your ongoing objections.

But we're wasting an unholy amount of time here. And I'm extremely -- I consider myself an extremely patient person, I'm fresh out of patience. And I'm getting close to pulling the plug and sending everybody home to think about you've done, in the corner, before we come back and try this again tomorrow.

And what a waste of time for a surgeon

because we all know what he ought to be doing.

So you ask questions, Mr. White your ongoing objection is noted. If you want to direct him not to answer, direct him, and then we'll leave it to the witness to decide whether he answers or not.

Because you have an ongoing objection, if she asks a question that I think is objectionable, I will intervene.

MS. DAEHNKE: Thank you.

BY MS. DAEHNKE:

Q. How many drafts of your report did you prepare.

A. One.

Q. Okay. How was it prepared?

MR. WHITE: Objection. Ongoing objection. I direct you not to answer that.

THE WITNESS: I've been directed by my lawyer not to answer the question -- by my counsel, so I will defer --

MR. WHITE: I'm not your counsel, but I'm just saying as far as like -- as far as what's taking place here, the relevance, and the possibility that we could be violating our confidentiality statutes through one of our

witnesses, yes, I am directing you not answer that question.

BY MS. DAEHNKE:

Q. Doctor, you referred to Mr. White as your counsel. You understand he's not your counsel; correct?

A. Yes. How should I refer to him?

HEARING OFFICER WOODMAN: Mr. White.

BY MS. DAEHNKE:

Q. All right. So he instructed you not to answer how many drafts there were, but you told us there was one draft.

I was asking you how it was prepared?

MR. WHITE: Same. Don't --

THE WITNESS: I prefer not to answer.

MR. WHITE: I'm instructing him not to answer.

BY MS. DAEHNKE:

Q. So you will not tell me whether you prepared it on your own with a draft, gave it back to counsel to review, and then gave it to you. You're not going to answer that, I presume?

THE WITNESS: Yes.

MR. WHITE: Directing him not to answer, and it's irrelevant.

BY MS. DAEHNKE:

Q. Did you consult any literature or learned treatises when you were preparing your report?

A. I prefer not to not answer.

Q. Okay. All right. You are -- all right. So just -- you have a copy of the report on your computer. You've been instructed not answer -- just to get this -- you did have discussions with Mr. White before the last hearing. You had discussion with him yesterday.

What discussions did you have with Mr. White yesterday in anticipating of testifying here at the hearing?

MR. WHITE: Go ahead. Again, though, I'm instructing you not to answer, but if you want to, go ahead. It's up to you. But, again, it gets into -- it's a real gray area because it's all --

THE WITNESS: Generally speaking, we just reviewed some of factual pieces of the case and reviewed some details about where and when and what's expected of me in terms of behavior. But, really, mostly we just discussed the interpretation and the facts of the case.

BY MS. DAEHNKE:

Q. What do you mean by "the interpretation

and facts of the case," you mean Mr. White's interpretation of the facts?

A. No. Mine.

Q. Okay. So your review of the medical records and the file?

A. My review of the medical records and that file, what?

Q. Well, you agree that you weren't there?

A. I wasn't where?

Q. For the surgery, you didn't treat Patient A?

A. That's correct.

Q. Okay. So your opinion would be based on the medical records?

A. Correct.

Q. And you originally reviewed other documents that Mr. White has instructed you not discuss, but did you -- okay.

Did you tell me that you had any medical literature, had reviewed any medical literature as a part of your review and formulation of your expert opinion?

A. Yes.

Q. What medical literature did you review?

A. I would prefer not answer.

Q. Okay. You recognize that part of the charge against Dr. Barber is your apparent opinion that use of laparoscopic -- here, I can read it. Actually, I should probably ask you if this is your opinion.

Well, how much medical literature did you review, how many articles or treatises did you review in assisting in formulating your opinion in this case?

A. Same. I prefer not to answer that question.

Q. You prefer not to answer or -- I'm sorry.

When you san you prefer not answer, does that mean that you are --

MR. WHITE: You can --

BY MS. DAEHNKE:

Q. -- taking --

A. I am --

Q. Can we hold it, please.

A. Sorry.

Q. And I'm sorry.

Is -- Mr. White, are you following his prior directive not to answer because it's a little -- we have a court reporter, we're making a record, these things are important. I'm sorry it's

just so picky and your head is probably going to want to explode.

MS. DAEHNKE: Are you instructing him not to answer?

MR. WHITE: No. He can answer that. Literature that he consulted, yeah.

THE WITNESS: I'd have to refer back to the references on my report.

BY MS. DAEHNKE:

Q. Okay. So in order to answer my questions about what medical literature treatises you reviewed, you relied upon in formulating an opinion that you came here to testify that Dr. Barber breached the standard of care, you can't tell me because you won't give us a copy of your report because Mr. White has instructed you --

MR. WHITE: Objection. Argumentative. No question.

BY MS. DAEHNKE:

Q. Just so I understand, just so I'm clear, you have reviewed your report that we can't see in order to tell me what medical literature or treatises you relied on to say that my doctor breached the standard of care; is that accurate?

MR. WHITE: Objection. Argumentative.

And also there's nothing that says that it has to be turned over at all, ever.

MS. DAEHNKE: That's -- the -- we're not there.

HEARING OFFICER WOODMAN: The objection is overrulled. You can answer this question.

Please ask the question one more time.

MS. DAEHNKE: He said he would have to review his --

MR. WHITE: He can form his opinion on a learned treatise without turning over the learned treatise. That's --

MS. DAEHNKE: That's not --

MR. WHITE: -- evidence 101.

MS. DAEHNKE: That's not my question. And thank you, king evidence 101.

HEARING OFFICER WOODMAN: Okay. We're --

MR. WHITE: Oh, okay. All right.

MS. DAEHNKE: Well, you -- look, I asked the doctor if he had relied on any medical literature or treatises in formulating his -- oh, god. Move away, go ahead, I would actually like some room.

If he had relied on any articles, medical literature, treatises in formulating his opinion

that he's giving here today that Dr. Barber breached the standard of care. And he said, "I don't know. I've have to review my expert report," which then --

THE WITNESS: That's not what I said. I said, "Yes, I did."

BY MS. DAEHNKE:

Q. Well, you said yes. And then I said which ones, and you said you'd have to look at your expert report; right?

A. Right. There's a difference between if I consulted other resources, and there's a difference between you asking me what goes on.

I did consult them, they're in my report, and they are referenced. I cannot provide them right now.

Q. I understand that. But you can't give me -- I understood that you reviewed them. You reviewed them?

A. Right.

Q. That's fine. Okay. We don't have them. We don't know what they were.

A. I'm sorry to hear that.

Q. I asked you -- well, it's your duty. The Board has the burden proof. You're sorry to hear that? Really? We're going to --

MR. WHITE: Objection. Argumentive.

MS. DAEHNKE: Another witness is going to adopt this attitude?

HEARING OFFICER WOODMAN: Get on with your questions.

BY MS. DAEHNKE:

Q. I was just trying to make sure that I understand your expert opinion is that you can't cite to me the literature or the learned treatises or anything else that you reviewed because you'd have to review to your expert report. That's all.

A. It still isn't a question that you asked. I'm still waiting for you to ask me a question. You're making big, broad statements and putting words in my mouth, and I refuse to accept that.

I'm happy to answer questions truthfully and honestly. I'm here to get to the bottom of this. But you're not asking me questions; you're making broad statements and trying to make me adopt things as my own, and I do not want to do that.

Q. So I would ask the court reporter to read back the question that I asked before Mr. White objected, because I thought your answer was fine, and we were getting along, but we couldn't.

HEARING OFFICER WOODMAN: And she can't

read it back.

MS. DAEHNKE: I understand. That's what -- that's why.

BY MS. DAEHNKE:

Q. So I can't just ask you a small question without incorporating all the stuff that's been said. You told me you reviewed treatises and medical literature in formulating your opinion; correct?

A. Yes.

Q. Second, I asked you could you tell me what those were, and you said you'd have to review to the expert report in order to get the names?

A. Correct.

Q. Okay. That's what I was trying to get at. And Mr. White doesn't want you to produce the report, so we got that.

A. It is required by me as part of my report formulation that I provide references and literature that I use to help formulate my professional opinion.

Q. Okay. And that's fair.

Let me ask you what are you referring to when you said it's required?

A. A list of requirements sent to the Nevada

State Board of Medical Examiners with the case.

Q. Okay. Nice. And so where is that document?

MR. WHITE: Objection. Relevance.

THE WITNESS: That's at the Nevada State Board of Medical Examiners.

MR. WHITE: We're talking --

BY MS. DAEHNKE:

Q. So I'm following up on --

MR. WHITE: Wait for me --

MS. DAEHNKE: Could we not be so disrespectful to --

MR. WHITE: I have a standing objection.

MS. DAEHNKE: He didn't finish -- let your witness finish. He was talking and you were objecting to him. He was testifying.

MR. WHITE: I understand. I've been in court before. You have stop --

MS. DAEHNKE: I --

MR. WHITE: -- when I have an objection.

HEARING OFFICER WOODMAN: All right.

MR. WHITE: How is it relevant what the Board requires him to do as far as -- we're talking about every -- like working as -- probably -- just I'll offer this: There's W2 stuff, I mean, it's so

irrelevant, Mr. Woodman.

MS. DAEHNKE: May I respond just quickly?

HEARING OFFICER WOODMAN: Please.

MS. DAEHNKE: I was following up on a question that the witness was -- he's not going to let the witness say anything. The witness said to you, looked at you, Hearing Officer, and said there's requirements in -- there's requirements that I'm given to list in my report the treatises and things I -- I was following up on that. That's all. I said, "Where are those requirements?" He said, "I get it from the Medical Board." I said, "Do you have those?"

I'm following up on a question from your witness who is trying -- who is actually trying to testify, trying to give testimony in this case.

MR. WHITE: I understand Ms. Daehnke thinks she's entitled to everything, but it is -- it's overruled. Okay? Fine. Well, irrelevant, though.

BY MS. DAEHNKE:

Q. And, Doctor, do you have that on your phone?

A. Do I have what?

Q. The document that you were describing that

had all the requirements you said that you sent. Do you have that at your house?

MR. WHITE: Why don't we look at everybody's phones. I mean, how is this relevant?

THE WITNESS: Those documents were returned to the Nevada State Board of Medical Examiners as a standard practice for every case reviewed.

BY MS. DAEHNKE:

Q. The documents that were sent to you by the Board were returned to the Board?

A. Correct.

Q. Did you return -- and you returned that when you returned your expert report?

A. Yes.

Q. Did you return any other documents to the Board?

A. I turn every document that I got from Board back to the Board.

Q. And that included what else besides medical records?

MR. WHITE: Objection. Again, we're going to go back through this, NRS 630.336 --

HEARING OFFICER WOODMAN: And your ongoing objection is noted.

MR. WHITE: And I instructed him not answer, I instructed him not to answer.

HEARING OFFICER WOODMAN: All right.

So, Doctor, leave it to you to answer or not.

THE WITNESS: I prefer not to answer.

BY MS. DAEHNKE:

Q. You're following Mr. White's instruction not to answer, and that's -- we're just trying to get this -- Mr. White's letting you answer some things and some not, that's just fine.

All right. And what about any treatises that you have at home that you might have consulted, or online -- well, what kind of resources do you use now that you can do quick searches, did you use any online?

A. I don't remember. Generally, I chose resources that are specific to the case that I'm reviewing. It wouldn't help to present something that's of a different area.

The resources are unique to each case and they are relevant to each case and they are listed at the end of each case.

Q. Okay. Thank you.

In your expert report?

A. Correct.
Q. Like a bibliography?
A. Correct.
Q. Have you done trial testimony, expert review in court?
A. I've been subpoenaed on a case that I was not under -- as a witness.
Q. You weren't being sued?
A. I've never been sued. Correct. I was one of the --
Q. A treating physician?
A. Yeah. I was one of the physicians involved in a case, and I was in no way implicated, I was just testifying for civil reasons.
Q. You were not a defendant. I understand that.
A. Correct.
Q. Yeah, you're a treating physician not a -- was that in court or in trial?
A. That was in court.
Q. Okay. Have you given deposition before?
A. No, I don't think so. No.
Q. You're really excited to get back to that. Can't wait for the deposition.
All right. You are a member of the

American College of Surgeons?

A. Yes.

Q. Okay. And you are familiar with their expert witness guideline for testifying in hearings, the American College of Surgeons?

A. What about it?

Q. Are you familiar with their guidelines on expert witness testifying in court?

MR. WHITE: He isn't an expert witness. Objection. He's not an expert witnesses. He's a peer reviewer.

MS. DAEHNKE: Okay.

MR. WHITE: He did an independent medical review of this. That's part of due process in this case, part of the IC's --

THE WITNESS: Yeah, I'm not an expert witness.

BY MS. DAEHNKE:

Q. Hmm. That's fascinating. You didn't treat the patient, you're not an employee of the Board.

A. Sorry. I'm not being treated as an expert witness by the system here. So if we're talking about a difference between medical expertise and being an expert witness, I don't fall into the

compensation and protection that an expert witness gets.

I simply am a peer reviewer, ma'am.

MR. WHITE: Yes.

BY MS. DAEHNKE:

Q. You're being offered as someone who is qualified to testify about the standard of care that Dr. Barber, as a 35-plus-year general surgeon as to her standard of care. And you are being held out as someone who's qualified, so you're -- you don't consider yourself an expert in the standard of care?

A. I consider myself to be a peer of Dr. Barber, which is why I reviewed the case, ma'am.

Q. I'm -- I don't understand the difference between a peer reviewer and an expert witness --

A. I'm not sure I do either.

Q. Okay.

A. In terms of all the specific legal and technical terms, but with those -- because those rules are permanent, those definitions are not made by physicians or medical committee, that's under your pervue.

Q. Sure. Standard of care is a phrase and a concept that you're familiar with?

A. Correct.

Q. You were familiar with that before you came into this room?

A. Correct.

Q. You were familiar with that before you were retained by the Board to be a peer reviewer?

A. Correct.

Q. And the standard of care, what's your understanding of the definition of standard of care?

A. What a reasonable and well-trained surgeon would do under similar circumstances.

Q. Exactly. Yeah. And that's what you're testifying to here today; correct?

A. Yeah.

Q. Yeah. And that's the legal standard, that's what expert testimony is. You need experts to testify as to the standard of care. The Board can't -- as Mr. White said, due process requires you and Dr. Barber to have someone of equal training testify that -- or similar training, testify that they violated standard of care; right?

A. Um-hum.

Q. I understand that may be expert witness compensation in depositions and trial is higher than the Board would pay, and experts get a lot of money. I understand that distinction.

But -- so are you saying, then, or would it be your position that as a member of the American College of Surgeons that you are not bound by the guidelines that be are issued by the American College of Surgeons about testifying in court or trial?

A. What's the question? I'm sorry. Your questions are very long.

MR. WHITE: Objection. Relevance. It's not relevant.

THE WITNESS: I'm having trouble figuring out what you're asking me by the time you've reached the end, I've forgot the beginning.

Q. That's fair. That's fair.

HEARING OFFICER WOODMAN: I'm overruling the relevance objection. Break it down for him.

MS. DAEHNKE: Okay.

BY MS. DAEHNKE:

Q. I think you told me that you're a member of the American College of Surgeons. I'm asking you if you -- I had been asking you about their guidelines, and then you said you're not an expert, and we had a discussion about that.

MR. WHITE: Also --

MS. DAEHNKE: I'm trying to give context.

MR. WHITE: I know.

MS. DAEHNKE: It's too what?

MR. WHITE: Do we have -- has this been produced? We have the American College of Surgeons' guidelines anywhere that we could refer to at least as part of evidence in this case?

MS. DAEHNKE: Sure. If you can get on the wi-fi here, we can put them up.

MR. WHITE: No. It was supposed to be produced about a month ago on May 2nd.

MS. DAEHNKE: No. Rebuttal -- no --

MR. WHITE: You're not rebutting anything. You're asking -- you're doing cross-examination. It's not rebuttal.

MS. DAEHNKE: Yeah, I'm doing --

MR. WHITE: Is there anything here? I don't have anything. How is he supposed to refer to anything?

HEARING OFFICER WOODMAN: Okay.

MS. DAEHNKE: I asked him if he was familiar and if he's a member, and he said yes. And then you got off on a tangent saying he wasn't an expert.

HEARING OFFICER WOODMAN: So, here's the problem I have. I'm not a judge with a behalf. I

don't have a jail cell where I can sit people down for a few hours holding them in contempt.

And this is going to be an absolute tragic waste of resources, but I'm suspending the rest of this hearing. I want this on the record. I am going to reach out to Dr. Spirtos, who is the head of the Medical Board. I'm going to have a very frank conversation with him about confidentiality.

And I will communicate with the parties here after I've had a satisfactory conversation with Dr. Spirtos about reconvening this. I think it's a tragic waste of this doctor's time. I think it's a tragic waste of lawyer's time. I think -- you've got a medical expert here from across the country, it's a tragic waste of resources.

But, you know what, we are just regrinding the same problem over and over and over again. And, again, I wish I had bailiff and I wish I had a jail cell because I'd sure be using it. I don't have that.

So what I have is the ability to suspend the hearing and reach out to the head of the Medical Board. And as I said -- and you can communicate with each other, do not communicate with me. I will reach out to you folks once I have communicated with

the head of the Medical Board, which I've never done in the more than a decade that I've been hearing these cases. But it's time to do it now, and that's all I'm going to say.

And, Doctor, thank you for being here. I appreciate your testimony. I took a lot of notes and we've got a transcript. Obviously we're not done. We're in the middle of cross-examination. And I think this is a waste, but we've already wasted too much time today, and I'm not going to be responsible for wasting anymore time.

I'm not going to let counsel respond. I'm going to go off the record. My gratitude to our court reporter and to you, Doctor.

(Hearing suspended at 4:02 p.m.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on June 4, 2024, for the hearing at the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 257 pages, inclusive.

DATED: At Reno, Nevada, this 17th day of June, 2024.

/s/ Brandi Ann Vianney Smith

_____

BRANDI ANN VIANNEY SMITH

4

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

In the Matter of the Charges and Complaint Against:

Case No. 23-11660-1

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.
_____/

TRANSCRIPT OF HEARING PROCEEDINGS
Day 1
(continued from June 4, 2024)

Held at the Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Thursday, April 3, 2025

Reported by: Brandi Ann Vianney Smith
Job Number: 7051978

A P P E A R A N C E S:

THE HEARING OFFICER:	PATRICIA HALSTEAD, ESQ.
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	DON WHITE, ESQ. Senior Deputy Gen. Counsel Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov
FOR RESPONDENT:	PATRICIA DAEHNKE, ESQ. DRR Law Group 2110 E. Flamingo Road, Suite 212 Las Vegas, NV 89119 pdaehnke@drrlawgroup.com

ALSO PRESENT:
Meg Byrd, Legal Assistant

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RENO, NEVADA -- APRIL 3, 2025 -- 8:30 A.M.

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HEARING OFFICER HALSTEAD: We're on the record in case number 23-11660-1, In the Matter of the Charges and Complaint Against Annabel Elizabeth Barber, M.D. This matter was initially heard by a different hearing officer, Hearing Officer Woodman, on Tuesday, June 4, 2024, and there was a transcript of that proceeding and this is a continuation of that proceeding as recorded in that transcript.

The reason this is a continuation is because in the interim, there was an issue that was, arguably and as I ruled, resolved by a District Court Order on a writ that had to do with production of the investigative file. I issued an order on that titled "Order for Matter to Proceed to Continued Hearing," which was signed on November 1, 2024. This is that continued hearing.

I'll have the parties, please, make their appearances, and, Ms. Daehnke, you can introduce your client.

I'll start with you, Mr. White.

MR. WHITE: Don White, Senior Deputy,

Nevada State Board of Medical Examiners, here on behalf of the Investigative Committee.

MS. DAEHNKE: Patricia Daehnke, I'm here with Dr. Annabel Barber, respondent.

HEARING OFFICER HALSTEAD: And I'm Hearing Officer Patricia Halstead.

We spoke briefly off the record before this matter started. We confirmed that Exhibits 1 through 5 will be admitted. Mr. White has produced an updated Exhibit 5, which is the CV for Nicholas Spoerke M.D., F.A.C.S.

(IC's Exhibits 1 through 5 were admitted.)

HEARING OFFICER HALSTEAD: My understanding from Ms. Daehnke, who will correct me if I'm wrong, is that there is no objection to the updated Exhibit 5 being placed in where the prior Exhibit 5 was.

Is that correct?

MS. DAEHNKE: That's correct, Your Honor.

HEARING OFFICER HALSTEAD: Okay. The updated Exhibit 5 will now be the current Exhibit 5.

There was a discussion and a request by Ms. Daehnke to ensure that prior proceedings related to the respondent in matter 22-11660-1 were part of this record. That has not been at issue before me.

I will review that and address that in my findings.

Both parties have asked for their objections in the record as previously transcribed to be deemed ongoing objections. Those objections, as they relate to production of the investigative file, are overruled, and then the objections as otherwise stand as they were ruled upon at the time.

Both parties have indicated that they will defer to the record as already recorded, including reliance upon their opening statements as given.

The record, although we're starting new with Dr. Spoerke, will be available for use with regard to his testimony in any way the parties deem appropriate.

Have I missed anything that needs to be placed on the record at this point?

MR. WHITE: I don't believe so.

HEARING OFFICER HALSTEAD: Ms. Daehnke, anything from you?

MS. DAEHNKE: I just want to state a sentence just to clarify the case numbers on there. For purposes of this continued hearing, that Dr. Barber preserves and reserves her objections as set forth in both public filings for cases 22-11660-1 and case 23-11660-1, and also as stated,

request for records from the investigative file.

HEARING OFFICER HALSTEAD: Okay. Anything further?

MR. WHITE: No. I don't understand what that last part meant, though, request for records? Like --

HEARING OFFICER HALSTEAD: She wants to preserve her objections with regard to the request she made for the production of the investigative file.

MR. WHITE: Oh, okay. I thought you mentioned that, Ms. Halstead, earlier.

HEARING OFFICER HALSTEAD: I did. And she was reiterating.

MS. DAEHNKE: I was just reiterating also respondent's position that those should have produced sua sponte.

HEARING OFFICER HALSTEAD: I note that we're going to have to be careful about talking over each other. Let's take a queue from whoever I'm looking at at the time to speak. I will be meaningful.

Mr. White, I believe it was your witness.

MR. WHITE: Okay. I will get Dr. Spoerke.

(Dr. Spoerke entered the hearing

room.)

HEARING OFFICER HALSTEAD: Welcome back, Dr. Spoerke. I'm Patricia Halstead, I'm your latest hearing officer.

DR. SPOERKE: It's nice to meet you.

HEARING OFFICER HALSTEAD: Nice to meet you. We appreciate you being back again.

Can you please raise your right hand to be sworn.

(The oath was administered.)

HEARING OFFICER HALSTEAD: Can you please state and spell your name for the record.

DR. SPOERKE: Sure. Nicholas John Spoerke, N-I-C-H-O-L-A-S, J-O-H-N, S-P-O-E-R-K-E.

HEARING OFFICER HALSTEAD: Thank you.

Go ahead, Mr. White.

MR. WHITE: Thank you. There is one other thing I wanted to say, it's sort of a housekeeping thing, it doesn't matter if it's on the record.

Patient A is down in Las Vegas in the office down there watching. From here, we can't see him, but he can see us. Just wanted to let you know that.

Ms. Daehnke, last time we were here for a hearing, was inquiring about who was down there

watching. We didn't set it up so we can see him. There's no reason to see the Vegas office right now, but just to let everybody know who is watching the proceedings.

HEARING OFFICER HALSTEAD: I think everyone recalls, but we're not to refer to Patient A's name. Patient A is to be referred to as "Patient A."

MR. WHITE: Yes.

MS. DAEHNKE: With regard to the last hearing, we had exclusionary rules invoked because of we were not certain who is here, who was in the room, and it wasn't immediately apparent to Mr. White or to the other Board staff, but then did see him. But we didn't have an exclusionary rule for him.

HEARING OFFICER HALSTEAD: Will Patient A be testifying?

MR. WHITE: He will not.

And also -- I was about to do that, invoke the exclusionary rule, so I think we should invoke that so that witnesses' testimony isn't mixed up.

HEARING OFFICER HALSTEAD: Any concerns about that, Ms. Daehnke?

MS. DAEHNKE: All we have are experts and

Dr. Barber, so -- yeah. Dr. Baskies is only testifying tomorrow, so he will obviously be -- he was here last time, but you didn't get to meet him.

We just -- I mean, Dr. Baskies will obviously -- and he knows from the last time because he was here -- know about Dr. Spoerke's testimony.

HEARING OFFICER HALSTEAD: Okay. I just want to make sure that we're all on board with the rule of exclusion, and in light thereof, Patient A can sit and watch the proceedings.

MR. WHITE: Correct. I will not be calling him.

I know that there was a thing that came up last time -- and I saw it when I was reviewing the transcript -- that Ms. Daehnke believes it was okay for experts to hear one another's testimony or to inform them what we're talking about.

I object to that. I think the exclusionary rule is the exclusionary rule, that witnesses don't -- aren't told what -- they don't get to sit in and listen to what the other witnesses are saying, whether they are deemed experts or peer reviewers or anything. Just wanted to make sure we're on the same page with that.

MS. DAEHNKE: We're not on the same

page with that.

HEARING OFFICER HALSTEAD: All right. My experience is that it is up to the judicial officer or the hearing officer in this case, and it hasn't been my experience that that is done in these proceedings. But having said that, that is common in civil proceedings. But, again, this is not a civil proceeding, this is an administrative proceeding.

Because expert testimony is specialized, typically in District Court experts are allowed to stay in to advise the attorneys and to evaluate the other expert's testimony. I don't have a problem with that.

Mr. White, if you have a problem with that, you're certainly welcome to preserve that for the record.

MR. WHITE: Yeah, I do. And I -- Dr. Spoerke here has blocked out one day. I don't think he's available tomorrow to sit and watch. I could be wrong, he can correct me right now, he's sitting next to me.

If he's available to help with any kind of rebuttal argument against their experts tomorrow, I think he's back to work tomorrow as far as I know,

but --

DR. SPOERKE: If you need me, I can be available.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: Did you say that your expert already reviewed from Dr. Spoerke's testimony?

MS. DAEHNKE: No. But Dr. Baskies was here last when Dr. Spoerke had testified. While (inaudible).

THE REPORTER: I'm not sure what do to here with you having no voice.

HEARING OFFICER HALSTEAD: Do you want her to move?

MS. DAEHNKE: I will do this (indicating), if that is better.

THE REPORTER: I just need to be able to hear you.

MS. DAEHNKE: I understand. I wish I had an easy solution.

HEARING OFFICER HALSTEAD: I don't want to talk for you, but under the circumstances, are you saying that your expert was here when Dr. Spoerke was testifying?

MS. DAEHNKE: No. My expert came and was

here for the second day, so we were outside. When Dr. Baskies came over during the first day, I prepped him for his testimony so he's aware, and he's also aware because his opinion is in the Complaint.

HEARING OFFICER HALSTEAD: Right. So you spoke about Dr. Spoerke's testimony with your doctor?

MS. DAEHNKE: Yes, of course. I have a duty. But Dr. Baskies did not observe Dr. Spoerke.

Nor is Dr. Baskies going to be on the Zoom, even though Meg did provide it to Dr. Baskies, we can tell him don't watch Dr. Spoerke.

HEARING OFFICER HALSTEAD: I don't have a problem with the experts being aware of what the other expert is saying.

MR. WHITE: Okay. I totally respect that.

HEARING OFFICER HALSTEAD: Because, you know, it comes down to the experts, and if you don't understand what's said, you know, both experts need to be able to say their opinion in an educated way that helps me, as the goal, to help make a decision.

MR. WHITE: To surmise -- summarize, you have no problem if experts are watching the other experts?

HEARING OFFICER HALSTEAD: Based on the request made in this case, it's not some blanket rule to be imposed throughout every proceeded that I do from now on, but it was made -- and the request was made in this case, and in this case, my ruling is that the experts can be to excluded from the rule of exclusion.

MR. WHITE: Okay. Okay.

HEARING OFFICER HALSTEAD: And having said that, I don't know a case where the experts aren't aware of what the other expert has said or is going to say regardless of the rule of exclusion. I think that typically happens in these proceedings.

You can correct me if I'm wrong, Mr. White, but I'm pretty sure the experts are aware of what the other expert is saying routinely.

MR. WHITE: They are just not in -- sometimes --

HEARING OFFICER HALSTEAD: Correct.

MR. WHITE: -- not in the room.

HEARING OFFICER HALSTEAD: And they are not in the room now.

MR. WHITE: And in criminal proceedings, you don't have witnesses sitting in the courtroom watching everything else, other witness, even if

they are experts, you don't see that. They are sequestered and pulled out of the room.

HEARING OFFICER HALSTEAD: Not necessarily experts, and it depends.

Having made my ruling, it doesn't matter because there is no other expert in the room.

MR. WHITE: Okay. Yeah. Okay.

I'm going to make one more comment. Would it be helpful to the court reporter if Ms. Daehnke and I switched? I don't know if that helps or not. Just throwing it out there.

MS. DAEHNKE: I can talk like this if that's better.

THE REPORTER: I can hear you when you talk like that. When you were whispering, I couldn't hear you.

MS. DAEHNKE: Well, it's painful. I'll do whatever so you can hear.

HEARING OFFICER HALSTEAD: I would really like to get started. This was supposed to start at 8:30 and it's 9:12.

MR. WHITE: We're ready.

HEARING OFFICER HALSTEAD: Thank you.

DIRECT EXAMINATION

BY MR. WHITE:

Q. Good morning, Dr. Spoerke.

A. Good morning.

Q. I just want to represent to you that your CV was admitted from the prior hearing, meaning it was admitted into evidence. In other words, it's been stipulated that it was -- it's authentic and it is what it is and you wrote it and it describes you.

It has been admitted into evidence, and at some point, somebody is going to see that, the Hearing Officer will get to look at it, the Board members, possibly, will get to look at it too.

However, I also know from speaking to you recently that there was a change, I want to put that on the record, there's been one addition, I think, to it, unless you have other things that you want to tell me about.

Your updated résumé, which you sent to me and I want to put that into evidence, I have it here and a copy of in front of you, what were the changes or additions that you made?

A. The main change is that my employment went from being a 12-year partner at Western Surgical Group to shifting to working for Weatherby

Healthcare systems.

Q. Is there anything else? That's it?

A. I updated my extracurricular, but that's not really pertinent.

No, the main change is my change of employment.

Q. Okay. And when you talk about extracurricular, are you talking about down at the bottom here, kind of your hobbies and --

A. Yeah, yeah.

Q. -- doing the father and husband --

A. Yeah, father and husband, wildflower, and birding, to what I had on there before.

Q. Okay.

MR. WHITE: I would move to -- I don't know if I need to, but I would move to admit the updated CV.

HEARING OFFICER HALSTEAD: It was already admitted.

MR. WHITE: Okay. All right.

HEARING OFFICER HALSTEAD: But thank you.

BY MR. WHITE:

Q. Doctor, what is your specialty in your job at Weatherby Healthcare systems now?

A. Similar to what it was at Western Surgical

Group, I'm a general surgeon with a specialty in trauma and surgical critical care.

Q. Okay. Could you describe a little bit about what that means, trauma and critical care?

A. Yes. We break up -- often we break up the specialization of general and surgery residents upon finishing residency into various subgroups. I chose to do a fellowship in trama and surgical critical care. That was a one-year fellowship.

What that translates into is I do acute care surgery, general surgery, I take care of the highest level of injured trauma patients, and I do quite a bit of surgical critical care, including ventilator management, resuscitation, et cetera.

Q. Okay. When you say "trauma injuries," would that be car and motorcycle accidents, things like that?

A. Car crashes, falls, penetrating traumas such as gunshots and stabbings, motorcycle crashes, yes.

Q. Okay. Obviously you have reviewed some documents that are all here in this -- in here in this (indicating), the Investigative Committee's exhibits regarding an inguinal hernia surgery.

Have you done any of these -- have you

done -- have you ever done a laparoscopic inguinal surgery on a hernia?

A. Yes.

Q. How many have you done, approximately?

A. Probably about ten, five to ten.

Q. Is it a pretty common surgery for a hernia?

A. Yes.

Q. Is there another way to do a surgery on a hernia?

A. Yes.

Q. What is that?

A. It's called an "open repair."

Q. All right. If you could just for a second, would you describe the difference between a laparoscopic hernia surgery and an open hernia surgery?

A. Sure. I'll start with the open because that was invented first.

That's a basic operation where the patient is under anesthetic, you make an incision over the bulge in the groin, then you're able to dissect the issues away from each other, put the hernia backwards and then repair the hernia with sutures and plastic mesh. That is the type of hernia repair

we've been doing for 60, 70 years.

Recently -- maybe not that recently -- laparoscopic or hernia repairs have come on board. That operation is still a general anesthetic, usually. It's -- rather than making an incision over the bulge in the groin, you make small incisions, usually at the umbilicus or in another location, to gain access to the abdomen, and then you inflate the abdomen with carbon dioxide. Then you put in a couple more small working ports and you use long, skinny instruments and a camera to pull the hernia contents back into the abdomen and then repair the hernia from the inside.

Q. What do you use to finish that up, mesh?

A. It's always mesh, yes.

Q. And in your estimation, how many open inguinal hernia surgeries have you done?

A. Quite a few. I would say a hundred.

Q. And just while we're on the subject, inguinal, what does that mean to the layperson?

A. Inguinal describes the -- to the layperson, it's kind of your groin area, what a layperson would call the "groin," what is referred to the region of it.

Q. And those typically happen on either the

left or the right side?

A. Yes.

Q. I'm kind of jumping around a little bit. I'm sorry.

How long have you been doing -- your scope of practice been based in general surgery?

A. Since 2012.

Q. So this is year 13?

A. Yes.

Q. How much of it -- how much of that time was based in critical care and trauma surgery?

A. The -- my time been has been divided approximately into thirds: A third acute care surgeries/general surgery, a third surgical critical care, and one-third trama.

It's about like that.

Q. Have you been practicing all along together and it's just that you don't do those surgeries -- you do those surgeries about a third of the time?

A. Yes. If you take a given month, a third of my shifts, call shifts, will be trama and a third will be surgical critical care and a third will be acute care surgery and general surgery.

Q. Just to clear up the record, when you came

out of residency, did you start doing critical care and trama surgery right then?

A. Yes.

Q. I got you.

A. And as well as general surgery.

Q. Have you also done bowel repairs?

A. Yes.

Q. How many have you done of those, if you can --

A. Hundreds of those as well, for a variety of reasons.

Q. I'm going to ask you to turn to page 108 in Exhibit 4, please.

A. Okay.

Q. There's an encounter date on the top there.

A. Yes.

Q. Is this the first time that Dr. Barber saw Patient A, to the best of your recollection?

A. Yes.

Q. Which was date of what?

A. December 27, 2018.

Q. What is -- for us laypeople, what does "HPI" mean, about half way or two-thirds the way down the page.

A. "HPI" means history of present illness.
Q. What does that say there, what was -- and where do they get that information? If you know.
A. Usually the history of present illness comes from the patient.
Q. Okay. And so maybe go through that paragraph, I think we might have to stop once in a while to find some of these things, I see there is a 54-year-old man.
A. Would you like me to read it?
Q. Sure. And then I'll tell you when to stop.
A. That's perfect.
"This is a 54-year-old man who was born with an omphalocele."
Q. And what is that?
MS. DAEHNKE: My exhibits are different.
HEARING OFFICER HALSTEAD: It's NSBME 108.
MR. WHITE: 108.
BY MR. WHITE:
Q. Back to -- I was about to stop you when you said "omphalocele." Could you please define that for us?
A. Yeah. In general terms, an omphalocele, for the purposes of this court, is when the

abdominal wall, the muscle of the abdominal wall doesn't close fully when we're a fetus. So when you're born, there's a gap between that left side of your muscle and the right side of your muscle, and the abdominal contents or bowels tend to protrude.

That is generally treated with multiple-staged operations to stretch the abdominal wall a little bit and keep the bowels safe, and then eventually turn the bowels all the way into the abdomen and close the abdomen back into a more normal configuration.

Q. Most people are not born with an omphalocele?

A. Okay.

Q. That would mean that their abdomen is closed at birth?

A. Yes. Most of us only have a bellybutton, but these babies have a much larger defect that requires surgery to get all the parts back into where they are supposed to be.

Q. Okay. And then starting right after "omphalocele"?

A. "And had a larger reconstruction as a newborn."

Q. Is that what you just described?

A. That's what I was just describing. It's usually a staged operation where they have a little pouch sitting on their belly and they -- the abdominal wall slowly stretches over a couple weeks and we're able to get the bowels back inside and close the muscle and the skin over the top.

It usually takes a couple of weeks and multiple operations.

Q. So for clarification, does that mean that this baby is staying in -- a baby like this would stay in the hospital --

A. Yes.

Q. -- and up until they are about two weeks old, they are getting this reconstruction surgery?

A. Yes. And I am not able to tell the extent of his operations, what the patient had exactly, but generally speaking when you have an omphalocele, you're an inpatient for a couple of weeks, you have multiple small operations to be able to get the abdominal wall closed.

Q. Okay. Would that result in scar tissue later on in life?

A. That is a -- definitely a risk factor for developing abdominal -- intraabdominal scar tissue later in life.

Q. All right. And then right after that, after "newborn," "He has"?

A. There, it goes on to say "He has subsequently had a large amount of his small bowel removed from SBO." That stands for small bowel obstruction.

Q. Okay.

A. And that is a process where -- in most adult humans who have had prior abdominal surgery, the most common reason for a bowel obstruction is scar issue from the previous bowel operation.

Q. In general terms -- I'll ask you a question then, in general terms -- and we don't know from this because we just have this small paragraph, but in general terms, somebody was born with an omphalocele, and then maybe has some scar tissue from those surgeries as an infant and may have an obstruction later on in life --

A. Yes.

Q. -- that require more surgeries?

A. Yes. And that's what it appears this patient had. He had a bowel blockage injury, bowel obstruction at some point earlier in his life, and, according to this, it says a large amount of his small bowel removed.

So the bowel was blocked and then a large section of the small bowel had to be taken out to relive the blockage.

Q. And then would you start with "He had a right"?

A. "He had a right inguinal hernia repair and now has left inguinal hernia. He has no GI obstructive symptoms."

Q. What is "GI obstructive symptoms"?

A. I think that -- GI obstructive symptoms are just when you ask a patient do they have normal bowel movements, do they have episodes where they feel, not constipated, but actually obstructed, like he was earlier in his life.

He has no GI obstructive symptoms. To me, it just sounds like he is able to eat every day and has regular bowel movements of some sort.

Q. I'm going to ask you to turn to page 111 in Exhibit 4. It looks like this is still, if I'm correct, Doctor, under the same encounter date?

A. Yes.

Q. So I'm going to refer you to six lines down, it says, "A hernia is present." Does that concern you at all, that it says a hernia present?

A. Yes.

Q. Why is that?

A. Well, it's very vague, it's lacking in critical detail.

Q. Does it -- and what detail would you like to see in there if you were reviewing this as his doctor?

A. If you look, the entire -- that entire line says, "Abdomen," and it says, "soft, bowel sounds are normal, no distension and no mass, there is no tenderness, there is no rebound, no guarding. A hernia is present," that seems to be a very incomplete description of this patient's exam.

For instance, there is no description of what type of hernia. It could be a ventral hernia, an incisional hernia, am umbilical hernia, an inguinal hernia. It's not stated here.

The laterality is not specified. It's required by law, like, the side of the hernia is correctly identified throughout the process, specifically to prevent wrong-side surgery.

And there's also no description of any of the other scars that this patient presumably has after having had an omphalocele and then explorative laparotomy with resection of a large amount of his bowel.

So according to this, it sounds like he has a normal abdomen with a hernia somewhere. I think that's a misrepresentation of what the patient's abdomen really looked like.

MS. DAEHNKE: I'm going to object. It lacks foundation and object to the term "misrepresentation."

HEARING OFFICER HALSTEAD: Mr. White?

MR. WHITE: All right. I can try to lay a better foundation if that's -- I think I did, but --

HEARING OFFICER HALSTEAD: Well, you don't have to, you can just respond to to me.

MR. WHITE: Ms. Halstead, is it foundation as far as this isn't a record of what happened?

HEARING OFFICER HALSTEAD: You said "foundation" and?

MS. DAEHNKE: I object to the term "misrepresentation" of what this patient's bowel looked like.

MR. WHITE: I was actually going to get to that anyway.

HEARING OFFICER HALSTEAD: Well, I'm overruling the objection.

BY MR. WHITE:

Q. Now, below it, it says "left inguinal

hernia," does that -- under "Assessment Plan," is that suitable?

A. I suppose it depends on who it would be suitable for. These notes are written for insurance companies, legal reasons, and communication. As far as whether or not that is appropriate or adequate, I guess, it's marginal.

Yeah, left inguinal hernia could certainly be the diagnosis at the end of the visit.

Q. Okay.

MS. DAEHNKE: I'm sorry, Doctor. Did you say "marginal"?

THE WITNESS: Yes.

MS. DAEHNKE: Thank you.

BY MR. WHITE:

Q. Without actually going in and looking, how would Dr. Barber know about any kind of scarring that she may encounter with this patient?

A. Well, there's no way to know with a hundred percent certainty what is going on inside. Instead, we have learned over the years which things tend to correlate with a large amount of scar tissue inside.

So one way you could, I suppose, help define what's going on is get a CAT scan, although

you don't tend to see any adhesive scarring when you get a CAT scan.

Q. You don't see that?

A. No.

Q. What would see that?

A. Really, the only way to see is to look with a laparoscope or with just doing an open incision and look with your own eyes. Take the patient to surgery and look with a laparoscope or with your own eyes.

It is the only way to really know what it looks like in there.

Q. When you do an open surgery on something like this versus --

A. Sorry. Let me clarify.

With regard to adhesive, to scarring, so if you're looking for scarring, the CAT scan doesn't tell you. The only way to find out is to look inside with your eyes. The CAT scan does give you some other information about anatomy, where prior staple lines are, et cetera, so it does give you some anatomy but does not give you very much information about scarring.

Q. Okay. You mentioned a word, "adhesion"; right?

A. Yes.
Q. Can you tell us what that means?
A. Adhesion is sometimes used synonymously with the scarring process we're talking about. Adhesions are -- they're usually little bands of tissue or sheets of connective tissue that fuse the bowel together abnormally to all kinds of things.
Adhesions can be between different loops of bowel, it could be to the blood supply to the bowel, it could be to the liver, female organs in the pelvis, it could be kind of all over. It could get stuck to everything.
Q. Before we come back to this page, we're going to mark that -- we're going to come back to 111 -- actually turn to page 109 in the same exhibit.
Do you see where it says "Surgical History"?
A. Yes.
Q. Can we go through that just quickly?
A. Sure. It says --
MS. DAEHNKE: Can we identify for the record what record you're looking at?
HEARING OFFICER HALSTEAD: He did. Exhibit 4, page 109.

THE WITNESS: About three quarters of the way down, it says "Surgical History."

MS. DAEHNKE: I have it. It's just -- it's a different document.

HEARING OFFICER HALSTEAD: It's the same document. What are you talking about? Look in that binder.

MS. DAEHNKE: Got it.

BY MR. WHITE:

Q. We talked about this before. It looks like right hernia repair at some point. We don't have a year?

A. Yes.

Q. Okay. And then --

A. "Omphalocele repair"?

Q. Yeah.

A. It says, "Omphalocele repair occurred at birth, required multiple surgeries."

And then the next bullet point is, "Small intestine surgery around 30 years of age, two-thirds moved."

Q. Is that a lot, two thirds removed?

A. Yes.

Q. What could be a result -- what could that result in for that patient?

A. Well, it depends on which two-thirds were removed and how the patient was able to deal with it.

One of the concerns that he would get by removing two-thirds of the bowel, as the primary purpose of the bowel is to absorb nutrients, is that you would not be able to absorb enough nutrients, and that can be anything from simple calories to vitamins and mineral.

And so you can encounter situations after two-thirds of the bowel has been removed where patients have nutritional deficiencies of all sorts because of the surgery they have had.

Q. Do different parts of bowel absorb different nutrients and vitamins?

A. Yes. Very much so, yes.

Q. Do you -- would -- this is just a question, I'm kind of curious, and it's also pretty important for this case, but would one-third of that -- would the remaining one-third eventually work as the whole bowel, would it --

A. It might.

Q. Does it actually start doing that on its own?

A. On some people it does, and then other

people, the can, for instance, absorb all the calories they need, but they can't get certain vitamins.

For instance, if you removed the last part of the ileum, patients tend to have trouble absorbing fat-soluble vitamins, A, D, and K, so you have to take special considerations when you specifically remove that part of the intestine to make sure the patient does not become deficient in those specific vitamins. That is just an example.

Q. How would you find out what -- if Dr. Barber and you don't know, you see there's two-thirds removed, how would you found out about that? Could you do a blood test?

A. Yeah. Generally we would run some blood work to measure the levels of these nutrients in question to see if the patient is getting through what they already have or if they need a supplementation.

Q. Now, in your experience and education and based on that, would removing two-thirds of someone's bowel, would that result in scar tissue in the abdomen?

A. It might. Again, there's no way to tell how much scar tissue is there without looking

inside.

But, thinking logically, we have a patient who had had multiple surgeries at birth to repair the omphalocele, had a small bowel obstruction, which we assume came from adhesive scar tissue about 30 years ago, and so in my mind, it would be logical that this patient is forming a considerable amount of scar disease -- scar tissue after he has surgery, which is a normal process, that's what most people do.

Q. Okay. And those could result in, like you said, adhesions, which would be some of the organs might be now attached to the abdominal wall through that scar tissue?

A. Yes.

Q. And you said it's a normal process. If you have had these kinds of surgeries, this is probably a normal result?

A. Yes.

Q. I want to make sure we're all clear.

Does -- have you ever seen or read anything where scar tissue has disappeared in somebody like this patient?

A. It does happen where you operate on a patient and they have quite a bit of scar tissue.

And then as it reorganizes over time, a period of weeks to months to years, that the scar tissue can kind of just fade away. It's not very common, once you got that pattern.

But you can have scar tissue that changes over time, yes. But generally once it's there, the patient tends to form adhesions with scars, so you know it's going to be there.

Q. Back to page 111, please, same exhibit, Exhibit 4.

We talked a little bit about -- it says "left inguinal hernia," I'm looking at, now, the "Assessment/Plan" part of page.

A. Yes.

Q. "Left inguinal hernia" is stated. We talked about that. It says, "Acquired short bowel syndrome."

Maybe you can explain that to us.

A. Yes. Acquired short bowel syndrome is a bit of what we were talking about before where a patient has something happen to them, something happens at the time of birth or they have a car crash, for instance, and have to have a large amount of their bowel removed.

But "acquired" means something happened to

them to have -- to result in this. And short bowel syndrome is a kind of a broad term for poor absorption of various nutrients due to the short length of the bowel that's remaining.

And short bowel syndrome can vary from protein calorie malnutrition, not able to get enough calories in, to just simple vitamin deficiencies, but it is a very serious diagnosis.

Q. Then skipping down, it says, "After review, schedule laparoscopic, possible open LIH repair."

Do you see that?

A. Yes.

Q. Okay. So does that tell you that there was -- was there contemplation of a possible open left inguinal hernia repair?

A. It appears, yes, according to the phrasing. Yes.

Q. Okay. And why would you do an open instead of a laparoscope?

A. Well, there's --

Q. Why would you do that?

A. -- there are lots of surgeons that do open operations, and that's a good operation and it's been done for a long time with really good results

when it's done well.

There are some measurable benefits, I think, to doing it laparoscopically, specifically -- well, I actually think the laparoscopic approach is probably a better repair overall.

Sorry. Was there another question?

Q. No. That's okay. I just asked: What would be the reason to contemplate an open left inguinal hernia repair versus laparoscopic?

A. Number one, if you can't do laparoscopic surgery. Number two, if the patient has had a lot of previous abdominal operations, then a laparoscopic operation is less attractive as an option.

The more operations, the more prior events that can cause scarring than a patient has, the more difficult it tends to be to do laparoscopic procedures subsequently.

And so you would consider, if you saw someone who maybe had -- you didn't think you were going to be able to access the abdomen and see laparoscopically, you might just do an open operation.

Q. Okay. And you had said that you might not be able to see and access laparoscopically. Why

would that be, what would happen?

A. Well, as we talked about when I described a laparoscopic procedure, we initially insert a small needle and then inflate the abdominal cavity with carbon dioxide. The goal of that is to move the intraabdominal wall up, away from the bowels, away from the spine, and it creates space that is not normally there, so there's a big area space.

In a patient who has not had abdomen surgery, generally speaking, the bowel is not stuck to the abdominal wall. The abdominal wall comes up freely and you're able to look around with a camera, 360 degrees, and see all of the abdominal organs.

If you have adhesive scar tissue, that can be more difficult. The reason being is if there's scar tissue from the bowel to the abdominal wall, when you try to create the space by insufflating, or inflating the abdomen with carbon dioxide, the bowel is stuck to the abdominal wall and therefore also comes up, and the potential space that you were trying to make into a real space is not -- is very difficult to work in. There is bowel and scar tissue in your line of sight such that often the operation is impossible or very difficult.

That's the main reason. And if you had

good laparoscopic skills that you would do an open repair because you wouldn't be able to see and safely perform the operation using a laparoscope because of their scar tissue.

HEARING OFFICER HALSTEAD: Mr. White, I just want to clarify for the rule of exclusion that other people have come in that are not going to be called as witnesses?

MR. WHITE: They are not. They are colleagues here, coworkers, both attorneys.

HEARING OFFICER HALSTEAD: I want to note that for the record.

MR. WHITE: They are just observing.

BY MR. WHITE:

Q. Next line down, it says, "Will start Juven for short bowel to maximize healing."

Explain that sentence to us, what is Juven and how could it help to maximize healing?

A. Juven is a nutritional supplement and sometimes can be very helpful to people with short bowel syndrome. And the concept of maximizing healing has to do with when we're going to do an operation, we have to cut tissues, dissect tissues, and so we want to make sure that, nutritionally, the patient is optimal so they are able to heal from the

operation that we do.

I think that's where the rationale for starting the Juven is to make sure the patient had all the vitamins and minerals he would need to heal from the operation when the time came for it.

Q. Okay. Normally, how long does a patient need to be taking Juven as a supplement before doing the surgery? If you know.

A. We don't really know because -- in this case, it's not a terrible idea, but we're not specifically treating one vitamin deficiency or another, and we haven't quantified or qualified the allegation of short gut syndrome.

You would not be able to tell based on the studies that had been done how long this patient would need to be on Juven for to maximize healing. There were no beginning -- there were no start points, no middle points, and no end points set for this treatment modality. It's just kind of nutritional supplement because of prior problems, so we don't know how long this patient would need to be on Juven to see some benefit.

Q. While we're on this record, I'll submit that it starts on page 104, it starts on page 108, and we're on the last page, page 111. We've gone

through 108, 109, and then we've just gone through some of 111 here too, most of it.

As a doctor in Nevada, you know that it's required to have timely, legible, accurate, and complete records; correct?

A. Yes.

Q. Do you consider this an accurate and complete record that would help you, as a doctor, know what is going on with this patient?

A. No.

Q. Why is that? And I know probably already commented on this a little bit, but if you could just kind of give us some bullet points.

What else would you put here if this was your patient?

A. Well, I think, the first thing I would have done in regards to the exam, we talked about it, the abdominal exam was probably prepopulated by one of the EMRs, but it doesn't sound like the patient had all -- for instance, you could have probably said: Abdomen is soft, non-tender, non-distended, has a well-healed midline scar, it has a reducible left inguinal hernia.

So you asked if this was complete and the answer is no, that that description of the abdomen,

the abdominal description is incomplete. It doesn't address the laterality, the type, or the reducibility of the hernia, all of which are generally commented on prior to repair.

Q. Would you also include in here that there -- and I want to make sure that we understand it -- you don't know you until you go in there with a laparoscope, we've already established that in questioning, but would you include in here that there could be some scar tissue based on his history?

A. Yes.

Q. I want to skip over now to page 115, which takes us to a new date, I think.

It's titled an "Operative Report," what does that mean?

A. Operative report is a, usually, verbal description by the surgeon of the important parts of the operation, and it's done after the operation is finished.

The operative report contains some elements that are required for billing, some that are required for quality, and some that are required for communication.

Q. Communication to who?

A. To any other healthcare professionals who may subsequently need this information to take care of their patient.

Q. So continuation of care?

A. Yes.

Q. We've established that surgery -- well, actually, I don't think we did. I don't want to jump ahead.

What surgery did Patient A have or was supposed to have?

A. Well, they are two questions. The patient was supposed to have a laparoscopic left inguinal hernia repair, and the patient had laparoscopy converted to laparotomy with repair of small bowel.

Q. You're on 115 there?

A. Yes.

Q. Okay.

I'm going to ask you just a pretty general question here, do you see any explanation in this operative note that gives us a reason for Dr. Barber's decision to do it laparoscopically versus open?

A. No. That would generally be -- in an operative note, that information is generally provided in the "indications" subheading, that

subheading is absent from this operative note.

Q. But it would normally be in here, indications?

A. Many surgeons, right after it says, "Estimated blood loss, 200cc," there would be somewhere that said: Indications for operation.

And maybe describe very simply or in a more complicated case in more detail what the indications for the operation were. It's not in every operative note, but it is in a lot of operative notes.

Q. Can you tell from this operative note if there were -- if CO2 was used?

A. No, it's not mentioned in here.

Q. Would that normally be a part of a complete medical record? Would you put that in there?

A. I would certainly say that the patient's abdomen was insufflated. Whether you tell them it was CO2 or not, the act of blowing air into the peritoneal cavity, the abdomen cavity is generally dictated, but it's also understood by other surgeons who would read this, that we tend to insufflated with CO2.

We don't always name it. We just say the

abdomen was insufflated to 15 millimeters of pressure.

Q. Fifteen millimeters, is that the space that you're talking about?

A. That's the standard pressure that we use to get the abdominal wall to come away from the bowels.

Q. Okay. Just for understanding purposes, when you say there is a space in there, how much are we talking about? Space to work in?

A. Yeah, it depends. It really depends on how elastic the patient's abdominal wall is. It's very hard to quantify how much additional space that you get.

Q. If you can't answer that, it's okay.

It would be different in every patient?

A. It would be different in every patient.

In a native abdomen with no scar tissue, the bowels are down, the abdominal wall is up, and you move around with the amount of freedom that you learned during training to safely see the structures and do the operation. It's not a lot of room, but it's not -- yeah.

Q. There's also, as you can see here, about a third of the way down in this paragraph under

"Procedure Description," do you see the words "No visualization"?

A. Yes.

Q. It comes after, it says, "A five-millimeter Optiview Trocar was advanced to the abdominal cavity."

What is that, is that the camera?

A. Yes and no. The Trocar itself, this five-millimeter Optiview Trocar is probably a thin, plastic tube that is quite durable that you can insert the end of the camera through, and it has a point on the end and you twist it as you go through the layers of the abdominal wall and you hope to be able to see the layers separate in the correct sequence, and at the end of your maneuver, you're hoping to be in a safe, open area in the peritoneal cavity with which you can work.

Q. Can you tell from this procedure description where the -- which side they were -- which side was being used to go into?

A. It looks like they started on to right side.

Q. Okay.

A. Subcutaneous tissue in the patient's right lower quadrant, yes.

And they were not able to see and --

Q. Is that what "no visualization" means?

A. Yes. No visualization means they couldn't see what they were doing.

It says, "No visualization could be seen and previous Trocar was removed and identical procedure was done."

Q. Identical procedure, do we know if Dr. Barber went in from the same area on the right or did she go in from the left?

A. Unfortunately, we do not know from the verbiage what was done.

But what I infer from that, being a surgeon, is that being unable to get good visualization on the right side, they moved to the left side.

Q. Okay. And I know we've beaten this up, but why is there no visualization?

A. In this patient, it is almost definitely because of a large amount of intraabdominal scar tissue, some scarring between the abdominal wall and the bowel. The bowel was tented up into the field of view and stuck there.

Q. When you say "tented up," the bowel is actually attached to the abdominal wall?

A. Yes. Through its adhesions, its connections, the scar tissue to the abdominal wall, it is tented up with the abdominal wall so the space you are trying to create is not there. The bowel that has come up with the abdominal wall is in the way.

Q. At that point, are you just pushing a camera into scar tissue?

A. No.

Q. Where is the camera?

A. The camera is usually perched at the only safe place you can see. We don't advance the camera unless we can safely see. We don't work at all until we can safely see.

And so a lot of times if you get in and you can't see anything, you pull -- we pull the whole system out and go to another spot or convert to another operation in order do something else.

If you get in and you're not able to see at all, usually we just take it straight out because it's not safe to work in the abdomen if you can't see.

Q. Okay. So it looks like started on to right side then moved to the left.

A. Yes.

Q. And then -- okay. What is midline -- and can you see where it says, "The midline was then tried"?

A. Yes. That sentence says, "The patient's left lower quadrant was the exact site of result," which is confusing give me, "the midline was then tried."

Q. Explain to us what that means.

A. To me, that sentence means that the left side also was full of a lot of scar tissue, and so now instead of trying the right side or the left side, an attempt was made to enter the abdomen through the midline.

That's right down the center from through where your bellybutton goes, it could be above or below it, but that's the line right in the middle of your abdomen.

Q. You kind of answered what my next question was, you said "above or below." You wouldn't go in through the bellybutton, you'd go in either above or below it with the Trocar?

A. You may go in the umbilicus, at the bellybutton here. But the pertinent part of this is the midline is where we do open operations through. If this patient has had an omphalocele, that, by

definition, means his midline muscle layer was not closed at the birth. He also had an exploratory laparotomy 30 years ago, that operation is done through the midline and closed through the midline.

The reason I tell you that is because the most common place for the scar tissue to form is in the midline where the operations were done.

Q. You would have had -- you don't do operations like he had, omphalocele, on the left or the right side, do you?

A. No.

Q. Always in the midline?

A. Always in the midline.

Q. And you had just said and I want to clarify, so you're going to have scar tissue from those procedures?

A. You are most likely to have scar tissue from those procedures in the midline.

Q. And so is -- would it be not highly recommended to go into the midline with a laparoscope?

A. I think that given that there was a large amount of scar tissue on the two previous attempts to gain access to the abdomen, going in the midline is not a good idea.

Q. Had this been your patient and you had seen the -- you had the no-visualization when you went in from the right side, what would you have done at that point?

A. Well, it's little bit difficult because I can't tell how much scar issue was there, it's not described, it just says "No visualization could be seen."

To me, "no visualization" means a large amount of scar tissue, and I would have at that point converted to an open left inguinal hernia repair.

Q. As you stated sort of at the beginning of your testimony, that involves -- does that involve going right to the spot of the hernia?

A. Yes.

Q. The bulge?

A. Yes.

Q. And doing an operation openly?

A. Yes. There's no more laparoscopic involvement at that point. You abandoned laparoscopy and just switch to an open hernia repair.

That's what I would have done.

Q. Would you say that, Doctor, that at least

as far as going in from the right side and realizing you had no visualization, that was probably the right thing to do, that was okay to at least make an attempt, laparoscopically, the first try?

A. I do think so. As I said, sometimes the patients don't form any scar tissue or they don't form it in the place that you're going to be working, so it's very reasonable to offer laparoscopy and start by trying laparoscopy.

It's very discouraging to see that much scar tissue on the first attempt. It's even further discouraging to see non-visualization on a second attempt to open. And it is ill-advised to then try and go in a third time through the area that is most likely to have bowel stuck to abdominal wall.

Q. Okay. Is it your opinion that -- well, let's get to it.

What does end up happening in this scenario? Does the hernia get repaired?

A. No.

Q. What happens?

A. When the attempted entry was done at the midline, it says, "There was suspicion of entering through the small bowel."

The surgeon thought she may have poked or

made a hole in the bowel at this -- or an attempt in the midline. So it says, "so mini laparotomy was done usually." Usually that means they drop the laparoscopic stuff and make an incision six inches or so in the midline right over where the Trocar, where the needle went in where they think the hole in the bowel is. Mini laparotomy was done.

And it says, "Small bowel injury was confirmed." So there was evidence that a hole had been made in the bowel.

Q. Let me just stop you for a second. As a doctor, you would be able to see that?

A. Not always. And depending on how big the instrument was she poked it with, you can't always see it. But usually you see green stuff or red stuff and you know that you've made a mistake, there's been a small bowel injury.

"The laparotomy was continued up and a great deal of bleeding occurred when opening the tissue." To me, that sounds like the omentum and the scar tissue are densely adherent to the abdominal wall, and they are having trouble getting in just to move the fascia and epigastrium. This is common after those operations.

Q. After -- not the operation we're talking

about, after the ones he's had as a baby and as a young man?

A. Correct, as a baby. Thank you for clarifying. Yes.

Q. Okay.

A. They control the bleeding. We did -- "Easily it had" -- that's not important. "The small bowel was grasped with a Babcock and placed adhesions around this to free up blank conformity. Again, the patient did very easily."

Q. What does that mean?

A. I don't -- you don't really know because it's not clearly written.

But it sounds like the injury was located, it was visualized with their eyes, they were able to grab it with a little grasper called a "Babcock," and then they were able to free up the scar tissue around this piece of bowel where the injury had occurred.

Q. What's an Endo GIA stapling device?

A. Part of the reason it's so difficult to read is because it is nearly unintelligible. It doesn't make sense in English and there are missing words and it's hard to piece in.

MS. DAEHNKE: Object. Nonresponsive.

HEARING OFFICER HALSTEAD: There's been an objection as to nonresponsive.

What was the question?

MR. WHITE: I asked him what is an Endo GIA stapling device, and he said it was difficult to understand what that is because --

THE WITNESS: I can answer that question.

BY MR. WHITE:

Q. Okay.

A. An Endo GIA stapling device is a small stapling device that we often use to connect two pieces of bowel.

It goes in through the Trocar, usually, and then it has two jaws that open up and you close them on the tissues and then when you fire the stapler, it staples the two pieces of bowel together and makes a loop in between them.

It can be used for a variety of things, but it's a small stapling device we use to staple and repair bowel.

BY MR. WHITE:

Q. Just a question, is there another way to secure the parts of the bowel back together besides stapling?

A. Yes.

Q. How is that?
A. With sutures.
Q. Okay. Which one is more common?
A. I can't say that one is necessarily more common. Now, the choice of how to repair each small bowel injury depends on what the small bowel injury looks like.

Usually when you have a small bowel injury after laparoscopy and there's a lot of adhesions, you have signed yourself up for a couple hours of open operation, freeing up the bowel, being very careful about where everything is, isolating the injury, and then either removing that piece of bowel with a stapling device or repairing it with a stapling device or with sutures.

I can't tell what was done in this case.
Q. I was just going to ask you that because do you know from this whether it was removed or repaired with the stapling? We know it was a stapling device, it looks like, but do you know whether it was removed or repaired?
A. It says "it was reinforced," it says, "it was closed," so it does not appear as though the bowel was removed.
Q. Okay.

A. Usually we have -- we're holding a clamp with tissue it in and we're able to slide the stapling device onto the bowel underneath the clamp.

But the problem we have with that is there's no description of how this was done. If that type of repair was done and done incorrectly, you can very easily narrow the bowel. And narrowing the bowel in this scenario can very easily lead to breakdown of that staple line and leakage of bowel contents into the abdomen.

Q. That's because it's narrowed?

A. If you do narrow it when you do that, you have to take special measures not to narrow the bowel when you repair it with a stapling device.

Q. Can that be seen with your own eyes, whether it's narrow?

A. It could be, potentially. But usually we test it with our fingers and the movement of air and fluid through the repair, the anastomosis. It's unknown if that was done here.

Q. You just mentioned a word, "anastomosis," what is that?

A. It's when you take two ends of bowel that are not connected and you connect them.

This patient did not have an anastomosis.

There was a hole in the bowel, and that hole was just simply cut off with a staple line to close the hole.

Q. Okay. What -- why are there blanks in this -- if you know, why would there be blanks, there's blank lines where there's the word?

A. The general reason for blanks in dictation like this is we dictate this into a phone to a dictation service, somebody who is paid then reads our dictation and types this into a note. They listen to our dictation and they type this up and it becomes part of the medical record. They type it for us.

If you say words that the transcriptionist cannot understand, they will often leave a blank and put a time signature where the blank was, where they heard it, that they couldn't hear what the word was, they couldn't understand it.

The blanks are almost always because the transcriptionist could not understand what the transcriptioner was saying.

Q. So would be fair to say that 2:01 on the first blank means that it's two minutes and one second into this transcription?

A. Yes. Usually that is what that means, two

minutes and one second of the transcription, I could not understand this word.

Q. The next one is at 2:07?

A. Yes.

Q. Okay. So there is a service that does this and then do they send it back to doctor, like, would you get --

A. Yes.

Q. -- they would send back to you to review?

A. Yes. When they are finished with it, it is a preliminary copy and must be signed either electronically or physically by the surgeon. It's the surgeon's note, but somebody else is doing the transcription of it.

Q. Okay. And so if you turn to page 116 right behind it, we don't know -- excuse me.

We don't maybe know what Dr. Barber's signature looks like, but we do have a signature line that says "Annabel Barber, M.D." and it's signed; is that correct?

A. Yes.

Q. Okay. So that would be -- normally that would be done after reviewing this operative report?

A. Yes.

Q. You'd sign it?

A. Normally this, it's kind of in the computer, you would read it, and then you would make corrections and sign it. If you don't need to make corrections, then you would just sign it.

Q. Normally -- well, whose responsibility is it to fill those gaps where there is just a space of line there?

A. That's the surgeon's responsibility.

Q. Okay. How would that be done? Would you call that service back and say, hey, this is what I said at that point, could you please insert it?

A. You could -- in modern days, the dictation goes straight into the computer, and so you have access to the text, you are able to just go in and edit it.

Q. Okay. You can go in and it edit yourself?

A. Yes. This dictation would come up as a preliminary operative note. Before you signed it, you would go through and fix these little things so it made sense to anyone who is going to read it.

Q. Okay.

HEARING OFFICER HALSTEAD: Mr. White, I'm sorry to interrupt you. How much longer do you have?

MR. WHITE: 15, 20 minutes, half hour

tops.

HEARING OFFICER HALSTEAD: Let's take a little break now.

Q. Okay.

HEARING OFFICER HALSTEAD: The time is 10:16, let's come back at 10:30.

(Recess from 10:16 A.M. to 10:30 A.M.)

HEARING OFFICER HALSTEAD: We're back on the record in case number 23-11660-1, In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D. Dr. Spoerke remains on direct examination.

I remind you that you remain under oath.

Mr. White?

MR. WHITE: Thank you.

BY MR. WHITE:

Q. I believe we are on page 115. Okay.

MR. WHITE: Where did we leave off?

HEARING OFFICER HALSTEAD: We left off at Exhibit 4, page 116, and you were talking about the signature after the correction of the notes by the surgeon.

MR. WHITE: Thank you.

BY MR. WHITE:

Q. I might have already asked this question,

Dr. Spoerke, but if -- would you have signed this operative report as it is, as it sits in here in this binder as an exhibit?

A. No.

Q. What would you have done?

A. I would have gone back through and read what had been transcribed and made sure it was correct and legible -- correct, accurate, and legible.

Q. And is this a complete record that would be helpful for another provider later on down the road?

A. No.

Q. So it's not complete either?

A. That is the main issue, it's not complete. And, yeah -- no, sorry, it's not complete record.

Q. I want to touch a little bit on the perforated bowel. We already establish that the bowel was perforated because it's in this operative report.

Is it a common complication of -- in a surgery that Dr. Barber attempted?

A. I guess "common" is a difficult word. It is probably the most common complication, but it is not common to have this complication.

Q. What is your estimation of the chances of this happening?

A. Well, again, it depends a little bit on what the patient's status is. I think in a patient who has never had bowel surgery, the chances of having a small bowel injury when entering are extremely low, probably less than one percent.

Q. When you say "entering," entering laparoscopically?

A. Entering the abdomen laparoscopically, yes. It would be very low, less than one percent.

Now, that number goes up the more scar tissue the patients have, and then kind of by extrapolation because we can't see the scar tissue, by the number of abdominal operations that a patient has had, generally they have more scar tissue, and generally that risk of having a small bowel injury and blindly entering the abdomen goes up considerably.

Q. I'm going ask you a question, I think we have probably already talked about this but just to complete it all, you had just said it's perforating the bowel, as it happened here, is more likely in a patient such as Patient A here?

A. Correct.

Q. Is that a combination of not being able to visualize what is in there and that the bowel is probably -- there was an adhesion and the bowel was stuck to the abdominal wall?

A. Yes.

Q. That's kind of a compound question. I'm sorry.

A. It is. Both of those are true. You're at a higher risk of injuring the bowel upon blind entry into the abdomen, that's the first thing, and then even if you're operating laparoscopically and there is significant scar tissue that you're working around, you also have a higher risk of damaging the bowel.

Q. Is it because what I just said?

A. Because of the previous scar tissue and adhesions.

Q. And just for clarification, in a patient that didn't have what we estimate the scar tissue that this patient had, the bowel would be down below, you would have a clear working area to get to -- most likely a clear working area to get to the left inguinal hernia --

A. Correct.

Q. -- to operate on that.

But in this case, probably had -- and it's just an estimation, I know, but probably had -- the bowel was attached to the abdominal wall?

A. Yes.

I guess I can go off of the operative note. There's a little bit of scar tissue which we would describe as there were some adhesive bands connecting the mid and small bowel to the midline abdominal wall, which I was able to take down safely with scissors.

This says, "No visualization could be seen," which in most surgeon's minds, that means there is a significant burden of scar tissue. A Significant amount of scar tissue.

We know and we -- we know that it was not safe to perform the operation through the right lower quadrant incision or the left lower quadrant incision because note that the surgeon moved to a third location.

If you can see where you're working, you stay there. If you can't see, then it's not safe, you move to another location.

I assume that it was not safe after entering on the right, it was not safe after entering on the left, so a third choice was made,

and that was in the midline.

Q. I think we already established this, but -- so what are the chances that if you can't see from the left -- from the right or the left and you have a patient such as this, Patient A, who had omphalocele and two-thirds of his bowel removed, what are the chances that the midline is going to be nice and clear for visualization?

A. It seems very hard to put a number on it. But what we can say is that the chances of having those adhesions is significantly increased compared to a patient who has not had that operation or those operations.

Q. To kind of clarify, you had said before that it was probably okay to go in from that right side, first side, laparoscopically?

A. Yes.

Q. You, in your opinion, have no problem with that and getting an idea of what you're looking at, and that's a good way to find out what you're looking at; is that correct?

A. Yes.

Q. A good way to find out if there's some scar tissue is going in there laparoscopically, at least trying it once?

A. Yes. And sometimes you can get in and safely work and everything goes perfectly. And sometimes it's very scarred and you're not able to work safely in the space you were hoping to create.

Q. Do you -- have you ever seen it in your own practice where you went in from one side, did you try and go in from the other side?

A. Yes.

Q. You have.

Have you ever seen it where it's pretty clear from the other side?

A. Yes, I have. I've seen times when they've got significant formation from -- from the right side, for instance, from their gallbladder, but we're able to still get in and leave those adhesions around and operate in a different part of the abdomen.

So, yes, sometimes you can get in.

Q. So maybe even going in from the left, after seeing nothing the right, going in from the left was also possibly a -- was that a good idea?

A. I don't think so, no.

I think that, given the patient's prior surgical history and the described no visualization from the right side upon laparoscopic attempts, that

I would have switched to an open operation at that point. It's very unlikely, not being able to see anything at all from the right, that there will be no scar tissue on the left and the operation would be able to be performed safely.

And I guess I will add on to that, that entry into the abdomen is done three times during this operation. Each time that it's done, it's done blindly, we can't see what is on the other side of the muscle that we are poking a needle through.

If a patient has never had abdominal surgery, we think it's still safe to poke that needle through the abdominal wall because we don't think the bowel is stuck there. But in a patient who has multiple bowel operations, that's exactly why we don't do it.

Q. Don't do what?

A. Don't do laparoscopic surgery.

Q. Laparoscopic. Okay.

Now, is there -- maybe this would help all of us laypersons. Is there a sequence of events that happens when you go in laparoscopically? And I guess my question would be do you first look in there and then you start poking around with needles?

A. It depends on how the laparoscopy is

obtained. Some folks poke a Veress needle blindly with a protective cap on it.

In this case, they are using an OptiProbe, which is kind of designed to see as you go in. You can see the colors of the tissue layers as you go, and if you get into the right cavity, you can generally see with that. But you don't have perfect visualization before -- or I guess any time you do a laparoscopic operation. Before you open up that last layer of fascia, you don't ever get to see the laparoscopy and what's underneath.

All of the described methods still carry a risk of injury in the bowel, including the OptiProbe or Optiview.

Q. Would you say that the -- there's more of a chance of injuring the bowel in this patient versus somebody who hadn't had prior surgeries?

A. Yes.

Q. The definition of malpractice is failure of a -- and this is just the -- not a statute, it's a regulation, NAC 630.040. It says, "The failure of a physician in treating a patient to use their reasonable care, skill, or knowledge ordinarily used under similar circumstances."

Would you say that at least going in from

the left side after no visualization and then going in the midline with the laparoscope, would you define that as malpractice?

A. Yes.

Q. Could you turn to 115 once more?

A. Sure.

Q. Can you tell from this report, this operative report, would you be able to tell how the bowel was operated on by Dr. Barber?

A. No.

Q. Why is that? What is it missing? If you can --

A. It's missing some key descriptors about how the bowel was closed. The operative report says, "Was grasped with Babcock clamps and the tissue below the Babcocks was closed using Endo GIA stapling device. This was reinforced using 3-0 Vicryl interrupted sutures."

As a surgeon, there are some key questions here: How big was the injury to the small bowel? How big in actual size, half a centimeter, a millimeter?

The OptiProbe that was presumably being used is larger than a Veress needle, so the size of the injury would be important here. The relative

location of the injury in relation to the blood supply of the bowel is also an important piece of this information because it helps you understand how to appropriately close and repair this injury.

And what is not described is how the stapler was laid, how the stapler was fired, the orientation of the bowel, the inspection subsequently to make sure that it was not narrowed. None of those details are included, so I'm not able to tell any of the details about how this was closed, just that it was closed with an Endo GIA stapling device.

And this becomes relevant because the repair failed.

Q. Yeah, we're going to get to that right now, actually. I'm going to have you turn to page 15, Exhibit 1.

Just for the record and for clarification, the surgery for the left inguinal hernia, he was there for that on February 22nd of 2019, as designated in NSBME 115 that we were just on, the operative report.

And then I want you to look at the date here, procedure for this is -- what date do you see as far as the procedure, at least the first date

there on page 115?

A. It says "2/25/19."

Q. So three days later?

A. Yes.

Q. And --

MS. DAEHNKE: I object to any questioning or testimony about this as it was not disclosed previously, it was questioned, and Dr. Spoerke has never testified about this (inaudible) it's new opinions.

THE REPORTER: I cannot hear you.

MS. DAEHNKE: It was not alleged in the complaint, it was not discussed during the first session of the hearing, and (inaudible).

THE REPORTER: Can you summarize that for me, Ms. Halstead, please? I couldn't really hear her.

HEARING OFFICER HALSTEAD: She says this is a new -- correct me if I'm wrong. She's saying this is a new line of questioning, and the basis for the questioning isn't premised upon an allegation in the Complaint. And she also raised concern that it wasn't addressed in the prior hearing.

MS. DAEHNKE: It's an undisclosed expert opinion that was not charged in the Complaint nor

addressed in the testimony on the first day of the hearing.

HEARING OFFICER HALSTEAD: Do you want to make a proffer about where you're going?

MR. WHITE: Yeah. It's Dr. Barber's records, it has her name next to it, and she injured the bowel because she put that in her operative report, and did the surgery to correct -- didn't -- wasn't able -- she had to -- she couldn't finish the surgery on the hernia because she had to go and repair his bowel, which she had perforated.

So three days later, he goes back to her.

HEARING OFFICER HALSTEAD: And you're tying that into that malpractice allegation?

MR. WHITE: Yeah. Well, it talks about that she injured Patient A's bowel in the Complaint on -- let's see. It says, twice, on paragraph 7 and 8 in the factual part of the Complaint.

And then Count I, malpractice, also says that it's incorporated as demonstrated by -- to the outlined facts, respondent failed to use reasonable care, skill, or knowledge.

I'll just keep going, "Ordinarily used under similar circumstances, continuing a high-risk laparoscopic surgery." Do you want me to stop?

HEARING OFFICER HALSTEAD: What I am gathering, before Ms. Daehnke responds because I can tell she's itching to do so, is that this is just a follow-up with regard to the damage alleged in the Complaint. Is that what you're getting at?

MR. WHITE: It was also -- it's that, and it's also malpractice because it wasn't --

HEARING OFFICER HALSTEAD: Okay. But Ms. Daehnke's point is that whatever was done on this date isn't part of the allegations of the malpractice claim.

MR. WHITE: Okay.

MS. DAEHNKE: Yes. Correct.

HEARING OFFICER HALSTEAD: So if you want to establish that is malpractice what she did on this date, it wasn't charged in the Complaint.

MR. WHITE: But it was because it talks about her perforating the bowel.

HEARING OFFICER HALSTEAD: Okay. When it's talking about perforating the bowel from the first surgery?

MR. WHITE: I'm sorry. Yeah, ask your question again.

HEARING OFFICER HALSTEAD: What I'm trying to establish is if you're trying to say that she did

something subsequently that was malpractice that isn't alleged in the Complaint, or if you're just tying it into the original charge of the damage that is alleged?

MR. WHITE: Definitely the original damage that was alleged, which is she perforated the bowel and then didn't -- he had to come back three days later with leakage of his bowels.

HEARING OFFICER HALSTEAD: Okay. It's -- you're trying to -- you're offering it to establish the first alleged damage that was done?

MR. WHITE: Yes. Correct.

HEARING OFFICER HALSTEAD: Okay.

Ms. Daehnke?

MS. DAEHNKE: I understand that. However, counsel just said it's also malpractice. That (inaudible) be elicited from this witness. It was not charged. The subsequent surgery was not charged as malpractice in the all the years. All the years, it wasn't elicited in the (inaudible) first hearing. It's an undisclosed opinion and it wasn't charged.

HEARING OFFICER HALSTEAD: Okay. So I'm going to -- here's the thing: I'm a lawyer and I get the arguments and I'm not a jury so I can bear it through the difference, and I've gotten censure

from judges too, so I feel your pain.

I'm going to hear it. I'm not going to hold respondent accountable for any conduct that isn't alleged in the Complaint. If it fits, then it fits, and if it doesn't, then it doesn't.

MR. WHITE: Okay. We'll just put it on the record, and that decision --

HEARING OFFICER HALSTEAD: We will. And you may continue.

MR. WHITE: Okay. Thank you.

BY MR. WHITE:

Q. What page are you on?

A. Page 115.

Q. What does it say next to -- okay. 2/25/19, it says "Barber" in parenthesis, then can you read that to us, after that it says?

A. "Exploration laparotomy with small bowel resection, negative pressure, wound dressing placement."

Q. What does that mean for us laypeople, what does "resection" mean?

A. It means the bowel was removed.

Q. Resection?

A. Resection, yeah.

Q. Okay.

A. And that may or may -- sorry, I don't have that operative note in front of me. I'm not sure if the bowel was removed at that point. I thought she was referring back to her original operation.

This is the 2/25 operation when the patient presented to Dr. Barber and at that time had an exploration laparotomy with small bowel resection.

Q. Three days later?

A. Yes, that is correct.

Q. From what you can tell, just to make this all clear, there was no resection or removal, they can be used interchangeably, February 22nd, but it looks like there was on February 25th?

A. Yes. February 25th and on March 1st of 2019.

Q. If you look at "HPI," can you read what that says there? I'll stop you when I need to.

A. It says, "Patient A is a 54-year-old male who presented two days status post-laparoscopic left" --

MS. DAEHNKE: I apologize. I need to -- I just saw something.

This is not Dr. Barber's operative report.

MR. WHITE: It's not?

MS. DAEHNKE: No, it's not.

HEARING OFFICER HALSTEAD: I want to make sure that you're looking at the same thing.

MS. DAEHNKE: Well, it's not what's --

HEARING OFFICER HALSTEAD: Is this what you're looking at (indicating)?

MS. DAEHNKE: It's exactly. Yes.

HEARING OFFICER HALSTEAD: Is it NSBME 15?

MS. DAEHNKE: Yes.

HEARING OFFICER HALSTEAD: It's an admitted exhibit and he's reading it, so your objection is just how he characterized it?

MS. DAEHNKE: How both characterized it, yes, as Dr. Barber's surgery and Dr. Barber's dictation. This is not Dr. Barber's words. It's a discharge summary from somebody --

HEARING OFFICER HALSTEAD: Well, you can address that in cross-examination.

Go ahead, Mr. White.

MR. WHITE: Thank you.

BY MR. WHITE:

Q. I think you read, "Two days post laparoscopic," I think?

A. Yes.

Q. You can start over. Patient A.

A. It says, "Brief HPI. Patient A is a 54-year-old male who presented two days status post-laparoscopic left inguinal hernia repair that was aborted due to extensive adhesive, diseases, and subsequent enterotomy."

Q. Okay. So there was adhesive according to this?

A. Yes.

Q. And subsequent enterotomy, what is enterotomy?

A. An enterotomy is, technically, a cutting of the bowel. In this case it means the injury to the bowel.

Q. And then he arrived complaining, go ahead.

A. "He arrived complaining of abdominal pain, nausea. The patient was found to have fecal material leaking from midline wound."

Q. Midline would be what, what would that be caused by?

A. The midline wound in this case would be the midline -- mini laparotomy that Dr. Barber made on the initial operation.

Q. Okay. And what could be one of the causes of fecal matter coming out of that wound?

A. Well, there's really only one of two

things that can cause fecal matter to come out of your wound. There's a hole in the bowel somewhere.

Q. Still?

A. Still. Or again.

Q. Okay. When this says "leaking," it's coming out of his -- if he was wearing clothes, it would get on his clothes?

A. Yes.

Q. Okay. After that, it says, "After adequate"?

A. "After adequate resuscitation, patient was taken to the operating room for an exploratory laparotomy. He was admitted to the general surgery service."

Q. Was that -- what do you -- can you tell why he had to be resuscitated from this note?

A. No, not from --

Q. What does that mean?

A. Resuscitated, usually, is what we refer to as from somebody gets sick from trama, appendicitis, from all kinds of things, then tend to get a bit dehydrated and a lot of their energy gets expended. Resuscitation is a process where before we undertake a number of interventions on a patient, we make sure that they have antibiotics, that they have adequate

IV fluid resuscitation, we do all the medical parts of taking care of a patient before we take them to surgery.

Q. What could happen to a patient -- what could be the results or the effects of having fecal matter leaking from a wound?

A. Well, there's number of effects, and some, I think reasonably obvious, but nobody wants to have stool leaking out of their anterior abdominal wall. It smells bad, that's the first thing, it's uncomfortable, it requires a lot of care and dressing changes. It can also be quite dangerous.

The fecal material coming out of the skin is the last part of the process that came from a hole in the bowel somewhere inside the abdomen and the stool is leaking out, the stool and all of the bacteria are leaking out in the abdominal cavity, and that can make you very sick because bacteria can cause infection, it could cause you to die, it can cause you to not be able to eat.

Anytime food goes past where the hole is, the output from the hole goes up, we have to take your food away, so most people are unable to eat until they get at least the output volume classified and is treated in some way.

MS. DAEHNKE: Objection. Lacks foundation, calls for speculation, it's undisclosed expert opinion, it's irrelevant to the charges in the Complaint.

HEARING OFFICER HALSTEAD: Do you want to respond, Mr. White?

MR. WHITE: I -- it's the same patients that had the -- I think we can see the course of events. It's relevant because it -- Patient A was in for a left inguinal hernia surgery and had to go to the hospital because of having his bowel punctured by Dr. Barber. Then he has to go back because it's leaking fecal matter.

I mean, the relevancy is right there. I can't remember her other ones, her other objections at the moment. What were the other objections?

HEARING OFFICER HALSTEAD: Relevance, undisclosed expert testimony.

MS. DAEHNKE: Foundation, hearsay, not charged in the Complaint.

MR. WHITE: Okay. Well, foundation and undisclosed, I think we already established that I think you are just going to listen to this and then give it its weight, depending on whether you decide if it was charged correctly in the Complaint. I

think we can at least make a record as to what happened here.

He is only opining to what he's reading from the medical records, which I know Ms. Daehnke has said that this isn't her medical record, except I'm looking at names all over this thing that say -- I'm looking at, just the top of this page, it says "Barber" six times on the top of page 15.

It says, "Admitting physician, Annabel E. Barber, M.D. Discharge physician Annabel E. Barber, M.D." It looks like he was there from 2/25 to 3/5 of 2019. All of those say "Barber" next to it.

I don't see where it can't be -- that it's not relevant or that we haven't made -- it's just a medical record. There's -- by the way, there's also a -- I don't have it in front of me, but there is an exception for medical records. They are -- purport to be -- this wasn't made in preparation for this hearing, these medical records that came from what happened to this patient at the time, and they were formulated then.

Dr. Barber's name is all over it, and I think Dr. Spoerke can speak to, as someone who has done many surgeries like this, to what he sees on this page.

HEARING OFFICER HALSTEAD: The objection's overruled. The exhibit's already in the record. He is an expert and he's explaining it, and I don't think that's beyond the scope.

MS. DAEHNKE: Well, there's been no foundation.

HEARING OFFICER HALSTEAD: He's the expert and this is a record.

Go ahead, you can continue, Mr. White.

MR. WHITE: Thank you.

HEARING OFFICER HALSTEAD: And just for the record, and I know that you heard, but I just want to make sure that it's there for the record that Ms. Daehnke -- was a little bit out of turn, but just to make sure that it's on the record that she maintains her objection to as hearsay, and I'm assuming the other list of her objections.

MS. DAEHNKE: Including that this was not discussed anywhere.

MR. WHITE: Well, this is certainly a medical record.

HEARING OFFICER HALSTEAD: I've already overruled. We don't need to go back and forth.

MR. WHITE: Got it. Okay.

BY MR. WHITE:

Q. Do you see where it says "Hospital course"?

A. Yes.

Q. What, if anything, happened after -- I guess we don't know what day it happened. Can you tell me what day things happened of note in this hospital course? I mean, I see one date there, March 5th.

A. Yeah. It looks like the last operation. From what I can tell from this discharge summary is that the first re-operation -- so the patient had the laparoscopic aborted hernia repair with the enterotomy and was discharged home.

The next encounter, according to this discharge summary, was on 2/25/19. But the patient -- as I recall, the patient was seen in the clinic once between -- the patient was seen in the outpatient clinic by Dr. Barber once between the original operation and this 2/25/19 operation.

But as far as I can tell from this, the patient was readmitted on 2/25/19, had an exploratory laparotomy with removal of a piece of small bowel because of stool leaking out of his wound. This negative pressure is something they

commonly use in this scenario so we don't close the abdomen, we leave it open because we know we're going right back.

Q. Okay. And you wouldn't discharge them either?

A. No, no, no. They stay in the hospital with this.

Did go back, two days later, which is common, had washed everything out and changed the vacuum dressing. It looks like there was a return to the operating room on 3/1/19, I guess a leap year, I can't tell with that -- it was two days later or four days later.

There was another exploratory laparotomy, another small bowel removal, and another negative pressure wound dressing placed.

And then the last operation, I can see where Dr. Barber was on 3/5/2019, which was just an abdominal washout, closure, which means fascial closure of the muscle, and then placement of the small wound back in the skin and subcutaneous tissues.

Q. You had mentioned discharged home after his first bowel surgery?

A. Yes.

Q. On February 22nd?
A. Yes.
Q. Does that concern you at all that he was in there for hernia surgery, bowel was perforated, operated on, and then discharged?
A. It does, yeah.
Q. What concerns you about that?
A. Well, I guess there's a few things. It's becoming more and more popular in these surgery centers to operate on someone's bowel, do an anastomosis, and send them home the same day.

But I think given the things that have gone on with this patient, it would have been a better idea to admit him, at least for the night, and make sure that he's feeling a way -- feeling okay, he's tolerating his diet well, and to have a frank discussion with him, once he woke up from anesthesia, about what went on.

Q. Take him from the surgery center, does that mean take him from the surgery center -- or have him taken from the surgery center and admitted to the hospital?
A. Yes, that would be -- I think that would be well advised in the situation. Admit a patient like this to the hospital after this original

operation.

MS. DAEHNKE: Your Honor, I have to object again. This is a further undisclosed opinion. It was not charged it was inappropriate to discharge this patient. It's never been mentioned in the Complaint. This is entirely new, completely new opinion that it was inappropriate to discharge the patient.

HEARING OFFICER HALSTEAD: Mr. White?

MR. WHITE: Let me go back to the Complaint.

It is included in there. Paragraph 10 says, "Respondent didn't enclose the incision and discharged patient without having repaired Patient A's left inguinal hernia. There was no documentation of the injury in the operative note, which was unintelligibly written."

Again, we go to -- it's incorporated by the legal language in paragraph 12, it says, "demonstrated but not limited to the above outlines facts, respondent failed to use reasonable care."

HEARING OFFICER HALSTEAD: "In making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair hernia on a patient that has an

extensive surgical history and surgical scarring in his abdomen, which is contradicted by medical literature."

MS. DAEHNKE: Exactly.

HEARING OFFICER HALSTEAD: So I don't see that there's an allegation about the discharge being a basis for the malpractice. I see that it was noted that he was discharged, but it's not charged as a basis of malpractice.

MR. WHITE: As a basis for malpractice. Okay.

MS. DAEHNKE: I move to strike all that testimony.

HEARING OFFICER HALSTEAD: I won't consider it for purposes of the malpractice claim. As far as it just being history or information, that's fine, but it's not a basis for a malpractice claim.

MR. WHITE: Okay. I withdraw it.

I'm really sorry this is taking so long, everybody. I'm trying to make it cohesive to the prior testimony.

HEARING OFFICER HALSTEAD: I'm really glad that you're taking it slow because I wasn't here for the prior proceeding. There's no need to apologize

for that.

MR. WHITE: Can we take about a five- or ten-minute break? What I'm doing, I'm going to go through some of the old testimony and just make sure we hit everything.

HEARING OFFICER HALSTEAD: You don't need to explain. That's fine.

It's 11:17, we'll come back at 11:30.

(Recess from 11:17 A.M. to 11:25 A.M.)

HEARING OFFICER HALSTEAD: We are back on the record in case number 23-11660-1, In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D.

We were at direct examination of Dr. Spoerke by IC counsel, Mr. White. Mr. White asked for a break.

Dr. Spoerke, I just remind you that you remain under oath.

BY MR. WHITE:

Q. I'd like you to turn to page 107, Exhibit 4. What is this we're looking at?

A. This is dated 2/22/19, it's a history and physical physician operative note.

In layman's terms, most insurance companies require an updated, accurate history and

physical exam within 30 days of the operation. And so if the clinic visit is more than 30 days before the operation, this form is used to act and to fill that requirement for a history and physical within 30 days of the operation.

Q. Is this done prior to operation?

A. This is usually done the morning of the operation in the pre-operative area, or the same day of.

Q. It looks like it is signed by the doctor at the bottom there?

A. Yes.

Q. If you look at "Physical Examination" on the left side of the page, what is -- and specifically under "Abdomen," what does "WNL" stand for?

A. Within normal limits.

Q. Would this patient be considered within normal limits in his abdomen?

A. No.

Q. Why is that?

A. Because he's had multiple prior abdomen operations that would have scars on his abdomen.

Q. So what should that have -- what would you change if this was your record?

A. Well, I would -- I tend not to use these because they are so brief and they tend to lack much of the detail that becomes important for the reasons we've talked about earlier, for the billing purposes, the communication purposes, and the legal purposes. This tends to be inadequate.

It can be adequate if you take your time with it.

But, among other things, I would change the description of the abdominal exam. I would un-click within normal limits and write: Well-healed midline scar, if that was present, reducible or non-reducible left inguinal hernia.

That would be more accurate, more complete.

Q. Okay. Thank you, Doctor.

Since we talked about it at the last hearing date last year, is different kinds of laparoscopic repair, I think there are multiple versions of it, can you just take us through those really quickly? I have extraperitoneal and transabdominal. What are those?

A. Humans are put together with various layers as we're fetuses, and these tend to be important later in life because they form the basis

for the planes that we're able to -- the spaces in the planes that we are able to work in when we need to go and do operations.

Total extraperitoneal repair does not enter the peritoneal cavity, it stays outside of all of that, and it tends to put the mesh between the peritoneum and the abdominal wall.

An intraabdominal approach generally goes into the peritoneal cavity, and then repair is done from inside the peritoneum.

Q. Is that what we had in this situation?

A. That is what was attempted, as far as I can tell. There's no indication that it was intended to be done with an extraperitoneal approach. As far as I can tell, a standard intraperitoneal laparoscopic repair.

Q. Going back to -- what page? It's about no visualization, the operative report?

A. Yes.

Q. It is something we talked about last time, last hearing date. Yeah, it's NSBME 115.

Would you write "no visualization" if there was just a small amount of scar issue?

A. No.

Q. Okay. I'm sorry I'm jumping around. I'm

trying to clean this up.

Is there a difference in the risk of bowel perforation between doing an open surgery and a laparoscopic surgery on that one?

A. Yes.

Q. Why is that?

A. Well, I think we've figured out over the years that when -- there's a certain small amount of acceptable risk that we all encounter when we are working with our hands and we can visualize the structures, and then there's a separate amount of risk that we tend to incur when we are using a laparoscope.

In this case, because of previous scarring and, therefore, the inability to see what you are doing safely, I think there's an increase risk by trying a laparoscopic approach versus an open approach in this case.

Q. Going back to the bowel injury and then the subsequent surgery to attempt to fix it, February 22, 2019, there was some talk about going on -- I'm referring -- I'm sorry -- page 186 of the -- you don't have it in front of you. It's over there. Page 186 of the transcripts -- the hearing transcript. It's down on 11 there -- or on 10. It

just says, "So size mesenteric versus anti-mesenteric, which part of the bowel was injured."

I guess the question had to be -- I just want to clear this up too.

What was referred to there? If you can take a look at that.

A. Line 10 of page 186 is referring to a description, the normal things that we describe when we're referring to an enterotomy or injury to the bowel.

Q. And you want to know some of those things? If you go up to 1, line 1 of page 186, it talks about the relative velocity of the injury, instrument, if it was a bullet.

Would you also help us with what is duodenum, jejunum, ileum, colon, why are those important and why did we talk about those before?

A. Well, so the duodenum, jejunum, ileum -- spelled I-L-E-U-M -- colon, those are all part of your bowel. The duodenum, jejunum, ileum are your small bowel; colon and rectum are your large bowel.

As we discussed earlier, different parts of the bowel do different things. Some parts absorb water, some parts absorb sugar, some parts absorb

certain vitamins, some -- so they are all a little bit different. The bowel is not the same everywhere along its length.

And so depending on which part of the bowel is injured, that would be important, especially in a patient with short gut syndrome who may or may not have troubles absorbing nutrients before surgery.

And then relative velocity of the instrument, those are a lot of times trama, when you have a bullet or something else going into the abdomen you need to know what that is just to think in your mind how much damage was done to the tissues so that you can do the correct repair.

In this case, it was probably a relatively low velocity and relatively low size. But that's why I commented on that. Any time you do a bowel repair, unless you're doing a bowel resection for cancer where it's very routine, how you're going to do it, and there's an injury, we usually describe the injury, and the reason is so that people can understand why you did which repair you did.

And the reason we say that is so that if it falls apart, we can understand why it fell apart and not let it happen again.

Q. So your testimony is that page 115 of the operative report does not address those concerns?

A. Correct.

MR. WHITE: Pass the witness.

HEARING OFFICER HALSTEAD: Ms. Daehnke, do you want to start now or take a break for lunch?

MS. DAEHNKE: A lunch break will be great.

HEARING OFFICER HALSTEAD: Okay.

(Lunch recess from 11:37 A.M. to 12:50 P.M.)

HEARING OFFICER HALSTEAD: We're back on the record in case number 23-11660-1, In the Matter of the Charges and Complaint against Annabel Elizabeth Barber, M.D. We took a break for lunch, we have reconvened, and the time is now 12:50.

We have both counsel and respondent present, as well as Dr. Spoerke, who I remind once again is under oath.

When we took a break, Mr. White had turned the witness over, so it's now the time for cross-examination.

Ms. Daehnke?

MS. DAEHNKE: Thank you.

CROSS-EXAMINATION

BY MS. DAEHNKE:

Q. Good afternoon, Dr. Spoerke. I apologize for my voice.

A. I understand.

Q. Let me ask you a couple questions. Did you review anything in preparation for your testimony here today?

A. Yes.

Q. What did -- tell me what you reviewed.

A. I reviewed my original report. I reviewed with Don some of things we discussed that were in the transcription of the -- what had happened at the first trial that we had.

Q. Okay. You reviewed your original report and then you discussed with Don some of transcription.

Did you look at the actual transcript?

A. I was not given the transcription, but I sat with Don and we looked at it together.

Q. You reviewed it with Mr. White?

A. I reviewed parts of it with Mr. White, yes.

Q. When did you do that?

A. Couple of weeks ago.

Q. Okay. And what did you discuss with Mr. White when you were reviewing that transcript?
A. I don't recall what we talked about specifically. It was two weeks ago. I think we were trying to catch up on where we left off from the last trial so we could continue on with some fluency to the second part.
Q. All right. And where did you determine that you had left off?
A. I think we determined we left off where the transcription ends.
Q. I understood you to mean where you left off in testifying about you opinions?
A. What's the question?
Q. I'm not sure what you told me, perhaps that's why I'm not asking the right question.
You went over the transcript, parts of the transcript with Mr. White to determine where you left off. Then I said, "Where did you leave off?" And you said, "Where the transcript ends."
Is that right?
A. Yes.
Q. Okay. Let me change the way I'm asking you the questions.
In your discussions with Mr. White about

the transcript in the first session of the hearing, did you feel that you had had an opportunity to express all of your opinions during that hearing?

A. Not sure what you mean by "all of my opinions."

MR. WHITE: Objection. Vague.

THE WITNESS: All of my opinions?

BY MS. DAEHNKE:

Q. Yes. All of your opinions.

A. I certainly have lot of opinions, but I don't think -- it's a tough question. No. All of my opinions in the world were not encapsulated during the last hearing.

If you could be more specific about which opinions or which topic matter, I'd be happy to help.

Q. Sure. Let me ask you something else.

When the court reporter was asking you about the spelling of ileum, which I had told her the correct spelling earlier, and I believe you just said to her: Well, everyone knows -- will know what you mean.

Are you telling me that you just didn't know what I mean when I asked you if you had an opportunity to testify about all your opinions?

A. No. I'm telling you that your question is very confusing. Did you ask me if I had a chance to give all of my opinions at a last trial? No.

Q. All right. Your answer to me was that you have lots and lots of opinions.

Have you formulated any new opinions since the time of your testimony in June of 2024?

A. No.

Q. Did you review any medical literature from the time of your first testimony?

A. Yes.

Q. What medical literature did you review?

A. I reviewed thousands of pages of medical literature in that time period. You have to be more specific.

Q. All right. When I ask you a question like that, you don't understand -- let me ask that you consider the literature that I'm asking about to be in reference to the case, and -- Dr. Barber's case, which her license is -- her medical license is at issue here.

You understand that, right?

A. Yes.

Q. All right. So when you just answered saying that you read thousands and thousands of

pages, you were talking about generally in your practice; correct?

A. Yes. I have continuing medical education requirements. I had to recertify for both my surgical critical care and my general surgery boards. So, yes, I've done a lot of literary reviews since we last met. Yes.

And they are in all kinds of areas: surgical nutrition, general surgery, trauma, surgical critical care, ventilator management.

Q. Did you review anything relating to laparoscopic hernia repairs?

A. No, not specifically.

Q. Do you teach?

A. Presently, no. But at the time we did the original one, yes, I was an adjunct professor at UNR and taught medical students.

Q. Ever teach medical students about laparoscopic surgery?

A. Yes.

Q. Did you teach medical students about laparoscopic hernia repair?

A. Yes.

Q. And at the time when were teaching those students, if I understand your testimony, the last

time and today, you had only done five to ten laparoscopic hernia repairs in your career; is that correct?

A. Yes.

Q. As opposed to at least a hundred open hernia repairs?

A. Correct.

Q. And in any literature review that you conducted, either prior to the first hearing or today, did you come across literature that discusses that open versus laparoscopic hernia repair is something that is very contingent upon not just the patient's comorbidities but also contingent upon the skill and comfort of a surgeon?

A. Yes.

Q. And -- I mean, it's a topic that is peer reviewed and there are studies about this; correct?

A. Um-hum.

Q. And you've reviewed those?

A. I can't say I've reviewed all of them, the things you're talking about --

Q. Of course not.

A. -- but I have read quite a bit of literature about laparoscopic versus open surgery, yes.

Q. Can you think of any that you have reviewed recently?

A. I cannot list them without going home and getting the references. I'd be happy to get those for you if needed them.

Q. No, I don't. You don't need to tell me the name, maybe the author or the journal?

A. It's all at home in a stack of papers and books. Or it's online, there's some called "Selective Readings for General Surgery." We have a number of different ACGME-approved, I guess, platforms that we use for our ongoing certification and for licensing.

Q. How many articles, whether in print or online, have you read about open versus laparoscopic hernia repair?

A. Probably 30 or 40.

Q. And -- all right. With regard to the comfort level of the surgeon and the experience and skill, how does that -- what did the article say about how that factors into the decision as to whether to go open or laparoscopic?

A. I think the biggest take-home point that I took from the discussion of surgeon comfort and the choice of procedure has to do with a TEP versus a

TAPP, not whether you do it open versus laparoscopic.

All of the things being equal, if a surgeon is more comfortable doing one type of operation, we tend to think that that's probably better for the patient. With the caveat that if that operation not safe, that is not the correct operation for the patient.

Q. So are you more comfortable doing open procedures?

A. I'm equally comfortable doing open and laparoscopic procedures.

Q. And are you testifying that you're comfortable with laparoscopic hernia repairs?

A. No.

Q. You're just saying open versus closed procedures?

A. Just so the court knows, there are cholecystectomies, appendectomies, Nissen fundoplications, gastric resections. There are hundreds of procedures that could be done laparoscopically, and there are some general principles that we apply to laparoscopy versus open procedures.

While I don't do a lot of laparoscopic

inguinal hernia repairs, I do a lot of laparoscopy.

MS. DAEHNKE: I move to strike that answer as nonresponsive to any -- there was no question.

BY MS. DAEHNKE:

Q. But thank you.

A. Was there a question?

HEARING OFFICER HALSTEAD: She asked a question and then you clarified. You're supposed to answer the questions that are asked, and then if Mr. White wants to follow up and ask you the things such as you offered, he's welcome to do that.

THE WITNESS: When does he do that, at the end of her questioning?

HEARING OFFICER HALSTEAD: Yes.

BY MS. DAEHNKE:

Q. All right. At the time -- no. Let me go back.

What portions of the transcript did you review with Mr. White two weeks ago?

A. I couldn't tell you.

MR. WHITE: Objection. Asked and answered.

BY MS. DAEHNKE:

Q. You can't tell me. Do you know --

HEARING OFFICER HALSTEAD: Can you repeat

the question for me?

MS. DAEHNKE: Sure.

BY MS. DAEHNKE:

Q. What portions of the transcript did you review with Mr. White two weeks ago?

HEARING OFFICER HALSTEAD: I don't recall that specific question being asked and answered.

THE WITNESS: I don't recall exactly which parts.

BY MS. DAEHNKE:

Q. Do you recall what subjects?

A. Not specifically, no.

Q. How about generally?

A. Well, generally, we are were talking about establishing me as and a competent peer reviewer for this. We had gone through how I saw some of the errors in the medical records were obvious, some of those specific things. The crux of the case. We're trying to see what we had done so we can generally stay on that vein and keep this moving forward.

Q. Sure. Did you change any of your opinions?

A. No.

Q. Did you retract any of your opinions?

A. Isn't that the same as changing? No.

Q. And you -- I believe you did tell us you didn't formulate any new opinions?

A. Not officially. Not in a written form.

Did I have any thoughts in my head that were different than that last time? I can't say. It's been a number of months since we had that last one. I can't in good faith tell you I have not thought about the case or had any new ideas.

There are no new major developments since the last time we met, no.

Q. When you say "not in any written form," the written form that you would be referring to is your prior report?

A. Correct.

Q. That you had prior to testifying the first time?

A. Yes.

Q. And you've reviewed?

A. Yes.

Q. And you haven't produced to Dr. Barber or her counsel because it's part of IC file and it's privileged; is that correct?

A. No, that's not correct, ma'am. I'm not in charge of supplying anything. I do not do that. I did not not supply anything.

HEARING OFFICER HALSTEAD: I understand the point of your question.

MS. DAEHNKE: Thank you.

BY MS. DAEHNKE:

Q. Were you asked to prepare a new report?

A. No.

Q. Were there any areas that you recall -- and I understand you said you can't really remember two weeks ago, what you reviewed specifically. Does anything come to mind that you felt that needed to be clarified in your opinions?

A. I cannot answer that question. There are an unlimited number of things that need to be clarified, and that would be false for me to answer the question that way.

I feel like we're heading back in the same circle here. Just ask me straightforward questions, and I will give you straightforward answers.

Q. At the time that you drafted your original report, that we haven't seen, and formulated your opinions that Dr. Barber violated the Medical Practice Act, what information did you have about how many laparoscopic hernia repairs Dr. Barber had done in her career?

A. The only information I had is that she

attempted at least one in her life, based on the records I was given.

Q. And I'm presuming that you would agree that the number of laparoscopic procedures -- laparoscopic hernia repairs a surgeon has done in their career or to the time of that surgery would be an important factor in determining the comfort level of the physician?

A. It could be.

Q. But was that not important to you when you were determining whether or not Dr. Barber breached the standard of care that violated the Medical Practice Act?

MR. WHITE: Objection. Relevance.

HEARING OFFICER HALSTEAD: Yeah. I'm going to overrule that.

THE WITNESS: Can you repeat the question, please?

BY MS. DAEHNKE:

Q. Wasn't -- wouldn't it be significant to you when determining whether a physician, a surgeon, such as Dr. Barber in this case, violated the Medical Practice Act or committed medical malpractice, wouldn't that be significant, the number of laparoscopic hernia repairs that the

physician had done in their career prior to the one at issue?

A. No. Not in this case.

Q. What did you see your role in this case? How do you perceive your role in this case?

MR. WHITE: Objection as to form. And relevance.

HEARING OFFICER HALSTEAD: Go ahead.

THE WITNESS: How do I see my role in this case?

Well, I was asked by the Nevada State Board of Medical Examiners to review the case. That would be my first role, to follow to a T the instructions that they gave me with the original medical records, come to the conclusions they asked me to come do in the request, write the report in congruence with their requests, according to my best abilities and according to my best understanding of the records I was given.

Subsequent to that, since we have gone to trial, if that is what this is technically called, my understand was to be here to help adjudicate the case, to translate and help clarify the -- I guess, the all the events that happened up to this point, and then try and answer questions honestly to get to

the bottom of the matter.

And to defer -- give my best information so that this panel can make a decision about what they think should be done going forward with this case.

Q. What's your understanding of now as opposed to when you formulated your opinion that Dr. Barber breached the Medical Practice Act and committed medical malpractice. What's your understanding as to her experience now?

MR. WHITE: Objection. Vague.

BY MS. DAEHNKE:

Q. Her experience with performing laparoscopic hernia repairs?

A. I don't understand the question.

Q. What is your understanding now, as you sit there today, as to Dr. Barber's experience in performing laparoscopic hernia repairs?

A. I have only evidence that she's ever done one, attempted in her life. That's the only record I've ever read of hers.

Q. You were not provided any information about Dr. Barber's background, training, skills, experience?

A. I was given a brief outline of what her

training is. I was given no information as to her laparoscopic cases, number of cases, her skill level, any of those things. I was only provided with her very simple, basic CV, and that's it.

Q. Okay. It was her -- you were provided Dr. Barber's CV?

A. No. I was provided with very short, three-line piece of paper that told me who she was, where she went to school, et cetera.

Q. Was that provided to you by Mr. White or someone at the Board?

A. Someone at the Board, yes. It came in the original box.

Q. Oh, the box. Okay.

Doctor, I'm just trying to find out -- I mean, it's not fair to ask you -- if you weren't provided the information, you can't use it to formulate your opinion; correct?

A. If I wasn't given information, I could use that to formulate an opinion. It would be very strange. Normally we formulate opinions on information we're given, so I will would agree with you, yes.

Q. Then let me ask again.

Do you or do not agree that the experience

level, the skill and training, the number of laparoscopic hernia repairs, the comfort of the physician is an important factor in judging whether or not to do an open versus laparoscopic hernia repair, just generally?

A. Those are part of the decision, but just part.

Q. Sure. And that's also part of the literature that you read, that that's a consideration?

A. Yes.

Q. And consideration in those studies that are conducted on the subject; correct?

A. Sure.

Q. Okay. Did you ever ask Mr. White what Dr. Barber's training was?

A. I don't recall.

Q. Did you ever ask Mr. White how many laparoscopic hernia repairs Dr. Barber had done up until the time of this patient's surgery?

A. No.

Q. Have you ever operated at Las Vegas Surgery Center?

A. No.

Q. Have you ever been there?

A. No.
Q. Do you know anything about Las Vegas Surgery Center, besides from what you've reviewed in this case?
A. No.
Q. Why did you leave your former job?
A. Oh, a variety of reasons.
Q. What?
A. You want all of the reasons I left my former job?
Q. Sure.
MR. WHITE: Objection to relevance. It's not relevant at all to what we're doing and how -- he has a closed universe. I'll just --
It's a closed universe of what was given to him, and it's really the medical records we see before us today. How is it relevant why he left his job that he had for last hearing?
HEARING OFFICER HALSTEAD: Ms. Daehnke, do you want to respond?
MS. DAEHNKE: The closed universe that the Board has provided doesn't limit me on cross as to his background, what he's doing now, what he was doing before.
I mean, there could be potential -- I

agree, personal and family, it's a fair question that I always ask experts, it's just why did you leave your last job.

HEARING OFFICER HALSTEAD: I see it as a question, like, is there a reason why left your last job that would impact your qualification as to how or why you're testifying here today, that's how I take it.

THE WITNESS: I'll answer the question.

The first reason is because since I started working and I finished training, I've been working full time, somewhere between 80 and 100 hours a week. I have two daughters and wife who works full time, and I think after 12 years of practicing full time, I decided I wanted to shift to making sure I had time to prioritize my family.

My father was also getting ill, and I wanted to spend some time with him before he passed away, which happened four weeks ago.

MS. DAEHNKE: I'm sorry.

THE WITNESS: So those are the reasons. The health of family, but no professional reasons other than I was working more than I wanted to and I wanted to put more emphasis on spending time with my father before he died and time with my family before

they are out of the house.
BY MS. DAEHNKE:
Q. Great reasons.
Are you doing locums work now or what?
A. I work for Weatherby Healthcare, yes.
Q. In what capacity?
A. I guess I have a work contract with them.
Q. Let me ask you about -- you were talking about the short H and P and the operative note as being necessary because one needs to be completed within 30 days of the procedure; is that correct?
A. That's according to most insurance companies, yes. And, therefore, most hospitals also have that policy.
Q. Sure.
A. Or surgery centers.
Q. Sure. The exhibit, just for the record, because it's in multiple places, what I'm referring to is the H and P, physician operative note, it's also post-op orders and discharge note. It's NSBME 107. It's also Barber 71, same one-page document. It was referenced by Mr. White a couple times, Exhibit 1, page 107.
Let me ask you, I think you said you don't like to use these forms; is that right?

A. Correct.
Q. And there's not enough -- a lot of room on these forms, is there?
A. No.
Q. So this -- my understanding, if you look at this, the left side looks like it's for a short H and P, a short history and physical; is that correct?
A. It appears to be, yes.
Q. On the right side, it looks like a brief op note on the top?
A. Correct.
Q. And then post-op orders, it says, "See orders sheet." And then it's also meant to be a short discharge note, it looks like; is that correct?
A. Appears so, yes.
Q. And then it looks like also follow-up, there's follow-up orders and medications; is that correct?
A. Yes.
Q. Okay. Then -- so, yeah, this seems -- this, in the records that were produced by Las Vegas Surgery Center, the sequential record of 108 and actually the Board produced to us as part of the

case, the records that's attached right after that, 108 through 111, is the lengthier history and physical that was done December 27th.

Is that what you see in your records too?

A. Yes.

Q. So the lengthier history and physical that you went over with Mr. White earlier today would be attached to this brief H and P, brief op note, and post-op in the record?

A. It often is not. The only history and physical operative record is the short form for a lot of cases.

Q. But in this case it is?

A. In this case, yes.

Q. And that's a good thing; right?

A. Yeah. Usually, yeah.

Q. Let me just say, I appreciate sometimes my questions are not specific enough and sometimes you're trying to provide additional information for everyone, and you did the same thing with Mr. White. I'll try and ask you appropriate follow-up and bring it back to this case. In this case, you agree this is a good thing.

There's a short op note, a brief op note, a brief H and P, with a full H and P attached?

A. No. I think this is a bad thing.
Q. Oh, it's a bad thing.
A. I think that they take a bad thing and improve it slightly by putting the original H and P, but this is a bad thing.
Q. And you're talking about the bad thing, the bad, bad thing being this document on 107?
A. I'm talking about two things: This document and what it allows and, two, how it has been filled out in this case.
Q. I understand your opinion.
And you have never worked at Las Vegas Surgery Center?
A. Correct.
Q. Do you work at ambulatory surgery centers?
A. Not for four or fiver years, but I have, yes.
Q. You've worked at ambulatory surgery centers through AICs?
A. Surgery Center of Reno, I have, yes.
Q. What --
A. Surgery Center of Reno, we have an outpatient that's part of the inpatient at Renown where I worked a number of cases.
Yes, I've worked at a number of surgery

centers. Some are attached to hospitals; some are not.

Q. And did the ambulatory surgery centers have these type of forms?

A. Generally, yes.

Q. And are -- you said your understanding is that, according to administrative code, these are mandatory for ambulatory surgery centers?

A. My understand is that a complete history and physical is required within 30 days of the procedure. The form that these choose is not.

Q. The form that the ambulatory surgery center chooses is not?

A. Correct.

Q. But you have seen these before?

A. I have.

Q. And at least this document in itself, without your criticisms of the way it's filled out, would meet the administrative code for ambulatory surgery centers?

A. Only if they are filled out completely, legibly, and accurately.

Q. Are you familiar with the code, the Nevada administrative code relative to ambulatory surgery centers?

A. No.
Q. With regard to the specific H and P, you are critical of the description of the hernia?
MR. WHITE: I'm -- not really an objection. Clarify which page we're talking about?
MS. DAEHNKE: The same page.
MR. WHITE: 107. Okay.
THE WITNESS: Am I critical?
BY MS. DAEHNKE:
Q. No. What are your specific criticisms, and I was -- understood it was the description.
A. Thank you.
I think I said among other things, I would change the description of the abdominal -- if I were to redo this, if I were to fill this sheet out, I would do a number of things differently on it, personally.
Q. Okay. What are those things?
A. I think, first, I would start off being more legible, the handwriting is difficult. I would be more complete with things such as short bowel and anemic, it often should have an additional level of explanation. I don't think --
Q. Hold on. Sorry.
Overall, you would be more legible?

A. More legible.
Q. And then the next is more specific?
A. More specific. And more complete.
Q. Okay. So now you are going to give me the example of being more legible and more specific and more complete?
A. Absolutely.
Q. All right. You said short bowel and anemic. You would add more to review of systems?
A. I have to tell you, short bowel and anemic are not review of systems. Short bowel, according to the previous note, is a diagnosis, it's a medical problem. It's in the wrong section. It should be under past medical history.
Q. You'd agree there is no room under past medical history for short bowel and anemic?
A. I would not agree. The handwriting is too large, there's certainly room to put that in there if you write smaller and more legibly.
Q. Doctor, you're looking at the same document that I am?
A. I sure am.
And I fill these out all time. If there's more things to write, you write small and clearly. That's important.

Q. Doctor, you said you don't use these, so you don't fill these things out?

A. I have filled out hundreds of these in my life, and you have to be very careful with them.

Q. Okay. So then now your criticisms include not writing small enough, which --

A. No. I didn't say not writing small enough. You asked --

MR. WHITE: Objection. Argumentative.

THE WITNESS: -- if there was enough room and I said there is enough room if you write more -- smaller and neat.

HEARING OFFICER HALSTEAD: So when there's an objection, I need to rule on that.

THE WITNESS: Sorry.

HEARING OFFICER HALSTEAD: That's okay.

And I would have allowed you to answer that, which you have already answered it. I think the reason it's drawing an argumentative tone is because -- argumentative objection is because of the tone.

BY MS. DAEHNKE:

Q. All right. Short bowel and anemic are in the wrong place?

A. Correct. Short bowel syndrome and anemia

should be in the past medical history.

Q. And what else are you critical of -- or what else would you have done if you were filling this out?

A. Under the physical examination, I would have written: No acute distress. Well developed, well nourished -- if that was true. Pupils equally round and reacted to light under the H-E-N-T. Chest and lungs would have been C-T-A, cleared to auscultation bilaterally. Heart would have regular rate and rhythm. Abdomen would have been -- if appropriate -- soft and non-tender, non-distended. Well-healed midline scar. Reducible, non-tender left inguinal hernia. GU and pelvic, would not have written T-E-S-T-S plus, plus. I would have written both testes are present within the scrotum.

Q. Let me stop you there. You understand what that means; correct? I'm sorry, my voice is going. You understand what testes and an arrow down means?

A. Are those arrows, are those pluses?

Q. Well, you just interpreted it mean both testes are descended.

A. No. I said testes plus, plus, which means both testes are in the scrotum.

We are not allowed to use these abbreviations, according to JCAHO, specifically for this reason.

Plus, plus and down, down is not allowed anywhere any medical record.

Q. Wow.

A. Yeah.

Q. Yeah. JCAHO doesn't allow --

MR. WHITE: Objection. Argumentive.

BY MS. DAEHNKE:

Q. JCAHO doesn't allow --

MR. WHITE: Is that a question?

THE WITNESS: Definitely does not allow --

BY MS. DAEHNKE:

Q. But yet you knew what --

HEARING OFFICER HALSTEAD: There was an objection.

MR. WHITE: I don't know what the narrative is going -- where this is going, but the exclamation of "wow," is --

HEARING OFFICER HALSTEAD: I'm talking. Let's just stick to questions and -- stick to questions, I guess I'll just leave it at that. Not commentary is where I was going with that.

BY MS. DAEHNKE:

Q. The information that you were just telling me that you would have put on this form, would you be using this document as short H and P and a short op note? Would you be using it as it's intended here, or would you be using it in lieu of a more formal H and P? I'm just trying to get why you would have included all of that information in here.

A. The reason I include that is because the requirement is a full, standalone H and P is completed within 30 days.

Furthermore, in this case it had been almost two months since the patient was seen in the office and day of the operation. In a 54-year-old man over approximately a two-month period, things can happen in their lives and change.

And so I think that with that time period to be elapsed, that this form should have been much more thorough, and it appears as it has not been done very thoroughly.

Q. Have you spoken to Patient A?

A. No.

Q. And you have no information, you have -- still to this day, you have no information as to Dr. Barber's experience, training, or skill or the

number of surgeries --

MR. WHITE: Objection. Asked and answered?

MS. DAEHNKE: I'm providing a brief foundation. Can I finish?

HEARING OFFICER HALSTEAD: Yes, you can finish.

BY MS. DAEHNKE:

Q. -- the number of closed laparoscopic procedures or what discussions she had with Patient A --

MR. WHITE: Objection. Compound.

HEARING OFFICER HALSTEAD: Go ahead and finish your question. If the witness can't answer it, he'll let us know.

MS. DAEHNKE: It's hard when Mr. White has now objected twice.

BY MS. DAEHNKE:

Q. -- and you don't know what conversations Dr. Barber had with Patient A prior to surgery; is that correct?

A. This is a little bit like Jeopardy. You really have to ask me a question because you keep making statements.

HEARING OFFICER HALSTEAD: Okay. All

right. There -- let's -- I don't -- I just want us to ask questions and answer. I don't want us to get in a position where we're being combative about how people are answering or asking questions.

I believe the first part of the question was a preface, and I'll take it that way. I don't know if you meant it that way, that's how I take it.

And so the second part of the question was -- frankly, I don't recall.

MS. DAEHNKE: I will withdraw and ask a different question.

BY MS. DAEHNKE:

Q. Doctor, do you have any information as to what conversations Dr. Barber had with Patient A prior to the surgery?

A. Yes.

Q. What information?

A. I have the information provided in the medical records.

Q. What information do you have about discussions that Dr. Barber had with Patient A prior to the surgery?

A. The same, just what's provided here in the medical records.

Q. You have not discussed it, but you saw

that patient signed an informed consent for the procedure; correct?

A. Yes.

Q. Are you -- is your opinion that the mistake, the description of what you would have on this brief op note and H and P, what you just said, you would have put -- is it your opinion that the standard of care would require any surgeon to enter all that information in this type of form?

A. No.

Q. Is it your opinion that that is what you do, which may be above the standard of care or your customary practice?

A. No. I do what I think is appropriate.

Q. And so -- I'm sorry. My voice cracks and sounds funny at different times, and I'm not trying to mean anything by what's happening here. I'm just trying to figure out if your opinion is this what you would do, and, in your opinion, I'm sure you believe you meet the standard of care or exceed the standard of care.

Is that a fair statement?

A. Yes.

Q. So I'm trying to discern from what you believe the standard of care and the Medical

Practice Act requires any information put on this form.

Does that question make sense?

A. Not exactly -- yeah, not exactly.

Q. Okay. I'm going to repeat a little bit for the framework.

You told us what you would put on this form (indicating)?

A. Right.

Q. Okay. What I'm trying to say is -- and what I think you told me is this is what you would do, but that's not necessarily required to meet the standard of care?

A. No, I don't agree with you.

Q. All right.

A. I can explain if you'd like, or clarify.

Q. All right. So then now from what you just said, I understand that everything that you testified to that you would put on this form is what you believe is required by the standard of care for any surgeon to put on this form, to enter on this form?

A. That's a statement, ma'am. Please ask me a question.

HEARING OFFICER HALSTEAD: She is asking

if you agree with that.

THE WITNESS: Say the whole thing again.

HEARING OFFICER HALSTEAD: This is what I am understanding the question is: The way that you testified you would fill out this form -- and correct me if I'm wrong -- is it your opinion that is the standard of care of how the form should have filled out?

THE WITNESS: No. What I'm trying to get at is there are components listed on here that have been decided by other agencies that are required as the minimum. My assertion is that it is the standard of care for each surgeon to completely and accurately fill this form out before they operate on patients.

In my opinion, that wasn't done here.

HEARING OFFICER HALSTEAD: Okay. And that is based on -- and so -- I don't mean to tie that, I'm just trying to, with your voice, get past this.

MS. DAEHNKE: I appreciate that, Your Honor.

HEARING OFFICER HALSTEAD: If the way you said that you would have filled it out, do you feel that was the way it should have been filled out to meet the standard of care?

THE WITNESS: Yes. My way, someone else's way, but significantly more than as such here.

HEARING OFFICER HALSTEAD: Thank you.

Does that address your question? You're welcome to follow up.

BY MS. DAEHNKE:

Q. I'm trying to make sure I understand. The way -- you are testifying that what you have told us you would put in this form is required for any surgeon who fills out this form to do in order to meet the standard of care?

A. No.

MR. WHITE: Objection. Asked and answered. And also foundation --

MS. DAEHNKE: He just said "No."

HEARING OFFICER HALSTEAD: Yeah. Go ahead.

MR. WHITE: -- also it's also -- now you're just narrating for us.

HEARING OFFICER HALSTEAD: Go ahead. Reask the question and allow the witness to answer the question.

That's overruled, the objection's overrulled.

BY MS. DAEHNKE:

Q. You said, "No."

Doctor, I believe you were just going to repeat my question. Can I ask you, what was your understanding of my question that you answered no to?

A. I think you were trying to ask if my standard of care is the same standard of care that all surgeons should be held to in filling out this form, and my answer was no.

But a higher standard of care than is demonstrated in this medical record. There's a million different ways to fill it out well, this is not one of them. It does not have to be my way, but it needs to be a higher level of standards than such as stated in this medical record.

Q. When you're saying "this medical record," you're talking about exhibit 107?

A. Correct.

MR. WHITE: Can I clarify, page 107, Exhibit 4?

MS. DAEHNKE: Yes.

BY MS. DAEHNKE:

Q. Doctor, the information that you indicated that you would put on this form you would agree is

found in the lengthy H and P?

MR. WHITE: Objection. Misstates evidence and misquotes the witness.

HEARING OFFICER HALSTEAD: She's just asking if he agrees or not. He can disagree. She's allowed to lead on cross.

THE WITNESS: Sorry. This is important. Can you ask again what it was?

HEARING OFFICER HALSTEAD: Let me take a stab, if I may, and you can correct me, shake your head or whatever.

I believe the question was: The information that you believe is missing and should be on page 107 of Exhibit 4 is -- and I'm just rephrasing the question, I'm not agreeing or disagreeing with it -- located in what is Exhibit 4, pages 108 through 111, would you agree or disagree?

THE WITNESS: Disagree very strongly.

MS. DAEHNKE: Thank you.

HEARING OFFICER HALSTEAD: Did I phrase that --

MS. DAEHNKE: Yes.

THE WITNESS: Just to clarify, the information that needs to be referred to from this page to the multiple-page history of the H and P is

not on the other H and P.

BY MS. DAEHNKE:

Q. I think you switched that.

A. The information is not on, anywhere, in either of the H and Ps.

So if you're using the short form history and physical to refer back to the full history and physical for completeness, the full history and physical that is being referred to is also incomplete.

Q. Okay. In what ways, in your opinion?

A. Well, as --

HEARING OFFICER HALSTEAD: Let's just take a break so you can catch your breath, because I think the court reporter is having trouble recording you.

Let's just put a pin in that question and come back at 1:50. It's 1:40 now.

(Recess from 1:40 P.M. to 1:51 P.M.)

HEARING OFFICER HALSTEAD: We took a break and now we're back on the record in case number 23-11660-1, In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D. We're in the mist of cross-examination of Dr. Spoerke by Ms. Daehnke.

Doctor, I remind you you remain under oath.

You may continue with this witness.

MS. DAEHNKE: Thank you, Hearing Officer. I have no further questions for this witness.

HEARING OFFICER HALSTEAD: Redirect, Mr. White?

MR. WHITE: Yes, thank you. Okay.

REDIRECT EXAMINATION

BY MR. WHITE:

Q. Dr. Spoerke, Ms. Daehnke asked you did you review anything regarding laparoscopic hernia repairs.

It's kind of a general question, do you ever stop learning and reading things about your profession and your practice?

A. Well, no, you're not allowed to. It's -- there's continuing medical education that's required for hospital recertification and for licensing.

So the short answer is no, we have educational requirements ongoing throughout our careers.

Q. Okay. And even if you're not trying to do your requirements for your CMEs, continuing medical education, do you still just sometimes find yourself

reading articles that are interesting that have to do with your profession?

A. Yes.

Q. You had mentioned before, I think, is there a thing called "SAGES" or something like that, short for something?

A. Yes. It's a strange acronym, but it's Society for -- I don't remember.

Q. General surgery?

A. No. It's Advance General -- I don't remember what SAGES stands for. SAGES is kind of the parent body -- or one of the parent bodies for a lot of the laparoscopic, kind of the laparoscopic industry. SAGES helps with all things laparoscopic. They help offer guidelines, they help offer recommendations, publish studies. They do all sorts of things.

Q. Do they have anything to do with ongoing certification and licensing?

A. I think they do.

Q. Okay. Not positive?

A. No.

Q. Not super important, but okay.

A. Not for general surgeons and not for trauma surgeons and not for surgical repair.

Q. Okay. Oh, so it's mainly for laparoscopic?

A. Yes. It would be for -- general surgeons, yes. It would be for something, laparoscopy or endoscopy, specific.

Q. You were also questioned about -- it kind of seemed to important -- that you had only done five to ten laparoscopic hernia surgeries.

Do you recall that?

A. Yes.

Q. But you've done laparoscopic surgeries hundreds of times or for other ailments or other procedures?

A. Yes.

Q. And you mentioned some of those. I didn't get a chance to write them all down, it was pretty fast.

What were they?

A. I've done lots of laparoscopic (inaudible), lots of laparoscopic appendectomies, laparoscopic gastrostomies to placements of laparoscopic stomach repairs, laparoscopic small bowel repairs, laparoscopic ulcer repairs.

Q. Okay. That's a good enough list so far.

And do those other procedures still

require your consternation with regards to whether they might have scar tissue like with this patient?

A. Yes.

Q. Would you be concerned with the amount of scar tissue that may possibly be in there going in laparoscopically on any of those other procedures you just mentioned?

A. For this patient?

Q. Yes.

A. Yes.

Q. Okay. You were asked before, a question before -- and I may get it wrong so I apologize in advance -- what is sent to you as far as when you're asked to do a peer review. Would you couch it in terms of that we are asking you to find malpractice, or are we just asking you to find what happened under the definition of malpractice?

In other words, are we asking you to find malpractice on a case?

A. No. The specific instructions are to do the latter of the two things. You review the case and determine whether malpractice was there, not to find malpractice.

Q. Take a look at the case, review it, apply the definition of malpractice, and, voila, you

decide whether or not it's there?

A. Yes.

Q. You also had a question about whether we provided you with Dr. Barber's CV, I think you said no; is that correct?

A. I don't ever recall seeing her full CV. I do recall seeing just, like I said, a few lines at the top of one page that says where she went to medical school and residency, things like that.

Q. So you could probably look that up on the website?

A. Yes. It's public information.

Q. Yeah.

And I represented, in fact, that we didn't even have Dr. Barber's CV, as far as I know, back then. I could be wrong. But not being an investigator, we don't have it. I think it was provided by Dr. Barber or by the opposing counsel.

You were asked a lot about how much experience Dr. Barber has and whether you knew how much experience she has in doing those surgeries, the vast experience she has.

Do you recall that?

A. Yes.

Q. Okay. My question to you is would you --

with the experience that Dr. Barber has, would you expect a doctor with that experience to abort the laparoscopy in this instance, this case, at some point when you have no visualization and do an open instead of laparoscopically?

A. Yes.

Q. If you look at pages 107, which was talked about extensively just now, the short history, and then 108 through 111, do you have any way to confirm if those pages actually were attached together at the time this patient was undergoing these procedures?

A. No.

Q. So is it possible that you could end up just with page 107 --

A. Yes.

Q. -- in your possession to figure out what is going on?

A. Yes. The other reason is I think that is because, usually, if there's a H and P stapled to it, you write: Please see H and P dated 2/27.

Q. Where would you write that?

A. Anywhere on the form, but specifically on the history of present illness.

Q. So it would actually refer them to the

other pages we talked about, 108 through 111?

A. I think if you were planning on doing this in very shorthand, with reliance on information of the other one, you should write on there that you're referring to a more complete document elsewhere.

Q. Would that be for continuity of care like we talked about earlier, whether somebody notes later on down -- it's a long question. I'm sorry. And it's not a very good. Let me rephrase it.

For continuity of care, would you want that reference on there just to help out somebody else, another provider down the line?

A. Yes.

Q. I don't think I'm familiar with JCAHO. Could you let us know what that is and why that was important during questioning by opposing counsel?

A. JCAHO is commissioned for possible accreditation in this country. And JCAHO has worked closely with the surgical residency educational programs to try and get ambiguous language out of the medical record, and the reason is to prevent medical errors and harm to patients.

And so in all -- part of your professionalism requirement as a general surgery resident in this country is that you have to learn

how to write things correctly in the chart, things that are approved and things that are not approved. Approved are words we can speak. For instance, I learned very early on in my training you can write MSN4 for morphine, you have to write morphine. With arrows and pluses, you have to actually write that. That's become a lot easier with the electronic medical record because people type much faster. But I was referring to shorthand abbreviations, a lot of those, including pluses and arrows, that we've been told repeatedly that those are not acceptable.

What usually happens is if a culture in a hospital continues to use all these abbreviations, JCAHO comes through, does a review, and then that behavior has to be changed because it's not tolerated anymore. That's what I was referring to.

Our professionalism standards as general surgeons require us to not to use unnecessary abbreviations.

Q. And, I guess, is it in an effort to make these forms more uniform in the language used? "Language" is a bad word, could be different languages, I suppose.

In the words that are used, not use abbreviations so it's understandable to everyone?

A. It's meant to clarify ambiguity. If I write all testes are present within the scrotum, you know what that means. If I write testes plus, plus, that could mean a lot of things.

There's some ambiguity with the symbols, which is why we've all been instructed to move away from that to clearer things that are safe for the patient.

Q. I'm going to read to you the definition of maintaining -- failure to maintain proper medical records. Okay? I want to take you through what we were just talking about with these medical records.

MS. DAEHNKE: Beyond the scope. And asked and answered.

HEARING OFFICER HALSTEAD: Well, it is beyond the scope of cross, but . . .

MR. WHITE: No. I was going to refer to the same exact medical records.

MS. DAEHNKE: It's asked and answered.

HEARING OFFICER HALSTEAD: Well, I don't know if he wants to clarify.

Go ahead.

BY MR. WHITE:

Q. Let me ask you this question: Earlier today when I was asking you questions about the

medical records, did you perceive those as being directly related to malpractice or to the statute of failure to maintain proper medical records, which has also been charged in this case?

A. The latter, the failure to maintain medical records.

Q. So medical records -- and I think we went over this once earlier -- they need to be timely, legible, accurate, and complete otherwise you could -- relating to the diagnosis, treatment, and care of a patient, it could constitute grounds for initiating discipline, which is what we have done, we've initiated -- at least charged it, it's alleged at this point.

And I think we already asked you this earlier, but do you see this as -- I think you already commented -- legible to you? And I'm referring to page 107 in Exhibit 4 (indicating).

MS. DAEHNKE: I can't see what you're pointing at.

MR. WHITE: Just the whole page. More or less the whole page of page 107.

THE WITNESS: It is marginally legible. It is not complete, but legible. There are multiple areas that are -- you have to assume or guess what

the author was thinking, it's not clearly written.

Q. Okay. That the whole page -- right? -- you can see some things and decipher some meanings.

A. Sure. Yeah.

Q. Would you say the symbols are also something that's not legible or complete?

A. Correct.

Q. Then turning to pages 108 through 111, overall, I'm not asking you to go through every single part of it, but in general terms maybe you can explain to us why this is -- either is or isn't -- well, actually it's legible because it's typed out, but it is or isn't complete per the statute?

MS. DAEHNKE: I'll object. It's been asked and answered.

MR. WHITE: I'm --

HEARING OFFICER HALSTEAD: Why don't you address that. Go ahead.

THE WITNESS: Yes. Specifically the description of the hernia in the abdominal section on page 111 is incomplete.

BY MR. WHITE:

Q. Okay. On page 111?

A. Yes.

Q. Okay. And also, as per earlier, did you have a problem with how the abdominal was described?

A. Yes. It's lacking a description of previous abdomen scars, which is relevant to this case, and it's lacking a description of the hernia.

Q. Are there any other parts in here that you see that you would improve upon?

A. Well, I don't mean to be overly -- I did find it a little strange that part of plan is to: Will start on Juven for short bowel to maximize healing.

But there are no --

Q. What page?

A. It's on page 111.

And it's a reasonable thing to do, but there are no nutritional markers in here listed at all. Usually if we are going to do that, we start them on Juven with, this is their diagnosis put together, malnutrition, some of nutritional deficiency, and then follow that.

It's concerning matches because it's -- there are no other end points, it's just started, but it's not commented on any of the other discharge planing or that he even has shorter bowel, and he was on TPN and he just had an infection, and short

bowel syndrome is not mentioned anywhere in that as part of the ongoing plan to maximize nutrition for what it is now a considerably worse nutritional insult than the original laparoscopic hernia repair.

A few minor points, points, nonetheless.

Q. Okay. I have nothing else. Thank you.

HEARING OFFICER HALSTEAD: Do you want to do some cross?

RECROSS-EXAMINATION

BY MS. DAEHNKE:

Q. When you were talking about page 107, this exhibit that we keep talking about, you mentioned the way it was documented violates JCAHO; is that correct?

A. I don't know it violates JCAHO, ma'am.

Q. Well, you said that.

A. No. I said that --

Q. Yep.

A. -- there are symbols on here that we are taught, as part of our professionalism training, to not use in histories and physicals.

Q. And when you testified, you said it violates JCAHO?

A. I testified -- I did not say it violates JCAHO. I said usually JCAHO does not like these.

And then when they review the hospital, the hospital gets some sort of demerit for having these sorts of symbols in their hospital's medical records. And then the hospital is, therefore, tasked with correcting the behavior of the people who are putting the symbols in the notes.

Q. You said a lot.

A. No. I said that the hospital gets a visit from JCAHO and something usually happens and the behavior has to be corrected. I was clarifying for who does the correcting for you.

Q. Okay. You -- I'm not trying to be facetious, you said that you just said that, you were clarifying for me right now?

A. Yes.

Q. Okay. All right.

And you're aware, of course, that JCAHO doesn't monitor ambulatory surgery centers?

A. I'm not aware of JCAHO's monitoring of surgery centers, no.

Q. You're not aware whether they do or not?

A. Am I aware if JCAHO follows -- you're not aware is not a question, ma'am. Please ask me a question I can answer.

HEARING OFFICER HALSTEAD: She's asking

you a question and she's asking you to agree or disagree with it.

THE WITNESS: I do not know.

BY MS. DAEHNKE:

Q. Okay. You were talking in response to Mr. White's question just now about surgical residency and JCAHO.

Have you ever taught residents?

A. Yes.

Q. When?

A. When I was a fellow. I participated in teaching people who were technically residents while at Renown Regional from 2012 to 2024.

Q. What do you mean "technically residents"?

A. Fellows.

Q. There's no residency program?

A. Right. There is a family practice residency.

So I do teach students all the time. But surgery residents, I interact with only when I was a fellow in 2011, and the fellows that I interact with Renown Regional are also in training, those are still considered residents.

Q. Are you still a member of American College of Surgeons?

A. Yes.

Q. Are you aware who the Nevada State Board (inaudible) to Board of Governors?

A. No.

Q. It's Dr. Barber.

Are aware as to any of the classes that Dr. Barber teaches at UNLV school of medicine?

A. No.

Q. Are you aware of anything about Dr. Barber besides what was provided to you in the package from the Board?

MR. WHITE: Objection. Asked and answered.

HEARING OFFICER HALSTEAD: I gave you a little leeway so I'm -- she's beyond where you were as well, I'll give you the last word, but we're going to wrap this up.

THE WITNESS: No.

MS. DAEHNKE: No further questions.

HEARING OFFICER HALSTEAD: You have the last opportunity.

MR. WHITE: Thank you.

No further questions.

HEARING OFFICER HALSTEAD: Would you like to maintain this witness or release him?

MR. WHITE: Great question. He might be coming back tomorrow because of what was determined earlier that they are allowed to sit in and watch other experts. I guess he'd be still here?

HEARING OFFICER HALSTEAD: You're maintaining him for potential rebuttal?

MR. WHITE: Are you good?

THE WITNESS: Whatever you need is fine.

MR. WHITE: Hold on. I'll be right back.

(Mr. White exited the hearing room.)

MS. DAEHNKE: What's happening?

HEARING OFFICER HALSTEAD: He's stepping out to ask a question. And we're still on the record, we have not gone off.

He hasn't excused him yet and he stepped out to ask a question and we remain on the record.

(Mr. White entered the hearing room.)

MR. WHITE: On further review, I'm going to release Dr. Spoerke.

HEARING OFFICER HALSTEAD: You are released and he's not holding you to come back for potential rebuttal. You are done.

THE WITNESS: Okay. Thanks, guys.

HEARING OFFICER HALSTEAD: Thank you for your time.

Mr. White, any other witnesses?

MR. WHITE: No. We rest.

I just want to make sure -- actually I should say before we rest, everything is in, everything is admitted, including his updated CV.

HEARING OFFICER HALSTEAD: Exhibit 1. I have Exhibit 1 through 5 as admitted, with the updated Exhibit 5.

MS. DAEHNKE: You rest?

MR. WHITE: Um-hum.

MS. DAEHNKE: Are there other -- the Hearing Officer brought up earlier, are there other documents that we're stipulating to before I start?

MR. WHITE: I think everything -- well, 1 through 5 is in. I don't know if I have any --

MS. DAEHNKE: We never had this discussion.

HEARING OFFICER HALSTEAD: Do we need to go off the record so you guys can have a discussion?

MS. DAEHNKE: Yeah.

MR. WHITE: Sure.

HEARING OFFICER HALSTEAD: Okay. It is now -- how much time do you need? It's 2:17.

MS. DAEHNKE: There's nothing interesting.

HEARING OFFICER HALSTEAD: We're still on

the record, so I don't want her to be recording all this. How much time do you need? Is 2:30 too much or too little time?

MR. WHITE: Perfect.

HEARING OFFICER HALSTEAD: It's now 2:18, we'll come back at 2:30. I anticipate you guys will discuss respondent's exhibits.

MS. DAEHNKE: Yes.

MR. WHITE: Yes.

HEARING OFFICER HALSTEAD: Thank you.

(Recess from 4:18 P.M. to 4:34 P.M.)

HEARING OFFICER HALSTEAD: We are back on the record in case number 23-11660-1, In the Matter of the Charges and Complaint Against Annabel Elizabeth Barber, M.D. Counsel are present with Dr. Barber. The IC has rested its case.

Ms. Daehnke, I understand you're going to call Dr. Barber; is that correct?

MS. DAEHNKE: Yes, that's correct.

HEARING OFFICER HALSTEAD: There was a housekeeping matter that we took care of during the break, and that is that respondent's Exhibits 1 through 13 are stipulated to and are hereby admitted. Some of them are duplicates, but rather than go through and figure them out, the parties

agree that it's just easier to leave them in that format for purposes of the hearing.

(Respondent's Exhibit 1 through 13 were admitted.)

HEARING OFFICER HALSTEAD: Dr. Barber, given you're going to testify, please raise your right hand to be sworn.

(The oath was administered.)

HEARING OFFICER HALSTEAD: We have the spelling of your name so I will forego that.

Ms. Daehnke, your witness.

MS. DAEHNKE: Thank you.

DIRECT EXAMINATION

BY MS. DAEHNKE:

Q. I would like to go through your training and experience. And we do have a copy of your CV, it's Exhibit 8. I know you don't need it, but if you would like the turn to Exhibit 8 in the binder in front of you. It was 8 to our Supplemental Prehearing Conference Statement, it's 8A.

MR. WHITE: For clarification, does that start on Barber 110?

MS. DAEHNKE: Yes. I'm using the same ones we went over at the break. 110, yes.

BY MS. DAEHNKE:

Q. Dr. Barber, what do you do for a living?

A. I'm a surgeon, a general surgeon, I teach, I do research, and I do surgery.

Q. Did you also teach at UNR?

A. Yes, I did.

Q. Tell us about --

MS. DAEHNKE: And permission to lead because of my voice.

HEARING OFFICER HALSTEAD: Do you have any objection to her leading on these preliminary background questions?

MR. WHITE: Oh, just for -- to speed things along? No, I'm fine with that.

I'll object if I see something that's --

HEARING OFFICER HALSTEAD: If it comes to an area of questioning that you prefer that she doesn't do that, just state so.

MR. WHITE: Okay.

BY MS. DAEHNKE:

Q. Dr. Barber, tell us, when did you work for UNR and then when did it become Kerkorian School of Medicine?

A. I was recruited to come and work for UNR in 1997. I kind of worked for UNR, but in Las Vegas

in 1997. I had the majority of the department of surgery in Las Vegas and eventually all of the departments of surgery for UNR Medical School in Las Vegas.

I always lived in Las Vegas since moving here from Texas. I worked for UNR in Las Vegas but from Las Vegas for years until UNLV medical school was formed. And that was formed, I believe, seven years ago. Actually ten years, officially, but the opening is about seven years.

I've had the same job and location and telephone number. I got a red patch on my coat, a blue patch on my coat, that was a big difference in my life in between UNR and UNLV.

BY MS. DAEHNKE:

Q. It was due to the restructuring?

A. Right.

Q. Tell us about that.

A. NSHE had only one medical school in the State of Nevada, and then University Nevada at Las Vegas applied and got approval to have a medical school, a separate medical school, down there, and so that separation from the UNLV and UNR. And, again, practice of medicine isn't quite like that, so we do what we do and get a different coat.

Q. And you are employed by?
A. By the State of Nevada.
Q. And NSHE is?
A. My W2 form comes from NSHE.
Q. What is that?
A. Nevada System of Higher Education.
Q. And you've been consistently employed by the university, the Nevada System of Higher Education since you came from Texas?
A. That's correct.
Q. In 1997?
A. Yes.
Q. Okay. And let me back up a little bit.
Where did you come from in Texas, what were you doing in Texas?
A. I taught for Texas Tech Medical School from 1992 to 1997, taught surgery there.
Q. And --
MR. WHITE: What was that in Texas?
THE WITNESS: Texas Tech in Lubbock, Texas.
MR. WHITE: I have an objection. I just looked over, there's notes and highlighting in this one. Is that intention of --
MS. DAEHNKE: No. That was from the last

hearing. That was supposed to be my binder.

MR. WHITE: Whose binder is that?

MS. DAEHNKE: It was my binder. Do you want to look at it?

MR. WHITE: No, I don't want to go through it and make sure everything's okay. I just -- typically we use a blank for witnesses.

HEARING OFFICER HALSTEAD: The respondent's exhibit are up there.

MS. DAEHNKE: No, they are not.

HEARING OFFICER HALSTEAD: It's one of those two up there. You can refer to that one.

THE WITNESS: Okay. Exhibit 8?

BY MS. DAEHNKE:

Q. Doctor, you were in Texas and teaching at Texas Tech?

A. Yes.

Q. Just tell us, if you would, what you taught?

A. I have training in both general surgery, cancer surgery, and trauma surgery, so all three of those at Texas Tech. I did research both in nutrition and shock and trauma, as well as in cancer, cancer things that were dealing with it.

And then when I moved to Nevada in 1997, I

still continued my research lab in trauma, but I stopped doing trauma surgery when I moved to Las Vegas because they wanted to close the trauma unit.

Q. Any they did?

A. And they did. Yes, they closed it. They only wanted -- you would either do trauma or general surgery and cancer surgery but you couldn't do both at the University of Nevada at that time.

And so that's why I stopped doing trauma then.

Q. And you did have training as a trauma surgeon before coming to Nevada?

A. Yes, I did.

Q. You just mentioned nutrition -- cancer and nutrition?

A. And trauma surgery and shock. We did how to resuscitate people with IV-fluids resuscitation. We did a lot of research and wrote a lot about that.

Q. And I want to talk about that in a minute.

What, specifically, with regard to nutrition?

A. When I was -- I did a fellowship in the middle of my residency, and it was a permanent research fellowship. At that time, we were doing a lot of both animal and human research, and nutrition

and shock, divergent education for my later practice, and then I had a fellowship from the American Cancer Society to study nutrition research, and I was able to join a lab and we were really able to actually join the two and show how that nutritional supplementation that you could mitigate some bad things from shock.

I also developed some supplementation that could help mitigate the problems, not just from hemorrhagic shock, but from infection. In animal and human models, we looked at shock in infection and really defined a lot of the physiology that was not known at that time. It came from papers from our own lab. And sort of ways we thought about shock in general.

In the past, the thought of shock is hemorrhagic shock versus septic shock is two very different physiologies, but our work showed that they were really the same thing at the end. That really changed the whole thinking of how to treat shock.

Q. When you are talking about your lab, what lab are you talking about?

A. Well, we had two labs at university in New York City. And we had studied completely shock

only, and the other studied nutrition and other permutations of nutrition. We had a number of both animals and human models of inducing shock and mitigating the horrible effects of shock with nutrition supplementation.

Q. Hemorrhagic versus septic, could you just tell us what those are?

A. Hemorrhagic shock is from bleeding from any source. We know that most in trauma, sometimes both, you have hemorrhagic shock from things that surgeons do to you. Septic shock is from infections.

Q. And so what type of nutritional supplements did you research and investigate?

A. Well, we looked at a number of different things that may help in mitigating the shock. And also we looked at, in shock, the intestine, your body shunts blood supply to various areas preferentially. When you think about the brain, your heart, the important things, so your body does -- because that's what your body does, we suffer. So it does it at the price of not getting enough blood to the intestine.

So the intestine then becomes leaky and you absorb things that you should not absorb that

can become poison, if you will, and cause shock worse and you can absorb bacteria, actually, and circulate bacteria in your blood.

So we thought that this happened, but we actually proved that it happened in both animal -- in animals and in people.

We put various tracers in people, fed them, fed animals and showed that they were absorbed into the blood and made the animals and other people sicker, or not, and in ways that were -- specifically, we looked at some, both IV nutrition, TPN, or total parenteral nutrition, giving feeds in both -- people, we do this all the time, but we had to show in animals, which was better, there are ways you can get the same amount of calories, carbohydrates, fats, and proteins as in food, the ideal diet by IV, but it doesn't work as well and we were trying to figure out why.

And those are a lot of the things were able to prove, what you did absorb -- your circulation straight through your liver, the circulation all over your body, that that's why that -- we've proved something that sort of makes sense, it's better to eat than to have all of your nutrition intravenously.

People thought that but you have to prove that it's really true. And we proved that if you were only given IV food and IV fluids and you were unable to eat that if you then got infected that you were much likely to get sicker and die than if you used your intestine for feeding, that it somehow padded, you if will.

And so we tried to look into what caused that, so that kind of was the inspiration to developing those nutritional supplements. And we looked at a lot of different supplements and we came up with the supplement in this thing that Juven is actually based on.

Glutamine, which is an amino acid found in the blood that actually if you have a problem, you have so much glutamine, and if you -- say you're hit by a car or whatever, you can get your blood drawn six hours later, your glutamine drops because your body says it needs glutamine right now, and so your levels in your blood drop precipitously.

We thought we could mitigate that by glutamine supplementation. That was really the inspiration and what we wrote a lot, a number, number of papers on. And later it was recognized by the people, and we did actually, with one of the

surgeons that we did a lot of the experiments in humans showing that is people did better and could gain muscle weight if they are really sick, we did it in a study in Long Island in AIDS patients. We did it in patients that had cancers, lung cancer and skinny cancers, cancers of head and neck, cancers that smokers and drinkers get, that they would lose weight even if they have the right amount of calories and were eating -- actually, we proved even if you ate more calories and you had this cancer and you did not have supplementation, you would still lose weight, even though you were eating more calories than the people that were in the supplement group that gained muscle weight.

So just, again, a proof of concept that things worked.

On down the line, after those publications --

Q. Are the publications in your CV?

A. Yes, they are.

Q. Please finish what you were saying.

A. Abbott Nutrition bought it and --

Q. Abbott?

A. Yeah. Abbott Nutrition bought the formulation we had of three amino acids. Then they

made Juven.

And so even though I've had extensive experience with giving this supplement to people and animals with various diseases, I -- I don't receive anything from it because it was sold. We just did the research showing it worked.

Q. So let me just divert for a minute.

A. Yes.

Q. You heard Dr. Spoerke discuss Juven today. You -- one of the order was for Juven for Patient A?

A. Yes.

Q. Why did you order Juven for Patient A?

A. Well, Patient A had a history of having a good bit of his small intestine removed, and when you have short bowel -- and he said, he told me he had short bowel, and I took it very seriously because, as Dr. Spoerke pointed out, you may or may not be able to absorb all the nutrients that you need in order to heal.

So that was something that I thought from my previous experience with Juven and people and with problems with their intestine, you could make their intestines healthier with these supplements.

We proved that if you gave those supplements for two weeks, then you would get the

amount of increasing the absorption of the small bowel of nutrients in order to restore a normal physiology to someone who has intestinal problems. We were actually able to get people off of IV nutrition by getting their intestine better enough to maintain themselves just with food and oral supplements and not have to be on IV nutrition.

I thought that would be a good kind of pre-habilitation plan for Patient A.

Q. So prior to the surgery?

A. Yes.

Q. And --

A. Because the surgery, even if everything had gone perfectly as planned, the patient would have faster healing and have less problems with any possible infections or absorbing any of his own intestinal bacteria.

It was in an effort to prevent any of those things from happening.

Q. What about anemia, did that have anything to do with it?

A. The patient had complained that he had been anemic. To me, that was an indication that, even though he was eating a regular diet, he was missing something. You have to have -- there are a

number of things that go into anemia, not just eating steaks or red meat. A lot of people are not able to eat enough leafy green vegetables.

And so those things prevent you from making enough for the other portions of blood, so you don't clot as well and things such as that.

Although outwardly you can measure things such as when a complete blood count and the comforts of metabolic panel that we pretty much do before every surgery, a lot of those can be normal. But then if someone has a stress, they -- just like I was talking about, the glutamine gets all used up, other things get all used up in your body too, and so if you can have sort of a pad to be supplement before surgery, then you're likely -- your bank is sort of padded so you don't get into overdrawn mode.

So that was my thought.

Q. All right. And when you prescribed it for Patient A, was it significant, in your opinion, to note short bowel syndrome and anemia and upcoming surgery as indications for the Juven prescription?

A. Yes. I think I discussed that with the patient and asked him that he do this.

Q. And he agreed?

A. Yes, he did.

Q. He thought it was a good idea?
A. I think so.
Q. Let me just, for the record, ask you to identify which articles you were talking about with regard to the studies and then Juven, please.
A. Yes. Article number 67.
Q. Sorry. Respondent's 8, starting at 110.
And then what number?
A. Its Barber 000121. The first one, 57, is -- we were looking at cancer-related weight loss, as I referred to earlier. Then you drop down to 59, and that's also on that. And then article number 61 is in trauma, using Juven.
Q. What you -- is this B, hydroxy B?
A. That is the same. I'm sorry. Yeah, it didn't have a name because we were just doing this with this powder that had numbers, and so those are the key ingredients of Juven. Beta hydroxy, beta methyl butyrate, arginine, and glutamine.
We're just going to have a nickname, call it "HMB."
Arginine and glutamine are amino acids and HMB is a metabolite of the amino acid leucine.
And the patent on that that this man, Dr. Rathemacher, created is that it tricks the body, the

body says, oh, I'm sick, I'm just going to get rid of all my muscle. It tricks the body even though you're in a crisis mode to actually put muscle on.

So that was the really wonderful, life-changing thing about the supplement that made the FDA say, yes, it can be approved. And that is what got Abbott Nutrition's idea of buying it and thought it would be worth it to do.

And so -- because it was the first time any nutrition supplement could actually put weight on that was muscle weight. Muscle is the body's bank account. And so if you look here in the doctor's office, look around and say, what's wrong with that person, and you see the skinny person with skinny arms and legs and this big middle, they've lost all their muscle.

So your body's bank account are in the big muscles in the arms, your biceps, and your legs.

Q. And --

A. And so it goes on and on.

We looked at all these, 68, 69, 70, 71, 72, 73, 74, 75, those were all on those -- I'm using that nutrition supplement to various things that we could heal better and use less antibiotics and help people.

Q. And you felt that Juven was appropriate for Patient A?

A. I thought it would give him the best chance of healing after surgery, yes.

Q. And he did take that course of Juven?

A. I think he did.

Q. All right. Let me go back.

We talked about Cornell. What years were you at Cornell?

A. I went there from -- I did my internship from 1985 to 1986. Then in 1987, 1988, I was a second and third resident. And then I put down this fellowship for next two years. And then I went back into residency for two years and then finished that.

Q. You graduated from medical school, that was the University of Texas, Houston, in 1985?

A. It was 40 years ago.

Q. Not trying to rub that in, just trying to go chronologically because I've been jumping around.

Just for time to get your training, Cornell, though, you did general surgery from '85 to '86?

A. That was my internship, yes.

Q. And your residency, '85 to '88?

A. Right.

Q. And that was New York Hospital, Cornell University also?

A. Yes.

Q. The research fellowship we talked about was '88 to '90, general surgery residency.

You did -- your residency, was it interrupted by the research fellowship?

A. Yes.

Q. Okay.

A. That was a planned interruption, if you will. I don't know what the meaning of "interruption."

Q. Okay. And then did you, in '92, looking at your CV, you were at the department of surgery at Texas Tech, what role did you serve there?

A. An assistant professor of surgery.

Q. And what is your title now?

A. Professor of surgery.

Q. You held -- again, just jumping to now, what other positions have you held at UNLV or UNR School of Medicine?

A. When I came to UNR, I became a associate professor of surgery. And then a few years later, I was promoted to professor of surgery and UNR. So when UNLV started, I moved in -- I did not have to

reapply for professorship, we were moved laterally.

Q. What is involved in being a professor of surgery at UNLV at the Kerkorian School of Medicine, what do you have to do?

A. To become a professor?

Q. Sure.

A. To be promoted to professor from associate professor, you have to say -- you have to show that you have made an addition to the medical literature, that you have made an addition to academic progress of the university in which you teach and you continue to do research, and that you add to the community of medicine through various things, participating in both the community and the state.

And pretty much to go from associate to professor, you have to show that you make a difference nationally and/or internationally as well.

Q. What did you do to show those things?

A. Well, I always participated in number of local, state-wide, national, international organizations, and so I was able to be successful in those. Those things are primarily surgical societies. And so I always have been heavily involved in the American College of Surgeons, the

International Surgical Society, the society for the surgery -- the elementary track was the gastrointestinal tract, the Surgical Infections Society, the -- I go to SAGES but I'm not an officer in there.

Q. What is SAGES?

A. It's the society that the expert witness earlier testified to. Just a surgical society. It's not -- it doesn't --

Q. Does it credential people?

A. No.

Q. Please continue.

A. And surgical society -- American Society for Parenteral Nutrition, European Society of Parenteral Nutrition, it's IV nutrition, parenteral.

Q. TPN is what?

A. Total parenteral nutrition.

Q. We talked about that.

A. Yes. We were trying to get into labs, TPN, so we could show it was safe so we could give it to animals.

Q. Okay. You talked about contributing to the community and nationally in order to make professor?

A. Yes.

Q. Did you describe most of what you can recall you did in order to achieve that status?

A. Well, I was able to work very hard with my own research. And then to actually be able to teach we had, every year, one of the surgical residents was out the residency as I did, and so they would continue to do the research that I was interested in and publish with me and present at various meetings both, again, locally, nationally, and internationally. I've been very involved in the International Surgical Society, and actually the president now.

It's for the education of surgeons all over the world.

Q. Which society are you the president of now?

A. International Surgical Society.

Q. And I asked Dr. Spoerke if he was a member of American College of Surgeons, understanding that -- was that something that contributed to you become professor or was that after?

A. I have always been involved -- been a member of the American College of Surgeons since I was a resident, but I presented at the meetings since I was a resident for the last 40 years, and so

-- it's something -- locally, I was the an officer in the Nevada -- not Nevada -- Medical College of Surgeons chapter, and then became, through various positions, the president. And I was a representative to the American College of Surgeon's committee on cancer.

Then I was the governor for the -- the American College of Surgeons have a governor from each state, and so I served as a governor for the last six years. I just finished my governorship.

The governors, they divide the number of governors into a number of things that try to promote various portions of surgery because -- well, the house of surgery is huge. And so I, with my interests with what they have been in, served on the patient safety and patient --

Q. Do you need a minute? Because you're talking really fast.

A. I do.

Q. Take a minute. Just take a beat, if you would.

(Witness reviewing documents.)

THE WITNESS: So through the American College of Surgeons, the board of governors, I served on the subcommittee on quality improvement

for the last three years.

Were able to look at -- able to publish some papers regarding the best way to give nutrition in cancer, that was through looking at all of the literature that had been published regarding patients undergoing cancer operations and show that what were the minimal requirements for you have the best chance of getting well.

And so my background in nutritional supplementation helped in that.

Q. For the American College of Surgeons, that is a board-certification?

A. No, it is not a board-certification.

You have to be reviewed and applied, you can't just fill out a form and become a member, it's not an actual board of certification.

American Board of Surgeries is different. It's ABS versus ACS.

Q. You're a member?

A. Absolutely. Been board-certified and recertified a number of times.

Q. Let me just ask -- taking a slight detour -- you have several specialty areas. Can you tell us about them?

A. Well, as I mentioned earlier, I did extra

training in cancer, both in nutrition and I got to serve a fellowship at a Memorial Slone Kattering Hospital in New York.

I have a practice -- in my practice now, I've always had a cancer practice. And then we are a smaller state and have to teach everything that comes into the emergency room and do acute care surgery. Dr. Spoerke spoke about earlier, I do that at the University Medical Center in Las Vegas, do those things.

Q. You're on call?

A. Yes, I am.

But through my cancer work, both -- I am actually going a little backwards, but I've always been involved in the Nevada Oncology Society, actually finished my term of presidency.

We try to get things in Nevada up to national standards and international standards through meetings and educational programs for the people who treat cancer in Nevada, both the north and the south.

Q. In looking at this, the papers that we have, you received an award recently that was the school -- maybe not that recently -- in the last several years that had your picture that the school

of medicine circulated?

A. I don't remember exactly what you're talking about.

Q. I'll find it.

Do you have expertise in gastrointestinal tract?

A. Yes, I do.

Q. Tell us about that and what that involves.

A. I sort of inherited a strange specialty, and it's in gastroparesis, in that a number of people have stomachs that don't meet normally, their stomachs are paralyzed. People are familiar with diabetic neuropathy, because, unfortunately, diabetes is so common now that people will often get neuropathy of their stomach, not just from diabetes but from many other problems as well, and that's something that I -- a number of years, about 15 years ago, a company was trying to see that if stimulating the stomach with electricity would help people lose weight. It actually didn't turn out to be something, but they had implanted this stimulater in someone, and then that person who was a bariatric surgeon retried and left the school. I was sought out to take care of this patient. And I had never heard of such a thing, so I had to become educated

about it before I agreed to take on this patient.

I did, I became educated about it. I became very interested -- it was very interesting to me these patients had these stomachs that didn't work and became an interesting physiology I began to study.

And it was an increasing problem, so I became an expert in it. Not only finding out that putting these electrical stimulaters in could help people who often have nausea and vomiting and pretty much have no life because, if you noticed, today every time we have a break, we get something to eat or drink, those people are unable to do that. This is how we conduct life.

These people are unable to do that because they vomit as many times as 20 times a day. So this stimulater can help some. It doesn't cure it, but it makes it better.

Then I found out doing another operation at the same time of that, a pyloroplasty, which is opening the bottom of the stomach, that the muscle to the end of the stomach becomes very large and strong from overuse, hypertrophied from vomiting so much. So if you cut that muscle, then the nausea and vomiting from the gastric region becomes even

better, and in conjunction with using the electrical stimulation, the patients do even better and can go off IV nutrition and can have more normal life.

Q. You mentioned bariatric patients and that bariatric surgery you left?

A. Yes.

Q. And that's obesity surgery?

A. Yes.

Q. My understanding of -- from other cases, is that most of the bariatric procedures involve rerouting the intestinal tract. Is that accurate?

A. Yes.

Q. Can you tell us about that and how it relates to your experience?

A. Yes. Bariatric surgery can be very complicated, and when we first started doing it many, many years ago, when I moved here to Las Vegas, it was becoming more and more done, and at that time we were not doing it laparoscopically and it was a big operation and a complicated operation. We were doing -- it was before the sleeve that is done so commonly in places now, it was done before the gastric bypass was done, gastric restricted procedures, we used to wrap the stomach in plastic and it didn't work, did a lot of things that didn't

work.

But the gastric bypass really has -- I wrote a paper with the guy that did it, Dr. Barry Fisher a long time ago.

At any rate, it can be a very complicated operation and the patients can become very ill. People, they were very familiar with people who have the complication of leaks from that, the patients can get very sick and have to have re-operations. It can be a very complicated surgery. It's got much better at it with staplers and things we use now.

With the laparoscope, being able to get to places that were much more difficult to access before we did laparoscopic surgery, robotic and laparoscopic surgery has really revolutionized that and made it to become a safe surgery when it was very not-so-safe and not so -- and much more difficult, it has become an easier operation and a more teachable operation than it was before.

Q. Let me stop you for a second. How many laparoscopic hernia repairs have you done in your career?

A. Not specifically, but I know I've done hundreds.

Q. And what about in the last week, how many

laparoscopic?

A. In the last week, I've done about ten.

Q. Where were those surgeries performed?

A. In the last week, I have only operated at University Medical Center in Las Vegas.

Q. I understand Las Vegas Surgery Center closed?

A. Yes. It recently closed last week.

Q. Okay. How many hernia repairs did you do this week?

A. This week?

Q. Yeah. The first part of this week before you came here?

A. This week, let's see, Monday I did -- I think I did three or four this week.

Q. Okay. At UMC?

A. Yes.

Q. Just for clarification, why, as an employee of the state, the Nevada System of Higher Education, do you do surgeries at UMC and used to do surgeries at Las Vegas Surgery Center?

A. University Medical Center doesn't have that many operating rooms. I often -- we -- they -- the University Medical Center is a county hospital so it's often burdened with the on-call operations

so that sometimes the elective, there's no enough operating rooms for elective operations.

So the elective operations that are straight, we're going to plan this and do this on this day in the future, sometimes they are done at other places that are not as busy.

Q. UNLV itself does not have a surgery center; is that right?

A. That's correct.

Q. And Patient A's surgery was at Las Vegas Surgery Center?

A. That's correct.

Q. And that's pursuant to an agreement between UNLV and, previously, Las Vegas Surgery Center to have --

A. Yes.

Q. -- it's surgeons --

A. I had -- I was credentialed there to perform surgery.

Q. All right. I guess my point being that sometimes -- you work for UNLV, why are you doing surgery at other places?

A. Because they don't have a place to do surgery. That's where you teach and do research. I have office hours, but we don't have -- you're

correct, we don't have a surgical suite so we have to operate at other places.

Most of the faculty operates at UMC and other places as well because, again, the volume is too much.

Q. And the patients that you do surgery on at UMC that come in through the trauma, could you just describe the types of surgeries, generally, that you see coming in?

A. When I'm on call?

Q. Yes.

A. Take everything that comes in. On call at UMC consists of acute problems with hernias that are stuck, that are incarcerated or stuck, that need to be fixed urgently. Gallbladder disease, patients cannot go home and have an elective surgery later because their problem's too acute, gallbladder is too inflamed. We have people who have intestinal obstructions where their bowels are blocked and we have to unblock them. We do a lot of laparoscopic work in doing that. Sometimes we do -- people who need to lose weight quickly and their intestines can become trapped from where they're mesentery to the intestine, loses a lot of weight so they can become trapped in that. That's a common operation. We

have infections of diabetic feet and also amputations and wound care. I've written a great deal about wound care in patients with diabetic feet. And then various abscesses.

It's not very elegant a lot of times, but things that certainly need to be done in patients, and I'm going to do them.

Q. And apart from when you're on call for UMC, are you also called in as surgical specialist for tricky surgical problems?

A. Yes. Sometimes I'm called by some of my colleges when things are complicated in a scenario that I'm more familiar than them, maybe. And so just when they're untoward events in the operating room, I'm called to come in and help.

Q. Can you give us some examples?

A. Well, re-operative surgery is harder than initial surgery because of scars there. Sometimes the anatomy is difficult to identify. With having done this a long time, I am often able to do that. Hey, this looks like this, that might be this, and doesn't look exactly like that, so maybe you might want to try that sort of things. We do that a lot in re-operative hiatal hernia, repair of esophageal hernias by where the esophagus is. Looking at the

liver and the liver system, there are things that don't appear -- when anatomy does not appear in person like it looks in the books, and things, just having seen a some number of surgeries over the years and done a lot of surgeries over the years, that I may be able to identify, gosh, that looks like this, and maybe you ought to try that, those sort of things.

Q. How often are you called in when one of your colleagues to address an interoperative complication or to do a tricky surgery?

A. I would say, thankfully, not that often. I would say that happens maybe every one or two months, thank goodness.

Q. You've heard what Dr. Spoerke's criticisms are of you. Do believe that it was safe to proceed with Patient A in the manner that you did on that February 22nd surgery?

A. Yes, I do.

And then I'm often able to do a laparoscopic surgery on someone that's had a number of surgeries before in trying to go into an area to obtain visualization, an area with scars, because it is completely unpredictable where scars will be after people have had surgery before.

Q. Why is that?

A. The scarring, interestingly, in Patient A, when someone has surgery as baby, it often heals with very, very little scarring or actually surgery in very young, days-old infants, often there is actually scarring that is visible later.

Even though Patient A had a number of surgeries as a baby, that does not predict the burden of adhesions later.

Q. "Burden of adhesions," what does that mean?

A. It doesn't predict that there will be lots of very dense adhesions. There are different kinds of adhesions, some are very dense, some are very wispy that are very easy to move, and some that are very dense that if you touch them bleed and tear things that they are attached to.

I found in my experience is it -- and it's written in the literature -- completely unpredictable to know. Some people that have had -- describe awful things that have happened to them in the past, and you look in and can see, it's like nothing happened. And others, they have had some small operation and they have terrible adhesions.

Again, a lot of research being done on

that. There is a lot of research being done on that to figure out who gets bad adhesions and what can we do to prevent them. That is not known at this time.

I found that in people that have had a lot surgery often, you can sneak in, if you will, to some place that you can maybe predict has less scarring and get a laparoscope in and get another Trocar, another entrance, close to that where you can see where it's safe to proceed. Again, very unpredictable based on what we were thought, oh, this patient had surgery before.

I've kind of gone through the generation, if you had any surgery before, you could not do laparoscopy, where that's really changed so much.

I believe in Patient A that he was in a little precarious position as far as potential wound healing, and that a laparoscopic surgery would be less of an insult, which this has been proven in the literature that it's easier to heal, you have faster healing from a laparoscopic surgery, less swelling, and easier to return to your life with laparoscopic surgery versus open surgery.

That was why I thought I should try to proceed in that way to try to get him the best chance to get better the fastest and get back his

life.

Q. Okay. In the records you describe that it's laparoscopic with possible open. Tell me what that means.

A. That was my plan after I saw the patient initially, that I actually order a CAT scan at that time to sort of predict -- it was unclear and we did not have past medical records absolutely how much of his intestine had been removed, and that this man was walking around, had a normal appearance, and was not on IV or nutritional supplements when I met him. He was able to maintain that with a diagnosis that he said to me, "Short bowel syndrome." A layperson knows these words, that gets my attention.

And so he had my attention, so I thought, my goodness, let me see if I could figure out what's missing, because often when people have had bowel resections, they don't know which portion of the bowel was removed.

Again, I had a little hint that something was going on because he had talked about anemia, and so I really wanted to examine that a little bit more. That was the reason I had the plan of getting a CAT scan to try to see. With contrast, we looked at how fast contrast moves. If the contrast is in

the small bowel still, then we say it's kind of slow, so maybe that there is adhesive disease and it indirectly predicts -- can predict adhesive disease. Or if it's in the colon immediately after -- after CAT scans they say we gave the contrast at this time and we did the films at that time.

You can look at the times of transit time, how fast do things go through, and so indirectly you can say the food goes through really quickly. Our food gets hung up, so that gives us an indirect hint of adhesive disease.

And then you could see that if there are pieces of bowel that, my goodness, they should -- everybody's seen pictures of bowel, it looks like a bunch of things going back and forth, a bunch of spaghetti or whatever -- there's just less, and you can see that on a lot of people that have had a lot of intestinal resection.

He did look like that on his CAT scan. There were no hangups, and it went through a normal time, so I thought it would be best for the patient to try to get well quickest, to do a less-invasive operation, to get that in there. If I could get a pace and see and repair the hernia without hurting the patient, that that would be the ideal thing for

him.

Q. The reason that you ordered the CAT scan -- was the CAT scan was ordered by you?

A. Yes.

Q. In order to determine if there were --

A. If -- to try to indirectly look at the -- if there was a change in time that the contrast went through the a bowel normally, if it got hung up, and that would give me an indirect thing that there are a lot of adhesions still. Or that he's -- a lot of people have adhesions that, no matter, they don't block the bowel. We used to say we would like to adhese the bowel open.

We have a tube that did that, so it would give the idea of was -- sometimes when you touch someone, you think there or may not be bowel within the hernia, sometimes you can't always tell because things are just a little mushy, so it gives you a better idea of where the hernia is.

And is there recurrence on the other side? Because often people have something, for instance the patient I operated on yesterday, had had hernia repair on the other side. I was operating on him and it had actually recurred, so I have to fix it.

I've always talked about people who had --

we've had people who have had hernias before, if I see it's recurred, I'm going to go ahead and do that at the same time.

Q. Do you advise the patient?

A. Yes. To give the most information you can get. To get an indirect look at the intestine, how much was there, if it were adhesed, if it were blocked at all, and to look at other groin too to see if there were other -- a second hernia, a recurrence on the side that had already been fixed.

Q. Is that similar as to why you document possible open because you don't know what you're going to get when you get in there with a scope?

A. Yes. And that the verbiage in consents where it goes on to say other indicated procedures, that is sort of what the agreement is. We're going to go to the surgery and fix what we can, and we may find something else. If we find something else, we don't talk about what we would do or what we would not do.

Q. And you mentioned you didn't have the records for this patient. Why is that?

A. The patient told me these things, but I did not have his surgical records. They were done in -- he was not born -- I didn't have his

gastroschisis thing --

Q. His birth --

A. His surgery when he was a baby.

And then the bowel -- the bowel resection had been done a lot of years before, so I did not have those records.

Q. But you talked to the patient?

A. Yes, I did.

Q. And did the CAT scan?

A. The CAT scan was helpful in the things that did not show. It did not show a contralateral hernia, it did not show a paucity of small bowel or it did not show any obstruction, and it did not show a hernia on the contralateral side.

Q. Was there anything in your medical judgment, including your training and experience and your education of all of the laparoscopic hernia repairs you've done, that indicated that you should not go in laparoscopically with Patient A?

A. No. I thought I would carefully go in, as I always do, and often you can find a space and just with a little bit of visualization, put another Trocar close and work it and work and make your space where you can see a little bit bigger. Sometimes it just takes a little longer and lot of

patience to move the intestinal -- the adhesion to the intestine or to the organs out of the way, carefully visualize, and cut the adhesions to allow visualization of the anatomy that you're trying to see.

Q. When you're talking about cutting the adhesions, some of the adhesions that you mentioned earlier can be wispy. Describe that.

A. Some you can just touch and move with an instrument.

Q. And you're moving your hand?

A. Outside the body, yes.

Some you can just push and then, I'll say, okay, I'm cool. And other times they are thicker, so sometimes we cut them just with scissors and sometimes with scissors and cautery too if they were bloody adhesions, but we have to be careful not to injure the bowel with cautery.

Q. Dr. Spoerke talked about and it's in the record, putting Optiview in and the scope. I don't think it was that clear.

What area are you looking at, a screen where it's projected?

A. Yes, let me try to explain that.

The Optiview Trocar is a hollow Trocar,

you can maybe visualize, although often you can't, instead of a pen going through this, you put your small, five-millimeter laparoscope and it goes down to the very bottom of this with a bright light. And the end is pointed, such as this (indicating), so you make an incision in the stem in the tissue with a knife, and then you insert this, about more than foot and a half long, and you hold this through this and gradually go through the abdominal wall and you see the layers, the layers would go underneath the skin in the subcutaneous fat, you go through the layers of muscle, which you can, going one, two, three, and then the peritoneum and then you're into the abdominal cavity. Then you put carbon dioxide in there to blow it up and give you space.

Then at that point, you take the -- there's a -- oh, you take the pointed part off, it sort of fits inside each other, and we leave this hallow part there, you take this off (indicating) of the pen, the pointy part.

Then you have this seal that keeps the CO2 in, and then you put your scope back in and you see. Sometimes you can see the space, sometimes not. I am going to describe in the best way possible, could not see when I first put the laparoscope in on

Patient A's right side. I went through the abdominal wall and put CO2 in, I could only see bowel, I couldn't see open space.

Then I decided to look at the other side and do the same thing.

Q. But when you're saying "see," where -- is it projecting on a screen?

A. Yes. The -- it's called a "video laparoscope" connected to the scope, it's at the very end, is a video attachment, and that goes to a screen so you can look up, look down, look up and down.

Q. How big is this screen?

A. They can be all sizes. In the new operating rooms, they are as big as this (indicating), but in the older operating room they are more like a television and smaller.

Q. Okay. So there's a camera and it's projecting, you're not looking through a Trocar?

A. No. A very long time ago, we did that.

HEARING OFFICER HALSTEAD: We're going to go ahead and take a break. We'll be back at 4:00.

(Recess from 3:49 P.M. to 4:04 P.M.)

HEARING OFFICER HALSTEAD: We're back on the record in the case number 23-11660-1, In the

Matter of the Charges and Complaint Against Annabel Elizabeth Barber, M.D.

Dr. Barber, I remind you you're under oath.

We're in midst of direct examination on your case, Ms. Daehnke.

MS. DAEHNKE: Thank you, Your Honor.

BY MS. DAEHNKE:

Q. Dr. Barber, we were talking about -- asked you to describe the Optiview, I believe that's where we left off.

How did the visualization with Optiview come about in surgery? What did -- was this considered an innovation?

A. I think it came about in the late 1990s, I don't know exactly when.

Q. And so describe for me, first, why did you believe that laparoscopic repair of Patient A would be appropriate as for the patient and safe?

A. I thought it would be appropriate in that on the CAT scan I did not see any prohibitive for that, and I did not see any, I think I mentioned earlier, any hangups of the intestine in the CAT scan, I did not see a hernia on the contra levels, and so I thought that there was the contraindication

based on that.

Q. That's what I was -- could you see a hernia on the contra-level side based on a CAT scan?

A. Many times, yes. Not always.

Q. And have you -- by your answer "many times," have you, indeed, seen hernias on the contra-level side in a patient that you are intending to take for laparoscopic hernia repair?

A. Yes.

Q. And is that an absolute contraindication?

A. Not at all.

Actually, it is believed by many if the patient has had an intention, an opened hernia repair and that they recur, it's much safer to do a laparoscopic repair because you're going through planes that have not been dissected before. It is actually a safer operation to do a recurrence laparoscopically if they had an open surgery before.

That was not the case in this, we're just talking about theoretics, but -- so for that reason, I found that many times, I think I mentioned earlier, if someone did not know they had a recurrence but indeed they did, so the opportunity of laparoscopy for the side which you're going for, if there is a recurrence you could fix that at the

same time.

Q. So you mean you're taking a patient in and the patient doesn't know they have a recurrence of a prior hernia?

A. Yes.

Q. And you're going in on this side, you see this, and you can set them for both?

A. Yes.

Q. Okay. And that was not the case for Patient A?

A. No, that was not the case.

Q. Why -- any other reasons why you thought it was safe to proceed laparoscopically?

A. Well, even though he was anemic and had some sort of prior diagnosis of short bowel, that he was not necessarily the most normal or healthy person because of his prior history, so -- again, I think I mentioned earlier, we do know that people's -- that one of the few advantages of laparoscopic versus open hernia repair and that is a faster healing and more of a return to -- and less pain following laparoscopic surgery versus open surgery.

Q. Why is that?

A. Smaller incisions, better visualization.

The laparoscope, the picture you see on the monitor is ten times greater than the naked eye, so things are bigger and easier to see.

Q. You mentioned when you were describing the procedure insufflating the abdomen. That's always done?

A. Yes.

Q. That's my understanding.

You insufflate with CO2?

A. Yes.

Q. It creates a bigger space?

A. Yes.

Q. You heard Dr. Spoerke being critical of the fact that the operative report didn't describe that the abdomen was insufflated with CO2?

A. Yes.

Q. What is your opinion about that?

A. I don't agree with that. I wrote this, I think that is similar to that, and I wrote it, obviously, using a writing instrument.

Q. So just explain that a little further, from your description of what you did, is it necessarily known by surgeons and others that you are insufflating with CO2?

A. That is the standard sufflation material.

Q. Do you usually write insufflated with CO2?
A. I don't.
Q. Do you -- in your opinion, is that a breach of the Medical Practice Act for not including "insufflated with CO2" in your operative report?
A. I don't think so.
Q. Is there anything else you can insufflate with?
A. I'm sure there, but it's not something that I've done.
Q. So then going back to Patient A, the initial Trocar with the Optiview, tell us about the next Trocar insertion.
A. I tried again on the left, the left lower quadrant, to create space there.
Q. Can you -- when going in on the left lower quadrant, you talked about this earlier, you can't anticipate the adhesion burden; is that correct?
A. That's correct.
Q. You heard Dr. Spoerke, although he testified differently earlier in the day, later in the day he said that it was not a wise choice, that you shouldn't have gone in on the left with the second Trocar.
MR. WHITE: I'm going to object.

BY MS. DAEHNKE:

Q. Do you agree?

MR. WHITE: I'm going to object. It assumes evidence not in -- it assumes facts not in evidence that he changed his mind or anything like that. He was always pretty consistent today, or very consistent.

HEARING OFFICER HALSTEAD: I didn't take that as -- it's a question by counsel, so I don't take it as fact. And I'll have the transcript.

BY MS. DAEHNKE:

Q. Dr. Barber, do you remember something similar to that in Dr. Spoerke's testimony this afternoon?

HEARING OFFICER HALSTEAD: It doesn't matter. I'll -- it's something I'll determine if he said it or not.

MS. DAEHNKE: Okay.

THE WITNESS: I've had good success in looking at the other areas of the body to be able to get space to see. I did not think that was a bad idea.

BY MS. DAEHNKE:

Q. You don't agree with that?

A. I disagree.

Q. Then after you could not visualize on the second Trocar, then what happened?

A. I looked in the midline to see if that would work.

Q. Same question, Dr. Spoerke, in the morning didn't say this, but in the afternoon he said that going in through the midline was quote, "ill-advised."

Do you remember that testimony?

A. I do.

Q. Do you agree with that?

A. I do not.

Q. Tell us why not.

A. Again, in my experience, I have found that it is unpredictable where adhesions would be, and it is unpredictable to obtain visualization -- it's very hard to predict where you will find visualization.

And so, again, this something that I do every day, and so if I were doing this I might try the same thing again.

Q. I'm sorry. You would try the same thing again?

A. I might.

Q. You might.

What is your comfort level with performing laparoscopic hernia repairs?

A. I'm very comfortable performing the surgery.

MR. WHITE: Objection. Calls for speculation.

HEARING OFFICER HALSTEAD: She can testify as her own comfort level.

BY MS. DAEHNKE:

Q. So the midline, what happened when you went --

A. When I -- I call it "when I looked in" through the midline, it looked like there was injury to the bowel. I thought I should find out, yes or no, is this true, and so that's when I did a laparotomy.

Q. And when you saw that -- the new document in your report was possible injury to the bowel; correct?

A. Yes.

Q. That's why you did the laparotomy?

A. Yes.

Q. At that time, did you have a opinion as to what the injury was causing -- what caused that injury?

A. I assumed it was a Trocar injury.
Q. And is that a recognized risk of this procedure?
A. Yes, it is.
Q. It's a known risk?
A. Known risk.
Q. Known risk and known complication?
A. Yes.
Q. So at the time -- the amount of time from the time that you put your first Trocar, the Optiview, and then the second and then to the midline, how much time expired between? Minutes or?
A. Minutes. I would say probably less than five minutes.
Q. And how big, if you could just do it by holding your fingers up or maybe --
A. The Trocars are five millimeters in size, and a centimeter is -- two and a half centimeters is an inch, so it's five millimeters, so that's very small.
Q. Okay. So those would be the incisions in the abdomen?
A. Incisions in the abdomen are small, and then with what I felt I had perforated or injured the bowel, that's with a very small instrument, a

Trocar, it was going to be a small hole, and so -- should I continue?

Q. Yeah. I was trying to just visualize how big the incisions are and how big the Trocar are.

A. The Trocars are really about the size of this pen (indicating). And when I felt, the hole was about the size of this portion of the pen, which is about five millimeters (indicating).

Q. You had seen the injury to the bowel, and so you went in, midline, and did you notice it immediately?

A. Yes.

Q. Okay. And when you were looking at the screen, what did you see?

A. I saw --

Q. How did you identify that there was a --

A. I saw that the bowel did not appear normal. I did not see small bowel contents. It looked like it was a piece of bowel with a dent in it or an incision of the actual intestine.

Q. You were able to identify that without any bowel spillage or bleeding?

A. It can bleed or it can spill. I don't not recall seeing spillage at that time.

Q. All right. Please continue.

A. The patients we operate on are usually fasting for a bit before, and so they often can have injury to the bowel that doesn't spurt out intestinal contents, necessarily.

I don't remember intestinal contents spilling out at that time.

Q. All right. And then you have Trocar and you convert it or you did a laparotomy?

A. Yes.

Q. What's a laparotomy?

A. It's opening the abdominal cavity through an incision. A laparotomy itself just means entering peritoneal and opening the peritoneal.

We often will say a "midline laparotomy," which is make an incision in the middle of the abdomen.

Q. And going into the middle of the abdomen, you consider it safe based upon your experience?

A. Well, I thought that was the easiest and most expedient way to see the area where I thought there might be injury. That was exactly where the Trocar was, and so it was going to be right below it. I thought that would afford the best and most immediate view of a possible injury.

Q. Did you suspect that there was injury

before you went midline or --

A. Yes. And that's why I did go in there. I wouldn't have opened a laparotomy had I not suspected an injury.

Q. And then what did you do?

A. I opened the skin's subcutaneous tissue and fascia and was able to expose the abdominal contents, which included a piece of small intestine just below the incision that, indeed, had a hole in it. It was very -- his bowel did not appear healthy, any of it.

When I -- a Babcock clamp is used because it's atraumatic, and you can put -- it doesn't crush the intestine, so you can pick up and move the intestine using this clamp without crushing it or injuring it. It's the most atraumatic instrument that we've have.

Q. What kind of clamp?

A. Babcock.

Q. Oh, Babcock. Okay. My ears are plugging up. Sorry.

The bowel didn't appear healthy?

A. It did not. It appeared -- we sometimes call this "friable," in that when you move it, it would sort of tear.

So when I -- in a normal bowel when something like that happens, you can repair it very easily with like absorbable stich or Vicryl stitch, it dissolves.

And when that happened, just touching his intestine, it bled and bled more. And so just in freeing the area of the abdominal wall in order to safely make sure that this was the only injury and that it didn't tear, it didn't seem to hold stitches well, it was sort of not -- the sewing bowel was thin and tore easily and it bled and a lot more than normal tissue bled.

That was why I decided that I wasn't very confident in the closure that I would usually do with sutures, and that it didn't seem like that was going to be holding enough. That's why I chose to put a staple line beneath that.

Q. What do you mean by the "staple line beneath that"?

A. Well, there was -- the bowel is a hollow tube, and there was a hole in the side of the tube. I put stitches in there and they didn't seem like they were closing well and it seemed like every time you put a stich, it would tear it a little bit more and make the injury worse.

A stapler has teeny, tiny staples that are not even -- less than a millimeter each, and puts a whole line of them in a row. If something is tearing, then you can usually get a piece of -- you hold up -- say you have small injury, you can hold a piece of bowel that's -- say you have a half a centimeter tear, you would maybe use a three- or four-centimeter repair just to distribute the tension along the lines of the intestine on either side of the tear to reinforce it so it would be a strong closure, one that would hold, because my stitches were not holding.

Q. You had an assistant surgeon in with you?

A. Yes, I did.

Q. And was Dr. Vest able to visualize through the Optiview what was going on?

MR. WHITE: Objection. Foundation. Who is Dr. Vest?

MS. DAEHNKE: An assistant surgeon. You identified him in your last witness list.

MR. WHITE: I agree. But to clear the record up, I don't think we know who it is. It's just a name mentioned all of a sudden.

MS. DAEHNKE: I just asked --

HEARING OFFICER HALSTEAD: I understood it

would be assistant surgeon.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: You said "assistant surgeon," and you referred to his name, so I assumed it was the same person.

BY MS. DAEHNKE:

Q. Who was the assistant surgeon?

A. Dr. Vest was the assistant surgeon. He was a resident at the medical school at the time.

Q. And would he be able to see?

A. Everybody in the room could see.

Q. Who else was in the room?

A. The scrub tech and the circulating nurse and the anesthesiologist, at least. I don't remember if others were there, but those were definitely there.

Q. And while you are -- you discovered the injury and you're trying to sew it, your stitches were not working, are you calling out to the surgical team?

A. I narrate myself, always, so that everyone in the room understands what I'm seeing, what I think I'm seeing, what I'm planning to do so that I have all the instruments that I'm using now ready, and what I might use in the future if this doesn't

work, then I would use this.

And so, therefore, the people, if things are not opened, they will go and get them and have them ready to use if necessary.

Q. And before you went into surgery, the team, the scrub techs who were setting up the surgery, knew that you were going to do a laparoscopic hernia repair, possible open; is that correct?

A. Yes.

Q. They would have had all the equipment there?

A. Yes.

Q. And even before the patient was wheeled in, there's a possibility that you would have to open the patient and done a laparotomy?

A. Yes.

MR. WHITE: I'm going to object. Now it's getting to a lot of leading questions for direct. "All equipment," I don't know what that means, maybe if we ask some questions, all equipment was there, maybe if we knew what that means.

HEARING OFFICER HALSTEAD: I don't think it's necessarily relevant what all the equipment was, but if you want to spend the time to do that,

you certainly can.

MR. WHITE: I'm just giving an example.

HEARING OFFICER HALSTEAD: Continue, please.

Earlier, Mr. White didn't have an objection to the leading, but I am hearing him having one now.

MS. DAEHNKE: I will continue in a less-leading fashion. Do you want me to reask those questions?

HEARING OFFICER HALSTEAD: No. You can continue on from there.

MR. WHITE: It's okay.

MS. DAEHNKE: All right.

BY MS. DAEHNKE:

Q. Did you have everything you needed to safely do the surgery on Patient A?

A. Yes, I did. Some instruments were not necessary, I wouldn't use a stapler, generally, in this thing, so it was not open, necessarily, but it was available.

Q. And when you said you self-narrate, would that mean -- what does that mean when you talk about --

A. As I am operating, I want to have

everybody stay with me in what I am doing now and what I plan to do after that, so to speak the majority of the time that I'm operating because I'm then generally teaching someone at the same time.

I think it's always helpful for the anesthesiologist to time their medications to keep the patient asleep, so I always try to say I think this is going to take about this long so that they can keep the patient asleep or, conversely, wake them up if that is not going to take that long so that we can stay in the same rhythm of the surgery.

That leads us also to get our times that the circulating nurse and the scrub tech need to do things that are required, such as to count and things such as that, and whether -- sometimes I need their hands to hep me and they can't count while they are doing those things like that.

Just to kind of keep the organization of the -- and the flow of the surgery going so that it's most efficient.

Q. If I understand you, for instance, when you put the first Trocar in, would say "No visualization"?

A. Yes. We can't see, so let's go on the other side.

And often it takes you to walk across the room around the patient to go say, I'm going to go from this side, as I don't have big muscles so I need to have everything ergonomically set up where I can do things well and not from an awkward position such as that.

Q. Is that also for safety reasons?

A. Absolutely, yes.

Q. Okay. You're on one side and around --

A. To the other side.

You have to, basically, tell everybody we need to regroup and you need to stand here, I need to stand here, so everybody can do their part in this to make everything go forward. It's definitely a team sport.

Q. Then when you announced that you couldn't see anything and you were going to have to around and go --

A. Yes. But everybody is looking at the television, so everybody can say, and people often will say, my goodness, do you see that? I see that. It looks okay. It doesn't look okay.

A lot of people are invited to comment and do comment.

Q. So when you said you were going to go in

on the other side, did anybody say, oh my god, no, that's not safe?

A. Not at all.

Q. All right. Then you're on the contra laterals?

A. I started on the right side and then I went over to the left.

Q. Did you -- were you on the patient's left side when you went midline, where were you?

A. I don't recall.

Q. Okay. So you were talking about a midline?

A. I generally would be because I'm right-handed, if I had to assume, I would assume. But I don't recall.

Q. All right. You were describing the injury and the stapler and why the sutures were failing, basically.

A. Yes. And just -- he -- when you open, a lot of times we were -- again, the adhesions that he had were very bloody and whenever you moved anything, it bled a lot more than usual.

Q. Okay. Did you ever -- did you come up with a reason for that?

A. I thought it affirmed my fear that he had

short bowel syndrome and he did not -- his nutrition was not the best, and that he probably didn't have small amounts of things that need to clot and have plenty of blood.

I was shocked but not surprised.

Q. So, then, what did you do?

A. I tried to loosen the bowel from attachments so it did not have tension on it. Tension can make the repair not heal as easily. Again, it was a little bloody, so I stopped the bleeding with sutures and clamping, suture and tie where appropriate, and then washed the abdominal cavity to make sure that the bleeding had stopped. Then I closed his abdominal cavity.

Q. Washing means what?

A. We use sterile saline to pour over the area of the opening of the abdominal cavity and looking specifically -- we can pour it or squirt, we have these little bulb syringes that would give -- do it a little bit more powerful than just a pour, just to see if you -- as you dry things with both suction, suction that we have in our hand, it's going to get to a bulb suction, very low pressure, or just dabbing with laparotomy pads, which are sterile gauze, to see and make sure that the

bleeding is stopped, when you touch it, it's no longer bleeding.

Q. And did you repair the hernia?

A. No, I didn't not repair the hernia.

Q. Why not?

A. I decided at that point that the patient had an unexpected problem and he was bleeding and that he was not in good as a shape as I thought he was to start with, so I should stop and get him better, and make sure there was nothing else wrong with him and get him off the table, that was enough anesthesia for today, and so I decided to close him and stop and make sure that he was okay.

Q. And the reasons to close, to stop the procedure, why would there be -- why would you be concerned about the anesthesia -- about the patient, the length of time the patient was under anesthesia?

A. Longer anesthetic is associated with more complications, and so I didn't want him to have any other problems. I thought I should stop now, and, again, make sure that he was okay from everything he had -- again, he had more bleeding than was expected in a patient his age and with very normal labs -- with normal pre-operative labs.

Q. When you -- it was intentional that you

did not repair the hernia?

A. I made a judgment call, and I thought that was the best judgment at that time to not -- to get this patient awake, to make sure he was okay, I had not injured him, and that he is going to be all right.

I though I won't do anything else right then except for close him safely, and then I'm going to wait and go from there.

Q. Did you have a discussion with Patient A after the procedure, after he was awake for the decision --

A. Yes.

Q. -- about what had happened.

A. When he was in the recovery room, I went and talked to the woman that came with him, and told him about what happened in the operating room. Often when people have had anesthetic, when you have a conversation with them, they really cannot remember the details due to various anesthetic agents that are used.

While you have a discussion with someone, I think you can't assume that they really understand, and so you have to have that discussion again. It's unpredictable. You can have a

conversation and it seems like the person is understanding, and they may or may not be because they will often say you never talked to me, and I can have witnesses say, yes, we did have this conversation with the nurses that's in the recovery room or the patient's family, and they just don't remember because of the anesthetic.

Q. Did you talk to them again?

A. Before he left the surgery center, yes, I did.

Q. And do you recall having conversation with the woman that was there -- is her name Mary?

A. I think so.

Q. There's a document, Mary, that's why I asked.

I think we covered this, but entry to the bowel is recognized risk of this procedure?

MR. WHITE: Objection. Leading.

BY MS. DAEHNKE:

Q. Is injury to the bowel a recognized risk of the procedure?

HEARING OFFICER HALSTEAD: Yeah, but she already prefaced it that she asked it before, and so it seems like a prefatory question.

If that's the case, go ahead.

THE WITNESS: Yes, it's a known complication, the laparoscopy.

BY MS. DAEHNKE:

Q. And it's in the consent form -- is it in the consent form?

A. I think the consent is very general. I'm not sure it specifically says that.

Q. Does it say "injury during the surgery"?

A. I don't know.

Q. I'll look at it.

Do you recall, did Patient A have any questions or did you intend to speak to him again after he was further away from being under anesthesia?

A. I spoke to him at the surgery center before going home. Does that answer your question?

Q. Yes.

Was Mary there also -- or the woman that was with him?

A. I don't recall.

Q. Did you think that it was safe to discharge him home?

A. I do.

Q. Tell us why.

A. After discussing this with the nurses that

were taking care of the patient in the recovery room and the anesthesiologist, Dr. Gomez, the patient was awake and alert and was stable, his wounds were clean and dry, no problems, so I thought that was safe.

He had instructions for very close follow-up in the next couple of days with instructions to call me prior to that if there were any problems that were unexpected.

Q. Who is Dr. Gomez?

A. He's the anesthesiologist.

And they had been tasked with perioperative care, and that they can stop an operation if they don't think that the patient is prepared for an operation, they can stop an operation during the operation if they think things are not going well or with the anesthetic, and they can make recommendations whenever the patient is safe to go home or not, that they have adequately recovered from the anesthetic that they can be alert and be under their own care or the care of someone with them.

They make that decision with the surgeon.

Q. You -- did Dr. Gomez, then, clear him to go home?

A. Yes.
Q. Did Dr. Gomez express any concern or indicate that he should stay a night at the surgery center?
A. He did not.
Q. Did you --
A. He did not express any concern. He did not think the patient needed to be hospitalized.
Q. Did the patient understand that he needed to come back in a few days?
A. Yes.
Q. What was your intent when the patient came back in a few days?
A. I wanted to make sure that he was eating all right and no fevers, that his wounds were healing, that he had appropriate bowel function, that his pain was under control, if he had any signs of infection.
Q. And the patient agreed to come back?
A. Yes.
Q. And the patient did come back?
A. I think so.
Q. How --
MS. DAEHNKE: I've completely lost my voice right now. How much longer can you go

(inaudible).

HEARING OFFICER HALSTEAD: It's 4:41. I'm trying to weigh your voice concerns with the time, how to better use our time effectively.

Are you able to understand?

THE REPORTER: Not really. I've been faking it, hoping my audio picks it up.

MS. DAEHNKE: I can see you --

THE REPORTER: Struggling?

MS. DAEHNKE: Yes. We're both struggling to get through this.

HEARING OFFICER HALSTEAD: Well, let's just be off the record for a second.

(Off-the-record discussion.)

HEARING OFFICER HALSTEAD: We're back on the record, briefly. After a discussion off the record, a discussion about timing, Ms. Daehnke's voice giving out, and anticipating time for tomorrow, it was agreed that we would adjourn for the day in anticipation of re-adjourning tomorrow at 8:30 in the morning and having sufficient time to finish with Dr. Barber prior to the other witness.

MS. DAEHNKE: Dr. Baskies.

HEARING OFFICER HALSTEAD: Okay. With that, we will be off the record for the day.

(Hearing adjourned at 4:44 P.M.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on April 3, 2025, for the hearing at the Nevada State Board of Medical Examiners, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 231 pages, inclusive.

DATED: At Reno, Nevada, this 16th day of April, 2025.



BRANDI ANN VIANNEY SMITH

5

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

In the Matter of the Charges and Complaint Against:

Case No. 23-11660-1

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.
_____/

TRANSCRIPT OF HEARING PROCEEDINGS
Day 2

Held at the Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Friday, April 4, 2025

Reported by: Brandi Ann Vianney Smith
Job Number: 7051983

A P P E A R A N C E S:

THE HEARING OFFICER:	PATRICIA HALSTEAD, ESQ.
FOR THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:	DON WHITE, ESQ. Senior Deputy Gen. Counsel Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov
FOR RESPONDENT:	PATRICIA DAEHNKE, ESQ. DRR Law Group 2110 E. Flamingo Road, Suite 212 Las Vegas, NV 89119 pdaehnke@drrlawgroup.com

ALSO PRESENT:
Meg Byrd, Legal Assistant

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I N D E X

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EXHIBITS

(no exhibits admitted)

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RENO, NEVADA -- APRIL 4, 2025 -- 8:34 A.M.

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HEARING OFFICER HALSTEAD: We're back on the record In the Matter of Charges and Complaint Against Annabel Barber, M.D., case number 23-11660-1.

Present are both IC counsel, Don White, and respondent's counsel, Patricia Daehnke, and Dr.Barber is present.

I remind you, Dr. Barber, that you remain under oath.

When we concluded for the day yesterday, we were in the middle of direct examination of Dr. Barber by her counsel.

Unless there is anything we need to address on the record prior to recommencing that?

MR. WHITE: The rule of exclusion still applies?

HEARING OFFICER HALSTEAD: It still applies, yes.

MS. DAEHNKE: So the only person who is here who is not -- is plaintiff in Las Vegas?

HEARING OFFICER HALSTEAD: Patient A, and

he's in Las Vegas, correct.

MR. WHITE: And not a witness.

HEARING OFFICER HALSTEAD: Correct.

Anything further?

MS. DAEHNKE: So for the timing of witnesses today, we have the interruption with 11:45?

HEARING OFFICER HALSTEAD: Correct. 11:45 to 1:30 we have to vacate the room.

MS. DAEHNKE: And Dr. Baskies was going to come at 11:00. We're going to see if he can come a little bit earlier. And then also Meg said she needs 15 minutes prior coming on to set up the Zoom.

I'll try to work within those time frames, get him a little bit earlier, if possible, so we can get more done.

HEARING OFFICER HALSTEAD: Great.

Your witness, Ms. Daehnke.

MS. DAEHNKE: Thank you, Your Honor.

DIRECT EXAMINATION (continued)

BY MS. DAEHNKE:

Q. Good morning, Dr. Barber. I'm going to jump around a little bit with some topics, but let me ask you something.

In your CV -- and you told us yesterday

that you're a member of the American College of Surgeons?

A. Yes.

Q. Now, are you -- what committees are you on?

A. Well, I think I mentioned yesterday, my term just ended for the board of governors, and I was on the best practices committee.

Q. Okay. What is best practices committee? Can you tell us a little bit about that?

A. It is a committee that has been trying to do exactly what it says, try to set out and make standards for best practices in surgery. And so what would be the most appropriate approach for various things. We did a big paper on nutrition in cancer patients. We were trying to work on some other things.

I may have mentioned to you, records, they come up with making synoptic operative notes.

Q. What is that?

A. Well, as you have looked at a lot of medical records, the operative notes can be from very short, just the facts, ma'am, to I walk into the room and did this and describe everything in the room, things such as that.

And so Dr. Spoerke mentioned yesterday, op notes are, unfortunately or fortunately, used for communication of what was important that was done, and they are used for billing as well. The Center for Medicare/Medicaid services that set up the CPT codes, the codes that we bill by, have really simplified things a lot (inaudible) administration in Washington.

At any rate, we used to have a number of different codes for things that we would get paid a little bit more, a little bit less, but that's all been boiled down, if you will.

So the synoptic operative notes have been really kind of been a result of that and to teach residents and surgeons to really say what's important. A lot has been really trying to work on giving a lot less detail that seems irrelevant in the long run in the operative notes. That's something we've been working on in best practics group.

We also did a lot telehealth, telemedicine to get things going, not only get the best things that came out of the pandemic, we can do a lot, see a lot more patients in a lot more places to really get people who were marginalized for whatever reason

to be seen and to people -- offices to be more efficient to have good telehealth to see, for instance, a post operative to have someone come and drive from wherever to come and see me to have me look at a wound, and they are doing well, and they can have -- it's more efficient for someone to see for something simple.

Or something, like I talked yesterday about patients, I met a person who was one of the surgeons in the state that does a certain surgery, so see people from a lot of places that come just for that surgery. I have a patient who lives in Wyoming that I just operated on a week ago, it's really hard for her to come and see me.

We are able to do a lot through telehealth. Not only -- of course we can do it, but to have -- we have to have the administrative stuff to -- if I see someone from another state, do our state laws allow that, does insurance allow people to be seen from other states, will they still be covered by that?

The medical schools can't decide if they still want to pay for telehealth or not. It's a conundrum.

MR. WHITE: I'm going to make a quick

objection. I would move to strike any references to political beliefs, what's going on in Washington, administration that were referenced just now. It's a long answer, but it was in there somewhere and I move to strike that.

HEARING OFFICER HALSTEAD: I honestly didn't interpret it one way or the other.

MR. WHITE: I was not sure either. I just thought --

MS. DAEHNKE: So --

MR. WHITE: -- it doesn't belong.

MS. DAEHNKE: -- the objection is?

MR. WHITE: Relevance.

BY MS. DAEHNKE:

Q. CMS, Doctor --

HEARING OFFICER HALSTEAD: It doesn't really matter. I don't need to rule on it because I doubt it's going to happen again, but was just a quick.

BY MS. DAEHNKE:

Q. Let me go back. And appreciate with my voice that you're talking and forcing me to ask you question by question, everyone's very patient with this.

CPT codes, what is that?

A. I frankly don't know what it stands for. But those are the codes that we -- when we say we want to do a surgery or any procedure, these are codified in the big book made by CMS that says this is -- if you a diagnosis, CPTs are probably procedural terms.

Q. And CMS?

A. CMS it's -- they would simplify the CPT codes because there used to be a lot more of them, and now there are much fewer. They said that -- we used to be able to charge if a hernia was bigger than three centimeters, we -- so they simplified and said we're only going to do these, these, and these, so it's much -- there are a lot fewer codes than there used to be.

HEARING OFFICER HALSTEAD: Are they billing codes?

THE WITNESS: It's a communication of what operation you wanted to do, you get approved by the insurance to do, by wherever you're going to do it in the hospital, the surgery center needs to approve it too, and then -- for billing.

HEARING OFFICER HALSTEAD: Thank you.

BY MS. DAEHNKE:

Q. Just to sort of tease this out, you have

an operative report, and you what? In general, if you're in private practice or at the school, you give it to billing person?

A. Yes.

Q. They look at it?

A. They read it and see if they agree with the way we've coded it and then submit the bill.

Q. If I understand what you're saying, previously -- and this is some years ago, up until now in some places -- you would have multiple different codes for the same procedure because it was sort of unbundled, if you will --

A. Unbundled usually refers to doing several operations at once and charging for each one of them. That's more what bundling means.

But the codes for different types of things are they -- "bundling" is a term that means something different than this, so they simplified the coded and made -- kind of grouped many codes into one.

Q. And synoptics, is that something that the American College of Surgeons came up with?

A. Yes. The committee on cancer, when they were comparing -- they wanted to make sure if you had cancer surgery in one place versus another

versus another and pretty much had an adequate operation, we used to -- the codes would sort of say that. But with the simplification or coalescence of the codes, the synoptic op notes in, say, breast cancer, whether you did a lumpectomy or a mastectomy, whether you took lymph nodes or what else did you do, or how you put breasts back together, constructed or not, things like that, they used to be unbundled and you would charge for each one of them.

Whereas, they said this is not so complicated, let's say if you do these five things it goes under this code, if you do these three things it goes under this code.

Q. Thank you.

All right. And so if you do hernia repairs, is there a specific CPT code for that?

A. Yes, there are. And they were actually redone a few years ago in that it used to be that if you did a small hernia or a big hernia, it had to be greater than X amount of centimeters, and they codified if you're under three to five centimeters, five to seven, things like that, so you would have to say in your operative note how large the defect was, whether you're closing it primarily, whether

you're going to put mesh in or not. I think you can't charge for mesh anymore.

Q. And now?

A. It's just simpler and more exact. You have to measure, you can't just say.

Q. All right. Let me turn your attention to that short op note in this case. It should be -- Doctor, the ambulatory surgery centers, what is -- is there a different patient population that the code to an ambulatory surgery center such as Las Vegas Surgery Center versus the a patient who would be seen in the hospital, just generally, for a hernia repair?

MR. WHITE: Objection. Lack of personal knowledge and calls for speculation.

HEARING OFFICER HALSTEAD: I think she's qualified to answer that.

Go ahead.

THE WITNESS: I told patients to go to an ambulatory surgery center if they were going to have a simple operation, if they were healthy enough, to be well enough to be discharged, to expect to be discharged after surgery.

Q. Well, then, actually let me ask you in response to Mr. White's objection, where do you do

surgeries?

A. I have privileges to do surgery at a number hospitals for the last 20 years. I have privileges at Las Vegas Surgery Center, which I operated at primarily as a surgery center case, to do my surgery center cases there. And I do occasionally work to Sahara Surgery Center and at specialty surgery centers.

Q. And I think Mr. White's objection was he didn't think you do surgeries at the hospitals. Is that correct or incorrect?

A. I work of at University Medical Center.

MR. WHITE: Can I explain, actually, since she's mischaracterizing my objection?

HEARING OFFICER HALSTEAD: I didn't take that that was your objection.

MR. WHITE: No, it's not.

HEARING OFFICER HALSTEAD: Her questions are not evidence, and I didn't take that the way it was purported to reflect.

MR. WHITE: Okay.

BY MS. DAEHNKE:

Q. Do you also perform surgery at hospitals?

A. I work at University Medical Center, I work at Mountain View Hospital, I have done

surgeries at -- I have privileges at Valley and some hospital in Reno.

Q. Okay. So back to you said that the patient's that go to ambulatory surgery centers are patients that don't need the hospital -- to be hospitalized.

Was that the case with Patient A?

A. I believe it was, yes.

Q. And what factors did you determine with Patient A as to why he didn't need to have his surgery in a hospital?

A. Well, just in his preoperative evaluation, he was on his own steam, even though he had some problems before, he healed well from that.

He did have some anemia reported, reported short bowel, but, again, I felt that was mitigating any chance of him having a problem by pre-having, if you will, Juven.

Q. Dr. Barber, do you have NSBME Exhibit 4, Bates-stamped 107 in front of you?

A. Okay.

HEARING OFFICER HALSTEAD: Which, for the record, is the same as respondent's Exhibit 5, page 71.

BY MS. DAEHNKE:

Q. I'm showing you -- could you tell us what that is, please?

A. This is a short form that incorporates the day of surgery H and P, and it has an op note, post-op orders, a discharge note all in one page. It serves as a follow-up from the office.

So this form was filled out on the day of surgery, and any changes from the full note from the office are recorded here.

Q. Okay. When say the "full note from the office," are you talking about the H and P dated December 27, 2018?

A. That's correct.

Q. And when you say "from the office," what office are you talking about?

A. This is my patient office.

Q. And that's UNLV school of medicine -- Kerkorian School of Medicine?

A. Yes.

Q. It's located at 3150 N. Tenaya Way?

A. It was.

Q. Yeah. Okay. At the time.

And so the patient came to your office at the medical school; is that correct?

A. That's correct.
Q. And that's where you conducted the initial consultation and H and P?
A. That's correct.
Q. And this was an elective hernia repair?
A. Yes, it was.
Q. Back to this document. Can we go through, starting in the upper left -- let me ask you real quick, are these H and Ps, short op note, are these used in ambulatory surgery centers and hospitals or just --
A. For the H and P that the hospital uses is a longer form and requires more information. And if -- there are rules that the surgery center to determine if someone is likely to be, able to be -- have a short surgery and go home. It's really set up for that reason, so this is --
Q. As a reminder?
A. Yes.
Q. Let me ask you -- and I don't see where -- there's an asterisk, but in the lower left -- left where it says, "Note if you dictate your H and P, you do not need to complete this portion."
What is that?
A. Some people will re-dictate the entire

thing rather than bringing in their note from the office. That's an option too.

Q. Again, when you are saying your note from your office, you're saying that the H and P listed in this production of documents and in the Board's is right behind the short H and P, short op note?

A. Yes.

Q. Okay. So on the left-hand corner of the page from the date down, what is that?

A. It's a short H and P form. The patient's chief complaint is left inguinal hernia, and the history of present illness, he had a pain and bulge in his left groin.

Q. Okay. Pain and bulge in the?

A. Left groin.

Q. Okay. That little circle?

A. Is in the left, L.

Q. Past medical and surgical history?

A. Was born with omphalocele and had abdominal wall reconstruction.

Q. And you learned that from the patient?

A. Yes, I did.

Q. And present medications?

A. He was on alprazolam and Revatio, R-E-V-A-T-I-O.

Q. Alprazolam is what?
A. It's a benzodiazepine that's used for anxiety.
Q. What about Revatio?
A. It's a drug that -- most people know it by Viagra, but this man was not using it for this reason. He was using for the reason it was initially invented, and that's for pulmonary hypertension.
Q. And review of systems, what's indicated?
A. That he has short bowel and amenia and had reported before.
Q. And this your handwriting?
A. Yes, it is.
Q. Then under the physical exam, what is WNL? Dr. Spoerke and I think you also said that's within normal limits.
A. Yes.
Q. Could you look at this. What does it mean here when you check off within normal limits?
A. It's not remarkable. Everything is -- nothing to say.
Q. With respect specifically to Patient A, his general appearance, when you say "nothing remarkable," what --

A. He was a normal-looking man.
Q. All right.
A. And his head, eye, ears, nose, and throat was not remarkable.
Q. That's H-E-N-T?
A. Yes.
And he was breathing normally, so it's not remarkable.
Q. You mean --
A. Where it says "chest and lungs," as with the heart.
And a lot of people say that they do all these things in preop, but they don't. For instance, when people say pupils were equal, round reacting to light, nobody brings a light and shines in it people's eyes in preop. It just doesn't happen. Most surgeons do not wear stethoscopes and listen to people's heart and lungs.
I think many people say they do and are not really telling the truth.
Q. So what you are saying with this, on the day of surgery, this short form, you are not -- because you're not shining the light in their eyes?
A. Right. So I'm not going to say I did.
Q. All right.

A. And this patient was seen by another doctor preoperatively, Dr. Vohra. I just saw the page.

HEARING OFFICER HALSTEAD: Where is that in the records?

BY MS. DAEHNKE:

Q. Was it records from the surgery center?

A. I think it's in the surgery center's records, but they were given to the Board from the surgery center because they were included within the surgery center.

If patients see other physicians, I have those records with me when I come to the surgery center.

Q. What do you mean by that?

A. Here it is. It's on NSBME 112. Doctor Sanja Vohra. "Okay from cardiac standpoint to proceed with the planned surgery and general anesthesia." That's on that page.

This patient has been seen by a cardiologist.

Q. That was on the same day?

A. No. It was before the surgery.

HEARING OFFICER HALSTEAD: For the record, according to the document, it was done on 2/14/19.

BY MS. DAEHNKE:

Q. That was after your initial history and physical?

A. Yes. When the patient had gone through the testing, make sure he was really okay to have a general anesthetic.

Q. Let just go back to that. What testing did you order for Patient A in preparation for surgery?

A. I think we spoke yesterday, he had a CAT scan, he had a complete blood count, a CBC, he had a complete metabolic panel, and he had a chest x-ray and EKG.

Q. And was there anything in all the labs and the radiology and the testing that would make the surgery at Las Vegas Surgery Center contraindicated?

A. No. He was slightly anemic, but there were no other abnormalities.

Q. All right. Then --

MR. WHITE: I'm sorry. Do you have -- are you pointing to a certain -- do you have the CT scan?

MS. DAEHNKE: It's in the records from yesterday. We're not going to put it on the --

MR. WHITE: Is there a report from it?

MS. DAEHNKE: Yeah. It's in your records and ours. Did you want to stop?

MR. WHITE: No. It's okay.

THE WITNESS: We talked about the labs and except for slight amenia, his hemoglobin was 9.1, his hematocrit was 29, they were normal.

HEARING OFFICER HALSTEAD: Which document are you referring to?

THE WITNESS: It's NSBME 88 and 89.

HEARING OFFICER HALSTEAD: Thank you.

THE WITNESS: And I neglected to say that I also did a urinalysis.

BY MS. DAEHNKE:

Q. And did you review all those records before the day of surgery?

A. I don't recall when I reviewed them, but I know I reviewed them before the day of surgery.

Q. It's your custom and practice?

A. Yes, it is.

Q. All right. Dr. Barber, can you direct your attention back to the short op, 71. We were at abdomen, left inguinal hernia, and do you agree with Dr. Spoerke that that should have indicated whether it was reducible or incarcerated?

A. I think that is, actually, irrelevant in

that often -- you know, you have a CAT scan showing he had an hernia, and we were going to do the same operation whether it's reducible or not, you can operate on it, and the same operation is done.

Q. What does reducible and incarcerated mean?

A. A hernia is basically outpouching of the abdominal contents from the abdominal wall. It could be anywhere in the abdominal wall. It's usually lined by the peritoneal sac, and whether it is incarcerated is whether or not you can reduce it. Again, the operation is the same, reducible or not.

Whether it has bowel in here or not, whether it has fat in it or not, they can be where you can push them back or whether you cannot.

Q. Reducible means what?

A. You can push the abnormality back in the abdominal cavity.

Q. And then incarcerated means you can't?

A. Right.

Q. And so in your opinion, does standard of care mandate that you put whether it's reducible?

A. I don't think so.

Q. And, I think you just told me this, why not?

A. Because the operation's the same. We're

already at the point where we're in preop and we are about to go to the operating room, and I'm affirming with the patient that this is your problem and this is what I am going to be operating on today.

Q. And then in GU pelvic, what is "GU"?

A. Genito-urinary. Pelvic exam, people rarely do those in preoperative areas either, but I just noted that this man's testes were both descended.

Q. That is what those two arrows mean?

A. Yes.

Q. All right. You heard Dr. Spoerke yesterday talk about arrows, that arrows were bad.

What is your understanding and why do you put those arrows?

A. I made it just pretty much as a note to myself. This the way we started, and that is, again, indirect -- the testicle can be incarcerated within a hernia too, and so it is kind of note to myself of this is what we are starting with.

Some people who have had some congenital abnormalities may have their testes that haven't descended, and so it's just sort of a note to myself of where are we today.

Q. And those two arrows, is that a common --

A. It's a note that they are descended into the scrotum.
Q. Are those two arrows signs that you have seen with your colleagues to use for descended testes?
A. Yes.
Q. It's not uncommon?
A. No.
Q. Do you believe that communicates that after the testes is sufficient to meet the standard of care?
A. Yes.
Q. All right. Then going down, following down on the left, what was your impression?
A. That the patient had a left inguinal hernia, and my plan was to do a laparoscopic repair.
Q. Is that your signature?
A. It is.
Q. I'm sorry, but can you see where it says that if you dictate your H and P you do not need to complete this, where that asterisk goes to?
A. I don't see an asterisk on any form.
Q. All right.
A. I believe you.
MR. WHITE: Where are you pointing to on

the page?

MS. DAEHNKE: Let me show Dr. Barber first.

MR. WHITE: Okay.

THE WITNESS: I don't have an asterisk.

MS. DAEHNKE: I do. Right there (indicating).

MR. WHITE: Okay. I see.

MS. DAEHNKE: I'm just trying to figure out where that asterisk is supposed to go.

THE WITNESS: I have no idea.

BY MS. DAEHNKE:

Q. Does that mean this whole left side (indicating)?

A. I assume so, but I have no idea.

My practice was to bring my notes from my office to help me remember my visit with them, and then I would fill this out. It's just a note to help us get going for the day.

Q. Just so we're clear, when you're saying -- and this is your custom and practice, not just with Patient A; correct?

A. That's correct.

Q. When you say "notes from your office," what are you telling us?

A. I'm bringing the consultation H and P from the office, or my office is having it sent so that I will be reminded of my visit with them and of the details of the visit and anything that may impact upon my surgery that day. And they have surgery. H and P is just a note, hey, we're here today, nothing's any different, we're ready to go.

Q. Thank you.

A. And, again, big affirmation with the patient before you sign the consent that we are on the same page, this is -- I've looked at you today, this is what we said we're going to do, and this is what we're going to do.

Q. And by affirmation, do you go over everything with the patient on the day of surgery again since it's from the time, the H and P?

A. Well, a number of people do. They gather a lot of -- all of the same information and more information, both the nursing staff does, the anesthesiologist has not met the patient before, they go over all of the information available too.

That's why I have something -- in a patient that's had some things in the past, have the cardiologist say, hey, you're fine, even though you're not that old, you're 54, you may have a heart

problem, so let's just make sure that things are a go.

Q. We talked about, both Dr. Spoerke and I think you might have mentioned that the patient's had the congenital defect and then a small surgery about 30 years prior?

A. I cannot remember if it was at age 30 or 30 years prior. It's sort of like, he was 54, so it was not that far.

Q. But the -- whether those medical records -- he had those out of state; is that right?

A. Yes.

Q. But if you had medical records from the more recent in Nevada, would you bring those with you?

A. Not necessarily, no.

Again, this is what we're dealing with now, today, and I have a recent CAT scan, and so the records of the past are really not that helpful.

Q. Would you have the labs?

A. Absolutely. You have to have labs.

Q. In the records from the CAT scan?

A. Yes.

Q. And then on the right-hand side, this is also your handwriting?

A. It is.
Q. There's another blank there for a date?
A. Yes.
Q. Interesting. Okay. Well, is this used sometimes where an H and P --
A. I've never done that, so I don't know.
Q. Do you know did Las Vegas Surgery Center come up with this form?
A. They come up with this form? It is the same form at all of the HCA-associated surgery centers, this form is the same. That is Hospital Corporation of America.
Q. And HCA has which hospitals in Las Vegas?
A. MountainView, Southern Hills, Sunrise, and -- I'm not sure. There's another one.
Q. You operate at those hospitals?
A. At Sunrise and MountainView, yes.
Q. And you've seen these forms there?
A. They are not at the hospital. No. They're at the surgery centers, the ambulatory surgery centers.

They have a number of surgery centers. That is a different thing. Sahara Surgery Center and the specialty surgery center I mentioned earlier, they have the same forms.

Q. All right. Then the right-hand side is what?

A. A brief op note.

Q. And I've seen in other records brief op notes that contained, whether it's a surgery center or hospital, they're just like either handwritten paragraph, or explain --

A. Yeah. The idea of that is that staff taking care of the patient -- we dictate operative notes not available, it takes some time, so the staff taking care of the patient immediately after the surgery knows pretty much what happened.

Again, just the facts of what may be making a difference, what did you come for, what was pre- and post-operative diagnosis, and what was actually done.

This is also communicated verbally to the recovery room and the anesthesiologist to make sure that everyone is staying on the same page, if you will. It said that the patient had a left inguinal hernia --

Q. Let me stop you. Go ahead with the anesthetic?

A. It was a general anesthetic.

Q. And what is the pre-op diagnosis?

A. Left inguinal hernia.
Q. And then the procedure?
A. Was attempted laparoscopy, laparotomy, and repair of the bowel.
Q. And what's indicated below that?
A. It was the surgeon, the surgeon, put my name and Dr. Vest as my assistant.
Q. And what were the significant findings?
A. The patient had adhesion, a small bowel injury and repair. That there were no specimens removed. That helps everyone know that, indeed, they are not looking for something that is not there and sent to the lab, how much blood is lost, and whether there were complications.
Q. And -- all right. In your opinion, Doctor, significant findings, adhesions, small bowel injury, and then?
A. Repair.
Q. Is that sufficient description of the surgery and what happened to meet the standard of care?
A. Yes. Again, this note is to communicate with the other doctors and nurses taking care of the patient what you did.
Q. And estimated blood loss, you talked about

the bleeding bowel, is 200ccs, a lot of blood.

A. A unit of blood is 250ccs. So 200ccs is a lot for a hernia repair, yes it is. It was very concerning.

Generally, blood loss for a hernia is less than 10, maybe 20.

Q. And the reason the patient had that much blood loss is what?

A. Because he had bloody adhesions and tissue that bled when it was just gently moved, very sensitive tissue.

Q. And the anesthesiologist monitors this as well during the surgery; correct?

A. Yes.

Q. And then what's complications?

A. Small bowel enterotomy and repair.

Q. You wrote, "Small bowel enterotomy and repair"?

A. Yes.

Q. You talk about this yesterday, but an enterotomy is?

A. An opening of the small bowel.

Q. And then it looks like, then, that is the end of the brief op note?

A. Yes.

Q. Okay. What's the section there?

A. It's the post-op orders, another sheet, order sheet, discharge note, and it says, "Significant findings," nothing is any different from that as above so I checked that box. The treatment was no different from that as above so I checked that box. And the patient is stable, so I checked that box.

Q. "Condition on discharge," is that meant to indicate when the patient was discharged home or is it the form, if the patient's discharged to home or another facility, is that meant to indicate at the time -- is this the discharge note giving authority to discharge the patient?

A. No. Discharge order goes -- discharge note just says what you believe the patient's condition is when you're seeing the patient before the surgery center or the hospital.

Q. Okay. What about diet?

A. Resume preoperative diet.

Q. And what does it --

A. You can't send someone home if they can't eat, so -- I thought he would be able to eat because his repair was good, I thought.

Q. And medications on discharge?

A. I gave him some Percocet, a pain medicine, it's oxycodone and Tylenol mixed together. Excuse me, acetaminophen, not Tylenol.

Q. What is indicated --

A. Patient should come back to see me in three days.

Q. And would the patient -- did you intend for the patient to go back and see you at your office at the university, the school of medicine?

A. Yes.

Q. And then what is the next sentence, final diagnosis?

A. There was nothing any different.

Q. It says "As above"?

A. Yes.

Q. All right. And is that your signature?

A. Yes, it is.

Q. Dr. Barber, let me ask you to look at your February 22, 2019 op report.

A. That's NSBME 115?

Q. 115 to 116?

A. Yes.

Q. Dr. Barber, first, let's talk about that op report that's got the blanks in it and such, how did you prepare this operative report?

A. Well, when you finish the operation, went to the recovery room with the patient, and we have a dictating desk in there, so I like to do any dictations right when they are finished so that you -- I think it's the most accurately done right when you finish. I was actually very kind of shaken in that this operation did not go smooth as planned, and then I had to open the belly and lost a good bit of blood, and it was not what I thought would happen happened.

So we went to the --

Q. Let me just stop you. It's -- where's the desk? Is it right outside the surgical suite or on the same floor?

A. There's only one floor. And the recovery room is about as big as this room, and the desk would be -- there would be a partition, and the desk about where I'm sitting. Only one person can sit there at a time. Tag in and tag out.

MR. WHITE: I'm going to note for the record that she said "as big as this room," we're sitting in the conference room in the Reno office, yeah, in the board room.

HEARING OFFICER HALSTEAD: Thank you.

BY MS. DAEHNKE:

Q. So everyone can see each other?

A. Yes.

Q. It's not on another floor?

A. No. There's only one floor.

Q. You said you like to dictate right after the surgery, and you did this case?

A. Yes.

Q. And you remember?

A. Yes, I do.

Q. And is that your custom and practice?

A. Yes.

Q. To pick up that phone at Las Vegas Surgery Center and dictate into the phone?

A. Yes.

Q. Then what happens, to your knowledge?

A. Okay. So you dial a number and it goes to a transcriptionist somewhere, then it's transcribed, and they give you a transcription note, a number.

Q. Look at -- can you just turn to the second page to --

A. Yeah. There's a job number underneath my signature.

Q. It says "Job number 931555"?

A. Yes.

Q. While you're there, what does the rest of that line indicate?

A. "AB," I have no idea. Those are my initials, but I have no idea.

Q. You don't know what that "Med RNDPR" is?

A. I don't know.

Q. All right. What's "D" with the colon?

A. Generally that's the date of dictation and the date of transcription.

Q. So the date of dictation is February 22, 2019?

A. Yes. Transcription is the following day, February 23, 2019.

Q. That's after that "T"?

A. Yes.

Q. Just -- could you also at the Las Vegas Surgery Center pick up a phone somewhere else and call into --

A. Yes.

Q. What was your custom and practice?

A. I didn't -- I wanted to finish my work before I left the surgery center.

Q. Okay. Let me ask you before we get to the contents again, when do you get, typically, or with this, if you remember, when do you get these

operative reports back to review?

A. This -- Las Vegas Surgery Center was the first surgery center in Las Vegas, very traditional, and so the operative notes were not -- they were nothing what is in a computer. The opportunity to correct operative notes as are done at other hospitals is not available at the surgery center.

Q. So as far as Dr. Spoerke saying that you had an obligation to go on a computer and correct this, were these available on the computer?

A. No, they weren't.

Q. Did any physician who did surgery Las Vegas Surgery Center in February of 2019 have an opportunity to correct their operative reports on a computer?

A. No.

Q. There was no -- was there any EMR with regard to operative reports --

A. No.

Q. -- in February of 2019 at Las Vegas Surgery Center?

A. No, there was not.

Q. Okay. So the process, it gets transcribed?

A. Yes.

Q. And --

A. You are not presented with your operative notes until you come to the surgery center again and they hand you a stack of papers to sign.

Q. All right. Was there any -- you heard Dr. Spoerke, and we've looked, there's gaps in this operative report with the timestamps.

Did transcriptionists ever call you and say, hey, I don't understand this word, please tell me what this word is?

A. No.

Q. Have you ever gotten a call from a transcriptionist in your 30 years to say I don't understand your dictation, please tell me what this says?

A. Not that I recall.

Q. Okay. Do you have -- well, if you know, would you have access to the transcription, what the transcriber was listening to?

A. If I do, I'm not aware of it.

Q. All right. So do you remember signing this operative report?

A. Not specifically, no.

Q. All right. But according to your familiarity with Las Vegas Surgery Center and your

own custom and practice, it would have been presented to you?

A. The next time I was there, they would bring me a stack of charts with sort the sticky things that you put on, go this page, sign on this line.

It would be on this page, which is page 116 of the exhibit, and with a sticky saying sign here. That's it. I signed the things I was supposed to sign.

Q. Okay. Let me --

A. I don't recall reading that note before I signed.

Q. And while -- when was the first time that you remember seeing this operative report?

A. When the case was filed.

Q. And the -- there's blanks and words that appear to be mistranscribed. When you signed this, did you notice that there were blanks and words that were mistranscribed?

A. No, I did not.

Q. If you had gotten this paper copy and noticed that there was something important that needing to corrected, what would be the method if there was?

A. You couldn't handwrite on the form.
Q. Why not?
A. Because when I saw it, it was a lot later.
Q. If you did -- Las Vegas Surgery Center allow the surgeons to handwrite on operative notes later --
A. I don't know they didn't.
Q. But for your signature after you signed it, then, would Las Vegas Surgery Center use the operative report to support its billing?
A. I think so.
Q. Was there someone at Las Vegas Surgery Center that would call the doctors if they hadn't signed off on their reports --
A. Yes.
Q. -- after a certain --
A. Yes.
Q. And that is the same procedure at many of the hospitals?
A. Yes. Actually, now we get an email, but at that time we didn't. Actually, you never got an email from Las Vegas Surgery Center.
Q. Didn't email. Okay.
A. Not that I remember.
Q. Do you remember, did you get a call

regarding this note (indicating)?

A. No.

Q. Okay. Will you look at this operative report, please. The pre-operative diagnosis was what?

A. Left inguinal hernia.

Q. And that was the same as indicated on this short H and P and op note that we talked about a moment ago?

A. Yes.

Q. What about post-operative diagnosis?

A. The same.

Q. The same?

A. Yes.

Q. Okay. And what is indicated as the procedure performed?

A. Laparoscopy converted to laparotomy with repair of small bowel.

Q. And by saying "repair of small bowel," what do you intend to indicate and convey there?

A. That there was a small bowel injury and it was repaired.

Q. And the surgeon?

A. I put my name.

Q. And the assistant?

A. Dr. Maxwell Vest.
Q. And the anesthesiologist?
A. Was Dr. Richard Gomez.
Q. And the estimated blood loss?
A. 200ccs.
Q. That's the same as indicated on the short op note?
A. Yes.
Q. Okay. Then what is next, the procedure description? And just because this has been talked about so much, can you just take us through after informed consent?
A. Well, most operative notes begin in the first two sentences, "The patient was brought to operative room after consent was obtained and then placed in" -- a standard position is supine, it's when patient's lying down. You can put the patients in other positions. That is often noted in the operative note in case there are any injuries or problems.
Q. What is this sentence, "The patient understood"?
A. I think that is a mistranscription. That should be underwent. Those are pretty much sentences that I start every operative note with.

"Patient underwent (inaudible) induction under general anesthesia," and so these are things --

Q. You think that the transcriber got --

A. Yes.

Q. You believe that should be "underwent"?

A. Yes.

Q. And that sentence makes sense with the word "underwent"?

A. Yes. Underwent a smooth induction of general anesthesia.

Q. Okay. Thank you.

What does next sentence --

A. "Patient abdomen was prepped and drapped in the usual sterile fashion."

Q. And is that what was done?

A. Yes.

Q. All right. And then what is the next sentence?

A. "A timeout procedure was performed."

Q. And what's is a timeout with regard to this?

A. The next sentence explains that. The patient's identity, the fact that antibiotic has been given, and all equipment was available was confirmed. And that's -- those are the content of

the timeout procedures.

Q. And is that literal that it's -- how does that -- is it announced, what happens --

A. Yes.

Q. -- when you give people timeout in surgery?

A. Yes. It's in the patient safety literature, the beginning of surgery, wanting it to be compared to a pilot taking off in an airplane, the safest thing to happen in the surgery.

We began this procedure of timeouts ten years ago. At the beginning of surgery, everyone would stop and either -- controversy of who starts the timeout procedure, whether it's the surgeon or the operating room nurse, so that everyone would be quiet and concentrate on what we're doing to focus on the specific that this is what we're here for, whether the patient had had antibiotics, whether they would have had -- everything is available in the operating room that it was thought to be needed for this operation, and so that we could not have doubts or problems or unexpected things to assure the safest operation possible.

Q. Thank you.

And what is the rest of that sentence?

A. That after this was confirmed, I injected some Marcaine, which is a local anesthetic, to the subcutaneous tissue, and I continued to make an incision.

Q. I'm trying to get you to look at the words because I want to make sure that this is accurately describing what happened and what's right.

The words that were transcribed there, "after which"?

A. If I were editing that, I would have a period and that would be a new sentence. And, "After which, a hundred percent Marcaine was used for the skin the subcutaneous tissue in the patient's right lower quadrant."

Q. Is that accurate?

A. That's my usual, I believe so.

Q. Then the next sentence?

A. "A five-millimeter Optiview Trocar was advanced into the abdominal cavity; however, no visualization could be seen, and the previous Trocar was removed and identified" -- I think I'm reading this wrong.

Q. No.

A. There's a semicolon, "However, no

visualization could be seen and previous Trocar was removed and identical procedure was done." That sentence doesn't make any sense to me.

Q. Can you figure out -- what does it identify? "No visualization could be seen," is that accurate?

A. I recall I put a Trocar in the patient's right lower quadrant, I didn't see space, I saw bowel, so I did not think it was safe to continue through the patient's right lower quadrant.

I recall trying again from the left lower quadrant. I do not feel that this operative note accurately reflects that.

Q. The next sentence, through, read the next sentence, "The patient's left lower quadrant."

A. "Was the exact site of result. The midline was then tried."

Q. And the next line, "Small bowel injury was confirmed"?

A. Well, there's -- "However there was a suspicion of entering the small bowel, so a mini laparotomy was done, small bowel injury was confirmed."

Q. Okay. So can you figure out how that should have been either punctuated or misdescribed?

A. I can describe it differently. If I were editing this, it would be different sentences describing more accurately: An attempt first made in the right lower quadrant with no visualization of anything but bowel. No space. And a second attempt in the left lower quadrant with the same findings. And a third attempt in the midline where there was a suspicion of small bowel injury, therefore, a laparotomy was performed.

Q. You told us when you went to the left and there was no visualization, you suspected an injury before you opened the midline; is that accurate?

A. I suspected that the injury was in the midline, not on the left or the right, if that's what you're asking.

Q. Yeah. I'm trying -- okay.

A. And, indeed, it appears that is where it was.

Q. All right. This, though awkwardly, conveys that there is a suspicion of an injury and it was confirmed?

A. Yes.

Q. And then continue with "The laparotomy."

A. "The laparotomy was continued up and a great deal of bleeding occurred." I think what I

was trying to say is that I needed to open a little bit more than a mini laparotomy into -- to continue the incision of the fascia upward into the epigastrium.

And so I really wanted to -- do you want me to read the op note or tell you what I did?

Q. I want you to read the op note, tell me if it's accurate, and if not, tell me why.

A. "The laparotomy was continued and a great deal of bleeding occurred and the small bowel injury" -- excuse me -- "when opening the tissue just to move the fascia and epigastrium."

Q. And you told us about that yesterday?

A. Yes, I did.

Q. Okay.

A. "These were controlled with clamps" --

Q. And that was when you were talking about the Babcock clamps yesterday? Although it's late, but when you say "the clamps," are they different clamps?

A. No. When people say "clamps," generally they are referring to hemostats, and so I was not referring to -- Babcocks are not used very often, so that was a separate part, talking about the Babcocks.

Q. Okay.

A. When people say they clamp and tie, they are generally talking about hemostats.

"This is to control the clamps and sutures in the appropriate position." "Appropriate position," I think that was a mistranscription as well.

Q. What do you think it should say?

A. In an appropriate fashion. That's just the way I dictate, generally. I don't usually say "position."

Q. So you would say fashion, but it was transcribed as "position"?

A. Yes.

MR. WHITE: Where is that?

THE WITNESS: About in the middle.

MS. DAEHNKE: The sentence starts with "sutures."

BY MS. DAEHNKE:

Q. Then the next sentence, starting with "we."

A. Generally, I would have said: We did this easily and had multiple suture ligations -- I believe "this" not there -- on the abdominal wall and omentum.

Q. Okay.
A. And say: The small bowel was grasped with -- it says "With the Babcock," but I would say: With a Babcock clamp and the adhesions around this to free up -- the blank there, I believe should be the small -- hmm -- I think it should be adhesions.
Q. Okay. Then parentheticals?
MR. WHITE: I'm sorry. Where?
THE WITNESS: Where it says "(2:01)."
MR. WHITE: Oh, for where the blank is?
THE WITNESS: Yes.
BY MS. DAEHNKE:
Q. So the small bowel was grasped with Babcock and the lines of adhesions around this to free up adhesions.
When you're dictating, do you generally speak as quickly you were a moment ago?
A. I think so.
MR. WHITE: Objection. That -- I think it calls for speculation. We don't how doing she was doing it at the time --
BY MS. DAEHNKE:
Q. Do you know, Doctor --
MR. WHITE: -- personal knowledge.
HEARING OFFICER HALSTEAD: But she can

testify as to the speed of her dictation.

MR. WHITE: In general terms, but it doesn't mean it really works for this case. We don't know what she was doing this day.

HEARING OFFICER HALSTEAD: She knows what she was doing. She's testifying as to her own actions.

MR. WHITE: Well, the question was: Do you in general -- I don't know if she used the word "general," but it was: Do you typically talk as fast as you did a moment ago?

HEARING OFFICER HALSTEAD: It's appropriate.

MR. WHITE: Okay.

BY MS. DAEHNKE:

Q. Doctor, just to clear anything up, did you transcribe -- what Mr. White was doing, finger typing -- did you type this?

A. I didn't type this.

Q. Was there any capacity at Las Vegas Surgery Center to enter operative reports into the EMR?

A. There is no EMR at Las Vegas Surgery Center. There was no way for me to type anything into a record there.

Q. And there's no way for you to go into any EMR because there was not EMR to correct this; correct?

A. That's correct.

Q. Afterwards?

A. That's correct.

Q. And then on the second page, you told us that the "D" on the second page, your understanding is that's the date it's dictated?

A. Yes.

Q. The "T" is?

A. The day it was transcribed.

Q. By the transcriber?

A. Yes.

Q. And your custom and practice, do you usually speak rapidly when you're dictating after a surgery?

A. Unfortunately, I think, yes.

Q. Okay. Thank you.

So after the parenthetical, 02:01 -- I'm sorry. What do you think that is, based upon your experience with transcriptionists?

A. I think it was the adhesions.

Q. What in parentheses is that -- what is that?

A. That's the part of the tape where the transcriptionist is having difficulty.

Q. The transcriptionist, you don't ever remember receiving a call from a transcription about things they couldn't understand or hear on any operative report; is that correct?

A. That is correct.

Q. Do you personally have access to the transcriptionist, however that is, a tape or electronic recording?

A. No.

Q. The next sentence, could you read that, and is it accurate or what do you think it means?

A. Next sentence says, "Again, the patient did very easily" -- that makes no sense to me and I don't believe that's what I said because it's a nonsensical statement.

Q. All right. Based on your custom and practice in dictating, can you -- is there any --

A. I really don't know what that means.

Q. So, no. Okay.

The next sentence beginning with "the" and then blank.

A. "The blank was injected with Trocar." I think I was trying to describe the injury, the

Trocar injury, I don't believe I injected anything with a Trocar. I think I was trying to say: Identify the injury with the Trocar, so grasp with the Babcock clamp and the tissue below the Babcock clamp.

At this point, I think I described yesterday, the tissue was not easily -- when you put stitches in, it didn't seem hold the stitches very well. Generally you don't want use cautery on the bowel, especially in this patient, the tissue was not hearty in that the usual things you do to stop bleeding were not as effective as usual.

Generally when you clamp and tie something, that's end of it, and he would still ooze.

Q. You told us yesterday it was friable?

A. Yes.

Those are -- that's kind of a funny word that other people don't use, but surgeons when do talk about tissue, that's what I'm describing in that when you touch it, it bleeds.

I don't really know the origin of friable.

Q. Then could you read the next sentence?

A. "Tissue below with a Babcock was closed using Endo GIA stapling device."

Q. And that's accurate?
A. Yes. I reinforced using 3-0 Vicryl stitches, just trying to put belt and suspenders on to make sure that this tissue that's difficult to work with will really stop bleeding and be sealed.
Q. And the belt and suspenders are the stapling and the --
A. Sutures. You can do one or do the other, but I did both.
Q. And was that, in your opinion, meet the standard of care?
A. Yes.
Q. And please continue.
A. "The abdominal cavity was irrigated thoroughly."
Q. Is that accurate?
A. I recall that is factual.
Q. Okay. The next sentence?
A. "Irrigation fluid is removed and the fascia was closed using O PDS suture from either end of the laparotomy."
Q. Is that accurate?
A. Yes.
"And the subcutaneous fat was irrigated with fluid."

Q. Is that correct?
A. Yes.
"Homeostasis was obtained after cautery."
Q. What does that mean?
A. Sometimes the subcutaneous fat can ooze as well, and it just means a final effort to stop the bleeding.
Q. What's the next sentence?
A. "The wound was closed with staples."
Q. The wound was closed.
What layer are you taking about there?
A. The skin.
Q. Is that in addition to what was stapled with the Endo GIA stapler?
A. No. That's a totally different stapler.
Q. Okay. And just so we're clear, what are you talking about when you're saying "skin," what are the layers?
A. Okay. I irrigated subcutaneous fat, you go from the bottom to the top, so I was on the top end of the operation and closed the skin.
The staples are faster to close with. You can sew it or staple it, so I stapled it because I really thought this man needed to be off the operating room table.

Q. And he needed to be off, you talked about this yesterday, your reasoning?

A. He had lost more blood than I wanted.

Q. Okay. Then?

A. And then the very small incisions, I closed with stitches because they can be done very quickly.

Q. So that is correct, "The laparoscopy incisions were closed with 4-0 Monocryl and Dermabond." Is that -- Monocryl is what?

A. It's a dissolvable stitch. And so that was in the skin, incisions, and the two very small Trocar incisions in the left lower quadrant and the right lower quadrant.

Q. And Dermabond is?

A. It's a skin glue.

Q. And you put that on after the stitches?

A. Yes. Just to seal, and the bacteria also.

Q. The next sentence --

A. "(Inaudible) was placed" -- and it should have been in, not "on," -- "an abdominal binder and allowed to emerge from general anesthesia and sent to the recovery room, having never been unstable and in good condition."

Q. Is that accurate?

A. Yes.
Q. Could you turn to the next page?
A. Yes.
Q. And could you read that and tell us if it's accurate?
A. "The patient's operative course with his wife and the patient will be sent home to return my office in two days' time."
Q. So the operative course was discussed with his wife?
A. Yes.
Q. You told us about that yesterday. Was the patient still under anesthesia or coming out?
A. I don't recall.
Q. Okay.
A. I think he was in the recovery room at that point, so he was not anesthesia.
Q. You're right, under the --
A. (Inaudible) dictating if the patient was still in the operating room.
Q. Right. Right. Sorry.
Post anesthesia, how long would the patient wait in the recovery room?
A. The recovery room stay can be from as little as a half an hour to as long as six or

eight hours, depending on what the patient needed. The patient is constantly evaluated to see if the patient was stable enough to go home as decided by both the anesthesiologist, the surgeon, and the nurses that were taking care of the patient.

One of the reasons I enjoy working at Las Vegas Surgery Center is because the nurses were not new nurses, they were older and had good experience, hospital experience with patients that were -- they knew who was sick and who was not.

And so I felt a comfort with them helping me with my patients because they were the first to tell me, Doctor, this patient doesn't look so good. I think we should go to the hospital.

And I had 20 twenty years' experience working with these nurses, so I knew that if the nurses told me this patient didn't look good, I really should listen.

Q. Okay. You told us yesterday the -- sorry -- anesthesiologist is also monitoring the patient?

A. Yes.

Q. Together with the nurses and yourself?

A. Yes.

Q. Could you turn to H and P, please,

December 27th, NSBME 108 to 111.

Now, what is this?

A. This is a copy of a record from my office. It was created on December 27th, 2018. It is a summary of consultation -- history and physical. It's an encounter from 12/27/2018, consultation note that can serve as a history and physical as well.

Q. It says, "New patient consult for hernia"?

A. Yes.

Q. Okay. Let me -- there's a couple of different copies of this from the various subpoenas that were issued and things. Okay. It's here.

So what is this in the upper left corner?

A. Its date, 2/22/2019, 10:07, page 14 to 17. I have no idea what that is referring to.

Q. What is this date with relation to this patient?

A. I don't know. I think that was the day the patient had surgery.

Q. Okay. Would the custom and practice of your staff to be to fax this over?

A. They usually fax it.

Q. Okay. Does this look to you --

A. I don't know.

Q. Okay. All right.

Doctor, you dictated this?

A. No. This is an EMR that I typed, parts of it, and this is prepopulated with a number of things that you can click on. It is an EMR, it's not something I typed a lot of, and I did not dictate it.

Q. Okay. So tell us, UNLV -- Kerkorian School of Medicine had electronic medical records as of the date?

A. Yes.

Q. But Las Vegas Surgery Center did not?

A. Yes.

Q. So would it be correct to presume that they didn't have any sort of system that worked together?

A. That is absolutely correct.

Q. So if you're at Las Vegas Surgery Center, there's no electronic medical record to pull up to communicate with the Kerkorian School of Medicine; is that accurate?

A. That is accurate. Nor any other office.

Q. All right. Can we just look at this and tell -- when you say "prepopulated," how was this prepared?

A. Sat at my desk after I evaluated the

patient and recorded my thoughts and what I found out about the patient.

Some of the form was filled by my medical assistant, some by me, and I had the right, then, to take things out that they put in, and I signed it at the end.

Q. All right. So this was -- do you remember seeing Patient A on this date?

A. Not really.

Q. Dr. Barber, tell us, you're sitting down at the school of medicine and a form comes up?

A. Yes. The day's schedule comes up and a form for each person with some things filled out already, prepopulated, then there are places that I fill in.

Q. So just starting from underneath "subjective," what you are telling us is the custom and practice at the school medicine and your personal custom and practice?

A. Yes.

Q. So what -- starting at "patient," what is prepopulated and what do you fill in?

A. I filled in the "HPI."

Q. Okay. The part above "HPI." So "subjective" down to "HPI," who fills that out?

A. It's prepopulated by what the medical assistants put into the computer.

Q. All right. Is this -- this paragraph under "HPI," -- well, what's HPI?

A. History of present illness.

Q. Did you type this paragraph in?

A. I think I did.

Q. All right. Can you read that to us?

A. "This is a 54-year-old man who was born with an omphalocele and had a large reconstruction as a newborn. He subsequently had a large amount of his small bowel removed from SBO."

Q. SBO is what?

A. Small bowel obstruction.

Q. Are those two sentences that you typed accurate?

A. Yes.

Q. And compete?

A. I believe so.

Q. Not missing any pertinent information?

A. I don't think so.

Q. Please continue.

A. "He had a right inguinal hernia repair and now has a left inguinal hernia. He has" --

Q. Is that accurate?

A. Yes.
Q. Please continue.
A. "He has no GI obstructive symptoms."
Q. Is that is accurate?
A. Yes.
Q. Okay. Please continue with "Review of systems."
A. That is a laundry list of symptoms that you can click through on the computer to say yes or no if a patient has any of these conditions.
Q. So when you say the "laundry list," is it -- what does it look like? Is it the first words on the left, what do you see before you type it in?
A. You don't type anything in these; you click on boxes.
Q. Okay. What comes up for you to click on?
A. Everything is listed from review systems to past medical history. All those things, you click on them as if the patient has them or not.
And so if they are -- and I believe they're all negative, we used to dictate: Ten system are negative.
This is the tales of the ten systems tat we ask the patients about, all of these symptoms, and if they answer positively, we change this and

say they do have this.

And in this case, the patient did not answer positively to any of these things.

Q. Okay. When you say we used to say ten systems are negative, what do you mean by that?

A. Before we had electronic medical records that we clicked on things when we just dictated office notes, histories and physicals, pretty much the same.

Q. H-E-N-T, it starts with negative, and then everything after that, is that accurate?

A. I believe all of the things that I wrote for the review of systems are accurate.

MR. WHITE: Objection. Mischaracterizing evidence. She said she didn't write them. She said she clicked boxes before.

I just need clarify what is going on.

MS. DAEHNKE: What's the objection?

MR. WHITE: Mischaracterization of the evidence, or misrepresentation of the evidence just presented. She just said she clicked these boxes for review of symptoms, but now she's saying -- you asked a question about her writing in stuff, so now I'm confused. Are we writing in stuff or are we clicking boxes on here?

That's my objection. I think it mischaracterizes the evidence or -- assumes facts not in evidence.

HEARING OFFICER HALSTEAD: Do you want to clarify?

BY MS. DAEHNKE:

Q. Doctor, just tell us how this was prepared.

A. Generally, I'm not writing these things, I click boxes.

That being said, if there is something that is different from things, I often will have a little cheat sheet of paper where I write and transcribe that onto that -- click through, clicking different boxes.

Q. What do you mean by that? Just explain that a little bit.

A. I think that patients don't like it when you are not speaking and talking to them. If you're looking in the computer, I think that that is unpleasant for may patients.

So I often will take notes on a piece of paper as I speak to a patient and then transcribe them into the appropriate boxes in the electronic medical records.

Q. What you're talking about is you're looking at the patient, listening and taking notes, and then will go click on it?

A. I don't do my electronic medical record while I'm examining a patient for the first time because I think that's rude.

Q. You reviewed this and is it all accurate from your review?

A. I believe so.

Q. Moving down to the next page, almost to the middle, "Medical History," how was that input -- how do you input on that?

A. This is, again, a combination of clicking boxes, both with the medical assistant and myself. These are options within the electronic medical records, and these were brought up as pertinent past medical history.

Q. Okay. So under "Diagnosis," it says "anemia"?

A. Yes.

Q. "Secondary to bleeding, 2, 2, small bowel resection."

Is that accurate or what does that mean?

A. I don't recall.

Q. "2, 2"?

A. I don't recall what that means.
Q. Would that make sense, "2, 2, small bowel resection."
A. I think it means due to. That may be a transcription error. I did have a Dictaphone to help in adding things to the electronic medical record. "2, 2, small bowel resection" to me.
Q. You think it's: due to?
A. Yes.
Q. It looks like some of these words, including "secondary to bleeding," and then "previously treating," and "as a child, has since," is in italics, does that indicate anything to you, in the italics, that is how it was input?
A. I have no idea what the italics mean.
Q. Under "Surgical History."
A. Yes.
Q. Looking at under "procedure," can you read that?
A. It says, "Hernia repair, right. Omphalocele repair, occurred at birth, required multiple surgeries. Small intestine surgery, occurred around 30 years of age, two-thirds removed."
Q. Would that have been the information the

patient gave to you?

A. Yes.

Q. That's accurate?

A. I think so.

Q. Okay. And what about family history?

A. "Family history problems, no, no problems. Mother murdered when patient was 17, does not know medical history."

Q. Medical history of mom?

A. Yes.

Q. Let me just jump back up for one second.

Under the surgical history, hernia repair and omphalocele repair, small intestine surgery, is that all meet the standard of care for recordkeeping in your opinion?

A. Yes.

Q. Conveys enough information, in your opinion, about this patient?

A. Yes.

Q. His past surgical history.

And then family history, was there anything remarkable?

A. Well, I take a family history to try to find out if patients have similar sorts of problems. The information I got did not show any of those

things.

Q. Then what about social history?

A. Social history, we ask about some things that may have an effect on the ability to take care of themselves, or have a -- if they have problems that we need to consider in considering what they might need from a surgeon's point of view, so we asked about that.

Q. Okay. Was there anything?

A. The patient had used tobacco occasionally and drank occasionally. And he had female mate and was divorced. He had one son who lives with his girlfriend. He recently moved from California. He exercised, strength training, did cardio, exercised three times a week.

Again, that helped me to know that he was relatively fit, that he had a -- recently moved to Las Vegas, but seemed to have a socially okay situation.

Sometimes patients in Las Vegas don't -- you find out that they are living alone and not able -- those sort of people that -- to be at the surgery center, you have to have someone bring you and pick you up and make sure that it's -- we often have people not be alone for 24 hours, so those are

important things to know about that patient preoperatively.

Q. Yesterday you looked at a record that indicated Mary was present?

A. Yes.

Q. And then under "Objective," could you tell what this is and whether there was anything --

A. We look at the patient's vital signs, height, weight, and BMI first. We look at their medications. And then we do a physical exam.

Q. And the vital signs, anything concerning about the patient's vitals?

A. Systolic pressure is a little bit high, he's 159 over 82, his diastolic, which is considered normal, that would not prevent surgery. Might be a little bit of white-coat hypertension, that's not prohibitive for surgery, is not stroke-causing hypertension. His pulse is 64, which is normal and relatively slow. He does not have any fever. His temperature is normal. His respiratory rate was normal. He was of average height, 5'9", and average weight, 175 pounds, with a moral BMI of 25. He was neither fat nor skinny, but normal.

Q. What's white-coat hypertension?

A. When people have no history of

hypertension, I mentioned on the previous page, the patient was previously treated for hypertension and is no longer hypertensive. So white-coat hypertension is somebody who does not believe themselves to have hypertension but every time they go to the doctor's office, their blood pressure is high. When subsequently tested in a non-stressful situation, such as at the grocery store, people would be asked to take their blood pressure, at home or at the grocery store, and report it back to the physician, and it was -- they don't have hypertension in those situations.

We term it "white-coat hypertension."

Q. Caused by the white coat?

A. Exactly. Being at the doctor's office.

Q. But for hypertension, was Revatio for hypertension?

A. That's for pulmonary hypertension, which is not -- it's not blood pressure medication. It's blood pressure in the lungs, in the pulmonary arteries. That is -- was probably a result from his birth.

Q. Result from his?

A. His congenital problems from birth.

Q. Okay. Under "Medications"?

A. Same medications I mentioned earlier in the history and physical.

Q. In the -- on the brief op note?

A. Yes, the same.

Q. And then the physical exam, anything remarkable or that you noted that would prevent this patient from having surgery at Las Vegas Surgery Center --

A. No.

Q. -- in the future? Okay.

Under -- let's see. The "Abdomen," could you tell us what is written there?

A. Again, the physical exam was also done through the electronic medical records by clicking on physical findings, and so that's what I did. And "Abdomen, the soft bowel is soft, normal, exhibit no distention of masses."

Q. What's the significance of that?

A. When patients have obstruction at their bowel, their bowels can be distended, their abdominal cavity can be distended, and people can also have distension if they have cirrhosis of the liver and ascites and fluid in their abdomen.

He didn't have anything like that. He drank regularly but didn't seem to be to excess. I

didn't see any red flags, things such as that.

He was not tender anywhere. He did have a hernia, but as I indicated, it wasn't tender. And rebound or guarding means that you are, really, signs of peritonitis, and so he did not have any signs of peritonitis in the hernia.

Q. And the description, at least in this part of the medical records, says, "A hernia is present."

A. Yeah.

Q. You heard Dr. Spoerke say that's inadequate and insufficient and malpractice.

Do you believe that your description, for purposes of this H and P, is adequate?

A. Yes, I do.

Q. And what --

A. If these were not adequate, it could not be approved as an electronic medical record. You have to have at least this -- these numbers of observations in order have it as an adequate electronic medical record that some organizations, such as the school of medicine, choose to be adequate for the office and hospital notes as well. This is Epic --

Q. Tell me what -- I've heard that before, what's Epic?

A. Epic is a company that makes electronic medical records. There's several companies that make electronic medical records.

Epic is a very large one. It's used by a lot of hospitals.

Q. Does the medical school still use Epic?

A. Yes, it does.

Q. Sounds a lot more exciting than what it is. Okay.

And then under "Assessment and Plan," what is indicated?

A. That the patient had a left inguinal hernia, he had acquired short bowel syndrome, and that the plan was to get a CAT scan to define his anatomy better. After review, scheduled laparoscopic or possible open left inguinal hernia repair, and start on Juven for short bowel to maximize healing.

Q. And -- okay. The sentence, "After review," what does that mean, review of the CT scan?

A. Yes.

Q. I know you talked about this before, but to define the anatomy better, what were you looking for prior to the hernia repair?

A. I was going to see if all his organs were

in the place that I would expect them. Sometimes people who have had congenital problems have organs that are in different places and different shapes and different sizes than expected.

Again, I think I said yesterday, I could see if his small bowel, if there were sort of big gaps in his abdomen where a small bowel usually would be or is it in the usual position in the middle. The colon goes like a box around the abdomen with the small bowel in the middle.

From his previous surgeries, where there were abnormalities that were clearly seen on the CAT scan that would prohibit laparoscopic surgery.

Q. And Dr. Spoerke said that the CAT scan wouldn't provide any useful information.

Do you disagree with that?

A. I disagree with that.

Q. Did you review the CAT scan yourself?

A. Yes, I did.

Q. Did you find anything that --

A. Would prohibit surgery? No, I did not.

Q. We have the CAT scan, is there any reason to look at that right now?

A. No.

Q. You just mention the bowel, how much bowel

does the average person have?

A. Small intestine is generally, in an adult, about 20 feet long.

HEARING OFFICER HALSTEAD: How much longer do you have because I'm debating timing. We need to take a break.

MS. DAEHNKE: We can stop now.

HEARING OFFICER HALSTEAD: About how much more time do you have? Not going to hold you to it, just trying to gauge. Yesterday you anticipated about an hour, but it's been almost two.

MS. DAEHNKE: 15 minutes.

HEARING OFFICER HALSTEAD: Let's take a break. We'll go off the record.

(Recess from 10:22 A.M. to 10:38 A.M.)

HEARING OFFICER HALSTEAD: It's now 10:38. We're back on the record in case number 23-11660-1, In the Matter of the Charges and Complaint Against Annabel Elizabeth Barber, M.D. Present are counsel for the IC, counsel for Dr. Barber, and Dr. Barber. We took a break and we were in the midst of direct examination of Dr. Barber by her counsel.

Dr. Barber, I remind that you remain under oath.

THE WITNESS: Thank you.

BY MS. DAEHNKE:

Q. Dr. Barber, I'm going to direct your attention to a few questions and try to wrap this up. We talked about your February 22, 2019 operative report, went through the way it's created and there's mistakes and blanks and things.

From your review of that, did you describe and note the bowel injury?

A. I did.

Q. Did you document the placement of the Trocars and the incisions?

A. In the -- I did in the left lower quadrant, the right lower quadrant, and in the midline.

Q. In the operative report, did you document that there was an injury and repair of the small bowel?

A. Yes, I did.

Q. When did you -- you looked at this, but when you noted, "However, there was a suspicion of entering through the small bowel, so mini laparotomy was done, small bowel injury was confirmed," what did you intend to communicate by that?

A. That I opened the abdominal wall and a larger incision in order see the bowel injury and

just to confirm whether I did or did not have an injury, and I did have an injury.

Q. And in your opinion, is this -- what you documented in this operative report, despite the gaps and mistranscriptions, is that accurate to meet the standard of care?

A. Yes.

Q. Do you believe that that operative report that you dictated and was transcribed violates the Medical Practice Act?

A. I do not.

Q. You looked at this short H and P and brief op note for ambulatory surgery centers?

A. Yes.

Q. Do you believe that that brief op note and H and P for ambulatory surgery centers breached the Medical Practice Act or violated the Medical Practice Act with regard to recordkeeping?

A. I do not.

Q. Do you believe you met the standard of care?

A. I do believe I met the standard of care.

Q. With regard to the surgery itself, you are aware that the Complaint alleged that you failed to reasonable care, skill, or knowledge ordinarily used

under similar circumstances.

Do you believe that you used reasonable care, skill, and knowledge ordinarily used under similar circumstances?

A. Yes, I do.

Q. And it alleges that you failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen.

A. I think I made appropriate decisions after appropriate pre-operative evaluation. And I think it was not a wrong decision to make to decide to do a laparoscopy in the fashion that I described.

Q. And do you believe that, although it's not charged, that your pre-operative work and evaluation of this patient was appropriate and met the standard of care?

A. Yes, I do.

Q. And didn't violate the Medical Practice Act?

A. I did not violate the Medical Practice Act.

Q. And the Complaint and the Board also

alleges that as part of the charge that what you did was contradicted by medical literature.

Do you agree with that?

A. I do not agree with that.

Q. Have you, in fact, reviewed medical literature that supports your decision-making in this case?

A. Yes, I have.

Q. Do you believe you used proper discretion in making your surgical decisions?

A. Yes, I did.

Q. Did you appropriately obtain Patient A's surgical history?

A. Yes, I did.

Q. And we didn't talk about length but we talked a bit, did you obtain pre-operative clearance for the surgery with this patient?

A. Yes, I did.

Q. And one of reasons you ordered the CT scan or the reason was to better assess this patient's anatomy prior to determining whether this procedure could proceed laparoscopically?

A. Yes, that's true.

Q. And then you had written in the records that we reviewed that after the CT scan you would

make that decision for laparoscopic versus open?
A. Yes.
Q. And then you reviewed the CT scan prior to surgery?
A. Yes, I did.
Q. And you told us that you felt that laparoscopic surgery would be less painful and would have shortened healing time, you believed?
A. Yes.
Q. And you started the patient on Juven to maximize --
MR. WHITE: I'm going to object to this line --
BY MS. DAEHNKE:
Q. Did you?
MR. WHITE: -- of questioning. I'm letting it go right now, but it's leading, asked and answered, it's just duplicative.
HEARING OFFICER HALSTEAD: That's all true.
MS. DAEHNKE: Yeah. This is my last question.
BY MS. DAEHNKE:
Q. Did you start the patient on Juven to maximize post-operative healing?

A. Yes.
Q. Okay. Thank you, Dr. Barber.
MS. DAEHNKE: No further questions.
MR. WHITE: What do you want to do? Do you want to go forward starting now? I want to know because I know there's a timeline, I don't remember exactly what it is for when Dr. Baskies is set to be --
MS. DAEHNKE: He's supposed to be here at 11:00.
MR. WHITE: Yeah, at 11:00, which is 15 minutes. I can't do this in 15 minutes, a cross-examination of Dr. Barber.
HEARING OFFICER HALSTEAD: What is your preference? I will defer to you.
MR. WHITE: Probably that we start Dr. Barber's cross and then go for the next hour until -- hopefully I can get it done in an hour, I'm not sure.
HEARING OFFICER HALSTEAD: We have to break at --
MR. WHITE: Right. 11:45; right? Which it's 10:45 now. 11:45 we have to break.
Actually 15 minutes early, huh, Meg?
MS. BYRD: 11:45 is 15 minutes early.

MR. WHITE: Oh, okay. Good.

So 11:45 we have to break. That's what I would prefer. I guess we need to get ahold of Dr. Baskies.

MS. DAEHNKE: Let me call him and make sure that he can come, then, after the -- what time?

HEARING OFFICER HALSTEAD: We get the room back at 1:30.

MR. WHITE: And if it -- I'm totally -- I'll go with the flow if he has to be here now and can't do it later. We can take people out of order too, we've done that before.

Let me know what Dr. Baskies says to you.

MS. DAEHNKE: Okay. The options are, ideally, we start at 1:30 or start now and --

MR. WHITE: I don't think 1:30 -- yeah, you're going to do redirect?

HEARING OFFICER HALSTEAD: Mr. White prefers to do his cross now and have Dr. Baskies come at 1:30 or shortly thereafter if he's not done with his cross.

But you have your redirect as well.

MR. WHITE: We may even want to push him back until 2:00 or something. I don't know.

MS. DAEHNKE: Okay.

HEARING OFFICER HALSTEAD: We'll go off the record and you can go consult with him.

(Recess from 10:45 A.M. to 10:54 A.M.)

HEARING OFFICER HALSTEAD: We're back on the record in case number 23-11660-1, In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D. Counsel are present, Dr. Barber is present, and she remains under oath.

THE WITNESS: Thank you.

HEARING OFFICER HALSTEAD: Mr. White, your witness.

MR. WHITE: Thank you.

CROSS-EXAMINATION

BY MR. WHITE:

Q. Dr. Barber, do you have anything to change on your CV?

A. I have not updated since it was published in the papers.

Q. Okay. And then maybe that you're no longer licensed in Texas since you haven't made a payment?

A. Yeah. I gave up my Texas license.

Q. You did. Okay.

And it expired when, 2019; is that correct?

A. That's probably true.
Q. And your license in New York is inactive also?
A. That's correct.
Q. And also, you did not recertify in 2022 for --
A. Board of Surgery, I am certified and have recertified -- I recertified two years ago.
Q. I think -- is that the one we're talking about? Let me see.
The page is Barber page 114. That's exhibit --
HEARING OFFICER HALSTEAD: It's going to be respondent's Exhibit 8.
MR. WHITE: Thank you.
THE WITNESS: I have maintained by board certification, if that answers your question.
BY MR. WHITE:
Q. I'm talking about -- I didn't highlight, unfortunately, I won't spend too much time on this anyway.
Are you supposed to recertify -- I'm talking about, about two-thirds down the page, your certifications?
A. It was recertified ten years later, which

is 2022, and then I recertified, yes, 2022.

Q. Okay. American Board of Surgery?

A. Yes.

Q. And you did recertify in 2022?

A. Yes.

Q. Okay. You just didn't put it in here?

A. Yes.

Q. Okay.

A. This was --

Q. That would be one of the things you would want to add?

MS. DAEHNKE: Well, that's an older CV.

MR. WHITE: Okay.

BY MR. WHITE:

Q. Dr. Barber, do you recall getting an allegation letter from Monica Gustafson?

A. Generally, yes.

Q. I'll refer you to the page, it's IC Exhibit 1, and it is page -- actually, I'm going to point you to your response, page 5 in IC Exhibit 1.

A. Yes.

Q. Okay. You said in there, about two-thirds the way down the page, it starts off, "In regards to this patient's allegations, I discussed laparoscopic versus hernia repair with the patient."

Laparoscopic versus hernia repair, would you understand what that means?

A. I think that "open" is not in the sentence where it should be.

Q. Okay. And it says, "Both in the office and in the surgery center prior to his operation. I do not recall his requesting open surgery."

Is that still what you think today?

A. Yeah.

Q. So do you have any documents to back up that you spoke to him about the risks and benefits of open surgery versus laparoscopic surgery to back up what you said here in your response to the Board?

A. Open and laparoscopic are pretty much the same.

Q. They are?

A. Yes.

Q. Okay. Well, you heard some testimony yesterday from Dr. Spoerke stating that it's very hard to see if you have a lot of scar tissue, which this patient had -- correct? -- if you were doing laparoscopic.

A. You can't predict --

Q. That's not my question. I'm sorry. Let me try it again.

You cannot see as well doing a laparoscopic surgery if a patient has a lot of scar tissue; is that correct?

A. It can be correct, but it's not always correct. It's unpredictable.

Q. Okay. And there's also the risk of perforating a bowel with a Trocar; is that correct?

A. Yes.

Q. And there's no Trocars involved in open surgery; is that correct?

A. That's correct. There are knives and instruments that can also --

Q. Yeah, there's no zero-risk of perforating something, even in open surgery -- right? -- it's not zero.

A. No. Not at all.

Q. My question before, though, do you have any documentation that we can refer to in here -- we have all your medical records that you sent -- correct? -- we have everything.

A. I have no additional records that I know of.

MS. DAEHNKE: I need to just object for the record that Mr. White is talking about -- or just note for the record, he's talking about NSBME

case 1919059, Dr. Barber's response to specific allegations in that letter dated October 28, 2019, which is not the complaint that's before the Board, just for the record.

HEARING OFFICER HALSTEAD: Okay. But just for the record, this is a resubmission of that same complaint; correct?

MR. WHITE: This is just -- that was an investigative number. We have two different numbers. I can explain to clarify for record.

HEARING OFFICER HALSTEAD: Okay.

MR. WHITE: It starts out with an investigation number for the investigators before it gets to legal. When legal gets it and it's assigned to us file a formal complaint, it gets a different number, which is the number we have on our Complaint now, 23- -- yeah.

HEARING OFFICER HALSTEAD: Okay. Thank you, Mr. White.

MR. WHITE: So this is the same -- I can represent that this is -- I will submit and represent that this is the same case, it's just going through the stages.

MS. DAEHNKE: And for the record, what you're reading is her response to the letter that

was right before it.

MR. WHITE: Correct. Yes.

MS. DAEHNKE: All right.

HEARING OFFICER HALSTEAD: I understood that.

MR. WHITE: I can clarify. Yes, there is a allegation letter that is page 1.

HEARING OFFICER HALSTEAD: And you referenced the allegation letter before you asked about the response.

MR. WHITE: Yeah.

HEARING OFFICER HALSTEAD: Please continue.

MR. WHITE: Okay. Thank you.

BY MR. WHITE:

Q. My question is, so was there any documentation that we don't see or we're missing that refers to your discussions with Patient A regarding the risks and benefits of open surgery versus laparoscopic surgery, like you described here that you did?

A. You have all the documentation that I have.

Q. Okay. The answer is no, you don't have any more documentation about your discussion with

Patient A?

A. That's correct.

Q. And, in fact, you told him that laparoscopic surgery would be less painful and provide him with a shorter healing time, I don't want to misquote you, does that sound right?

A. That is something that I usually talk with the patients about. I don't know the exact words I said, no I don't.

Q. Is it your belief now, as you sit here, that he believed you that laparoscopic surgery was the way to go?

A. I believe when he agreed to that, he believed that.

Q. Okay. Do you ever let the patient decide?

A. I don't understand the question.

Q. Yeah, it's not a good one.

Do you ever let the patient decide between options that you give them? Specifically for this case, would you let a patient decide between a --

A. I believe the --

Q. -- laparoscopic surgery and an open surgery, or do you make that decision?

A. I believe the decision is a shared decision.

Q. Do you feel it was a shared decision in this case?

A. I do.

Q. Did you discuss with him that, based on his omphalocele as an infant, his resulting surgeries later on, it could be a little more risky to have laparoscopic surgery?

A. I don't recall the discussion. I'll just answer that.

Q. You saw the patient for the first time on December 28, 2018; correct? I can refer you to that.

A. I believe it was the 27th in my mind, but I could be wrong. That's from the last few days.

Q. Yeah. Page 108, NSBME, it's the IC's --

A. Yes.

Q. Is that true, is that the encounter?

A. It says "12/27."

Q. Okay. My notes say "12/27/2018"; is that correct?

A. Yes.

Q. Okay. And you prescribed him Juven?

A. Yes.

Q. Okay. And that was because you thought that it would give him some extra nutrition or --

tell me, I don't want to misquote you -- extra nutrition, make sure he has enough nutrition, also it would make him -- it would help his short gut syndrome, and also, possibly, make the surgery go a little smoother?

A. Not the surgery itself, but the healing following the surgery.

Q. I can't remember what you said. I think you said -- how many weeks do they need to be on Juven when it becomes effective?

A. Two.

Q. Two weeks.

And this was almost two months?

A. Yes.

Q. Did he take it? As far as you know, did he take it for the full two months?

A. As far as I know he did.

Q. I'm going to point you Exhibit 4 page 87. I have a question for you about something here.

A. Okay.

Q. About three-quarters of the way down the page, under "Surgery Information," it says, "Unilateral inguinal hernia without obstruction."

MS. DAEHNKE: Could you identify what this is?

MR. WHITE: I'm sorry.

BY MR. WHITE:

Q. What is this page here, it says "Las Vegas Surgery Center" at the top?

A. Right.

I think it's what's called a "face sheet."

Q. Okay. Yeah. And it says "Patient Registration."

Do you fill this out?

A. No.

Q. Okay. Do you ever look at it?

A. Yes.

Q. Okay. Why would it say unilateral inguinal hernia?

A. Because I was planning to fix one side.

Q. Okay. Does it concern you that it doesn't say left or right there?

A. No.

Q. It doesn't. Okay.

And it says "without obstruction," that's true -- right? -- no obstruction in his -- does that mean in his bowel?

A. Yes.

Q. And then what is gangre, G-A-N-G-R-E?

A. Generally that code is gangrene. We were

talking earlier about codes, and they have unilateral hernia with -- and it says with or without obstruction or gangrene, that's one of the qualifiers of the code.

Q. Okay. What were they checking for?

A. That's for billing.

Q. I want you to turn page 107, please.

A. Yes.

Q. We've kind of kicked this thing around a lot, it says "within normal limits in the abdomen."

Would you change that now?

A. No. That refers to other things other than that hernia. It's referring to the fact that the patient does not have any other -- he doesn't have peritonitis, he does not have anything of remark -- that is remarkable, other than a left inguinal hernia.

Q. Okay. However, at this point you're aware as you're writing this and checking off that box -- this is a handwritten note, this is handwritten checked; right?

A. Yes, it is.

Q. Yeah.

So you're aware at that point that he has short gut syndrome?

A. That does not change the physical exam.
Q. No?
A. No.
Q. On page 108, are you concerned that it just says "hernia," there, you wrote in just "hernia" and not right or left?
A. No.
Q. No. Okay.
It doesn't concern you that these may be looked at by somebody else some day down the road in his patient history?
A. Well, if you look at the history of present illness, it says that he has a left inguinal hernia. And the next paragraph says "No."
Again, that is prepopulated by the medical assistant.
Q. Okay. Whose responsibility is it for records to be timely, legible, accurate, and complete per statue, your medical assistant or you?
A. It's my responsibility.
Q. You had mentioned yesterday you've done no trauma surgery since 1997. Why is that?
A. I've done some trauma surgery. Actually, there was a big shooting incident at Las Vegas, and I done some trauma surgery that night.

Q. I know the shooting you're probably referring to.

A. Yes.

Q. But why are you no longer doing them as a regular part of your practice?

A. Because I chose not to continue doing trauma surgery as the university medical center wanted the trauma surgeons only to do trauma, and I did not want to give up my general surgery and surgical oncology practice.

Q. Yesterday you talked a lot about, on direct examination with your attorney, IV nutrition during your direct examination.

Do you recall that?

A. Yes.

Q. And I think you said you had done some research on that; right?

A. Yes, I have.

Q. Before you were doing surgery in Las Vegas?

A. Yes.

Q. Was the reason for that -- was it relevant because -- was Patient A getting IV nutrition at any time?

A. He was not, but he had short bowel

syndrome, and any patients who have short bowel syndrome have to be on IV nutrition to have enough nutrition. It's always an option, and it can happen. I have several patients with short bowel who are on parenteral nutrition that I take care.

Q. Is Patient A one of those?

A. No, he's not.

Q. Okay. You mentioned yesterday on direct examination that you thought it was a good idea -- you thought Patient A said -- thought it was a good idea to take Juven as suggested, where did you put that in the records?

A. I put it in the --

Q. I see the word "Juven," but I don't see that there's discussion about having Juven.

A. I don't remember discussing it with him. I don't think it says that specifically in his note.

Q. Okay. We talked a little bit about SAGES yesterday, it came up.

Do you know what that is?

A. Yes. It's a surgical society.

Q. Does it have mostly to do with laparoscopic surgeries?

A. Partially laparoscopic, partially robotic-assisted laparoscopic surgery. And also

endoscopy and endoscopic surgery. That is not making incisions and going through the mouth or the rectum.

Q. Do you know what it stands for?

A. I think it's society association -- I don't know what the A stands for -- gastrointestinal surgery.

Q. Pretty close. Society of American Gastrointestinal and Endoscopic Surgeons. Is that right?

A. Yes.

Q. You also mentioned yesterday that some adhesions can be wispy, was your description, and some can be dense.

Do you remember that testimony yesterday?

A. Yes, I do.

Q. And you say it's unpredictable as to what scarring you're going to find in a patient in their abdomen; right?

A. Yes.

Q. Is that even with a CT scan?

A. Yes.

Q. Okay. So the best way, probably, to find out -- correct me, the best way to find out is probably going laparoscopically; right?

A. It's a way. Or you can see adhesions, certainly, with a laparotomy.

Q. Laparotomy?

A. Yes.

Q. But you were not doing that first, laparotomy?

A. I didn't think it was necessary.

Q. Right. Okay.

But even -- just whenever you have the scope in there, you can see -- you might be able to see the adhesions; right?

A. Yes.

Q. Can you tell the difference on the camera between a wispy one and a dense one?

A. Sometimes. Sometimes the wispy ones, you can actually see through.

Q. Did you cut away any wispy or dense adhesions while you were doing this surgery?

A. Yes.

Q. You did?

A. Yes.

Q. Did you put that in your notes?

A. Yes.

Q. You put in there that you cut away some stuff?

A. Yes.
Q. Really. Where? Can you point it out to us?
A. Yes, I can. I believe it's some of the areas we talked about earlier when we talked about the operative note.
Q. Operative note. Okay.
A. Yes. That's where the description is.
Q. That's page 115, I believe.
A. "Lysis of adhesions," about the middle of the page, before the exception, you see that?
Q. Before the exception, no, I don't see it. I will find it.
A. You will see, "Babcock and the lysis of adhesions." Right here (indicating).
Q. Okay. Lysis of adhesions?
A. Yes.
Q. "Around this to free up," and that's where the blank is from 2:01; right?
A. Yes.
Q. And that's one of the sentences that you said didn't make too much sense before, didn't you?
A. Yes. I believe it's saying: Free up the bowel.
Q. Okay. You also testified yesterday you

felt it was safe to go forward with laparoscopic surgery. I think you said it today too for his left inguinal hernia "even with no visualization of the hernia or the inside of the abdomen," that's your testimony; right?

A. Not exactly. My testimony, I thought it was easy -- it was acceptable to attempt to see laparoscopically. I attempted to see laparoscopically, and I was not successful in doing it.

Q. Right. So, then, the other side -- correct? -- you went from the right side and then went into the left side.

A. Yes, I have said that.

Q. I will represent that even Dr. Spoerke, our peer reviewer, said that it was probably okay that you did the first attempt from the left side -- excuse me. Let me say that again.

He even said that it was probably okay that you made your first attempt laparoscopically, regardless of the side, it happened to be the right side in this case.

MS. DAEHNKE: I'm going to object. I don't remember what he said, but it mischaracterizes the testimony.

HEARING OFFICER HALSTEAD: The transcript with bear it out, and you can deal with it in redirect.

BY MR. WHITE:

Q. I guess my question is, if you have no visualization, why do you try to go from the left side at that point?

A. In my experience, often you look somewhere else that there are no adhesions, there may be a lot of adhesions in one place and none in others. And I've had success in many, many, many surgeries in looking in another space.

That's why I attempted to do that.

Q. And then you attempted to go in from the midline?

A. That is correct.

Q. To repair the hernia?

A. To gain access, to see laparoscopy to successfully lysis adhesions and visualize the hernia in order to repair.

Q. Is that the point where you only saw bowel?

A. I saw what I thought may be an injury to the bowel, and I opened the patient's abdominal wall.

Q. And that's where you determined that the Trocar was the reason for the injury?

A. I thought it was. There was no other reason for an injury there.

Q. It leads me to another question. You had no visualization from the very first try. What point, Doctor, do you, I mean you, say it's time to stop trying this laparoscopically and we need to go in and do open surgery? Would you ever get to that point, or in this case, when does that happen for you?

A. When you're not able to visualize what you're supposed to see.

Q. Did that happened on the first try?

A. That was in that area, so there's -- again, I think I've said several times, the adhesions in one area of the abdomen does not predict adhesions in another area.

That's why I continued because, in my experience, I've been successful in obtaining laparoscopic views in multiple, multiple patients by looking in another place, and I can then take down the adhesions from the other side to free the entire abdominal wall of adhesions.

That's my practice in most patients who

have had previous abdominal surgery.

Q. You would disagree with Dr. Spoerke when he says there's gotta be a time when you just go to do open surgery?

A. Some surgeries are always done better open, some are always done -- not always. Some surgeries are usually done better open, and some surgeries are done better laparoscopically.

You say "better," and that's what -- how the patient can tolerate it, if the patient can get well from it, the patient can do well as a result of it.

And so I think it's in general.

Q. Okay. Let me be a little more specific, then. You would also probably disagree with Dr. Spoerke when he said yesterday that based on Patient A's history, that predominantly the scarring is going to manifest itself at the midline.

You disagree with that?

A. I disagree with that.

Q. All right. You testified yesterday that doing a laparoscopic surgery -- that there's literature, actually, that you had reviewed that doing laparoscopic surgery promotes faster healing than an open surgery.

What literature is that and do you have it with you?

A. I don't have it with me, but I review the literature regularly. I do teach at the University of Nevada School of Medicine, and so it's something I discuss with my residents and medical students very regularly because my philosophy is a very big part of my practice. I have an elective practice.

And so my patients -- I think my practice is different from Dr. Spoerke's in that he does mostly acute care surgery, people who have acute problems, where my patients that I operate on are more elective. I see them in the office and we plan the surgery together.

Q. Okay. That's fair.

Did you -- but you testified that there's literature. As the attorney for the Board, you've referred to some literature and I don't get to see that literature. Do you understand that?

A. I would be glad to provide it for you. It would take me a few minutes.

Q. Well, time's a little passed for that, but, yeah, thank you.

MS. DAEHNKE: We'll renew our request for the articles discussed by his expert.

HEARING OFFICER HALSTEAD: It's part of -- I'm just going to take that as part of respondent's ongoing objection to the nondisclosure of the investigative file.

MS. DAEHNKE: Thank you. Yes.

BY MR. WHITE:

Q. You testified that you ordered a CT scan before surgery?

A. Yes, I did.

Q. And it showed you some things, no prohibition, I guess, to doing the surgery; is that correct?

A. I don't use the word "prohibition" much, but I didn't see any contraindication to attempting laparoscopic surgery.

Q. Okay. Do you have that -- did you write a report based on what you saw?

A. I did not write a report.

Q. Did you review a report?

A. I reviewed the CAT scan and the report of the CAT scan.

Q. Do we have that review -- do we have a report of the review?

MS. DAEHNKE: Counsel, it's in your records.

THE WITNESS: Do you know the page it's on?

MS. DAEHNKE: Mr. White can find it.

THE WITNESS: I've seen it this morning, I know. Desert Radiology, I believe.

MR. WHITE: I've seen it. I just can't remember the page.

MS. DAEHNKE: It's in the records, Desert Radiology. It's also in the hospital record.

MR. WHITE: Page 95, this one? This says "chest."

THE WITNESS: That's not the CAT scan.

MS. DAEHNKE: It's Desert Radiology records.

THE WITNESS: It's under tab 4 in the big binder. I have it right here, CAT scan from January 15th.

BY MR. WHITE:

Q. Page 47?

A. Yes.

Q. Yes, I do. Okay.

You reviewed this?

A. Yes, I did.

HEARING OFFICER HALSTEAD: Which side of exhibits and which exhibit number page?

MR. WHITE: I'm sorry. It is in respondent's exhibit, page 47.

MS. DAEHNKE: It was also produced in here.

MR. WHITE: I'm sorry, Ms. Halstead, I don't have tabs in my binder.

HEARING OFFICER HALSTEAD: Just tell me the page number.

MR. WHITE: Page 47.

HEARING OFFICER HALSTEAD: It's going to be respondent's Exhibit 4, page 47.

MR. WHITE: Thank you.

BY MR. WHITE:

Q. The history here, is says, "Preop for hernia surgery," and then, "unspecified abdominal hernia."

Why is it unspecified? Why not put left inguinal hernia?

A. I have no idea.

MS. DAEHNKE: Objection. Speculation, foundation --

THE WITNESS: Radiology put that on --

MS. DAEHNKE: -- hearsay.

HEARING OFFICER HALSTEAD: Well, I think the answer was that this was not her record, this

was the radiologist record, so that would have been entered by the radiologist.

BY MR. WHITE:

Q. How did the radio- -- you ordered the CT scan; correct?

A. I asked my office to do it.

Q. Do you have the order in here?

A. I don't know.

Q. No. Okay.

A. It may be here, but I don't know.

Q. Okay. You cannot see any kind of scarring in a CT scan, can you?

A. You may see injury, evidence of it, but not scars, per se.

Q. Okay.

A. Sometimes there's thickened tissue that they interpret as scars, so that is not -- so the answer is -- can you see scars on CT, the answer is not no.

Q. Okay.

A. I don't think any scars were pointed out in this CAT scan report.

Q. And you mentioned that you reviewed this report?

A. Yes.

Q. When you say that, did you review it with your staff, did you review it with the resident that you were teaching, did you review it with the patient?

A. I don't recall.

Q. If you had written it down, we could probably recall that, couldn't we? If you had written it down that you reviewed it with the patient or you reviewed it with Dr. Vest?

A. Not necessarily.

Q. Well, if you wrote down, we would be able to tell who you reviewed it with; right?

A. I think that's true, yes.

Q. Yesterday when I asked you -- I want to clarify a little bit -- I think you testified, and I don't want to put words in your mouth, that the CT scan showed that there was nothing that would hurt the patient.

What did you mean by that? If I'm correct.

A. When you say that, I don't really understand.

Q. Or maybe no contraindications?

A. Contraindications, I don't -- I don't think I said hurt the patient.

Q. Okay.
A. I didn't see any -- by review the CAT scan, I didn't see any contraindications to attempting laparoscopic surgery.
Q. But it ended up, you did hurt this patient?
A. That's true.
Q. Yeah.
Did it concern you when you went in the first time from the right side and you just saw bowel?
A. When you say "concerned," I thought that I -- that there were scars there.
Was I concerned? Sure, I --
Q. Which way were you looking --
MS. DAEHNKE: Could you let the witness finish, please. She was --
MR. WHITE: Was that an objection?
HEARING OFFICER HALSTEAD: No. She's trying to -- she's just indicating that she's concerned that you guys were talking over each other, which I've also expressed concern about.
Just make sure that you don't do that as well.
THE WITNESS: Can you ask me the question

again, please?
BY MR. WHITE:
Q. Yes.
Were you concerned that you only saw bowel when you went in from the right side?
A. I think concern is -- I noted that, and often that is something that it -- I think "concern" is an interesting word, it's not necessarily used in that I noted that, and so I thought let me try from somewhere else because that's something I often see.
Am I concerned? Yes. I'm serious about what I do, and I'm concerned about the health of my patient, always, so I'm concerned.
I guess the answer is am I concerned, I'm always concerned when I'm operating, yes.
Q. I don't mean to infer that you don't care for your patients, Doctor, at all, but --
A. I'm sorry. I misunderstood what you're asking.
Q. No.
And then I have a follow-up question to that. If you were going in from the right side, you were looking for the hernia on the left side is; is that correct?
A. Yes.

Q. So you were looking across the abdomen; is that correct?

A. Yes.

Q. At that point, would you pretty much surmise that the scarring and adhesions were probably in the midline somewhere?

A. No.

Q. No?

A. No. I think I've stated, several times, that adhesions in one part of the abdomen does not predict adhesions in another part of the abdomen.

Q. How far did the Trocar get in on the right side to -- like, where exactly did you put the Trocar?

MS. DAEHNKE: Object to form. It's compound and unclear.

HEARING OFFICER HALSTEAD: Well, I don't think he meant -- he started a question and then he formulated a second question, which I think was the intended question.

MS. DAEHNKE: Okay.

MR. WHITE: Um-hum.

THE WITNESS: I recall -- what I wrote in my note was in the right lower quadrant. Where exactly in the right lower quadrant would

generally -- I had anterior and medial to the anterior superior iliac spine, which is a landmark of the hipbone. Do I know exactly where it was, how many centimeters from that, no, I don't recall.

Q. The hipbone is where you measure from, down here (indicating)?

A. Yes.

Q. Okay. But you don't know where?

A. No. We pretty much do it the same way every time.

Q. Like I asked you before, you're looking across the abdomen toward the left side?

A. You have to have at least three instruments to work laparoscopically. Generally one is in the midline, one is on the left, and one is on the right. You have a camera. You two instruments in which to work.

They are not in the same place and they have to be far apart from each other in order gain the best visualization to work.

Q. Let me clarify. Do you have three Trocars in this person at one time?

A. That's the usual method of laparoscopic hernia repair, at least three Trocars.

Q. You put them all in at once?

A. One at a time.
Q. But -- one at a time, but then you left the right one in and put one in the left side?
A. In this case, I took it out because I didn't see well.
Q. Okay. Just want to clarify.
A. I didn't understand what you were asking me.
Q. So normally you would leave all three in at once?
A. Yes. Your camera, the scope in one Trocar. There are instruments in the other two Trocars with which to move things around with your left hand. I'm right-handed, my right hand is my dominant hand, so that's where I do most of the dissection and moving things around.
Q. So the medical records should have read -- and when I say "medical records," I'm referring, again, to the operative report that we've gone through a few times. I just want to make sure we have it clear.
Page 115 --
HEARING OFFICER HALSTEAD: We're talking about IC Exhibit 3, page 115?
MR. WHITE: IC Exhibit 4, page 115.

HEARING OFFICER HALSTEAD: Thank you.

BY MR. WHITE:

Q. Did you have another Trocar -- did you have another entry point through a Trocar on the left side where the hernia was?

A. No. The Trocar is not where the hernia is. It's well away from the hernia.

We have -- I think I describe, the instruments are sort of instruments on sticks. The sticks are about two feet long, so you can't -- you're not on top of -- you're a ways from the hernia.

Q. But I'm just trying to clarify that you said many times you have three Trocars in at once, but in this case you did not do that?

A. I didn't get to that point in this patient.

In this patient, I was trying to get enough visualization to clearly see three Trocars to have a safe surgery. That was not done because I had to open to that -- that was the goal, which I did not achieve.

Q. You went in from the right for a left inguinal hernia, that didn't work, no visualization, so you go in from the right side. Now you're on top

of the hernia almost?

A. No. And you're incorrect when you said in the right side again.

I went in from the right first to look around -- over the abdomen.

Q. I'm sorry. To the left?

A. Then I went to the left, approximately in the same plane, not over the hernia, well away from the hernia.

Q. Okay. That's what I meant.

A. I think that that --

Q. But you did go on the same -- at one point, you went in the same side, the left side, you put a Trocar in there on your second attempt?

A. That is the usual way that laparoscopic is done, through three incisions, one in the midline and one in the right lower quadrant and one in the left lower quadrant.

HEARING OFFICER HALSTEAD: May I, for purpose of my own understanding, ask a couple questions?

MR. WHITE: Yes. You're absolutely allowed to ask questions.

HEARING OFFICER HALSTEAD: Thank you.

So I understand, because this is getting a

little choppy for me, can you just explain, step by step, what you did? Were' not in the -- we don't know what this surgery looks like.

If you could just step me through, step by step. I hear you explaining and answering the questions, but it doesn't come across consecutively.

THE WITNESS: Yes.

HEARING OFFICER HALSTEAD: Thank you.

THE WITNESS: Generally we put in three Trocars in order to have a camera that can visualize adhesions within which to work. To start doing that, you have to have space with laparoscopy, with insufflation and CO2 in order to separate -- what that does is pushes the abdominal wall up and the intestines down.

Sometimes the intestines are -- and other structures too -- not pushed down with the CO2 and there is scars or adhesions, and we use those often interchangeably. So I was trying to gain visualization of left groin in order to -- from the inside, in order to open the peritoneum and expose the hernia.

HEARING OFFICER HALSTEAD: You did that with one incision and one Trocar in putting the camera in? I just want to make sure I'm

understanding, step by step, so at this point you made one incision, put in the Trocar and put in the camera, and you couldn't see?

THE WITNESS: The Trocar and the camera go in together, yes.

HEARING OFFICER HALSTEAD: Okay. I didn't know if it went in and then the camera went in.

THE WITNESS: No. That would be very dangerous.

HEARING OFFICER HALSTEAD: Okay. This is why I want you to step us through it.

For Patient A at this point, you made one incision on --

THE WITNESS: A five-millimeter incision first on the patient's right side.

HEARING OFFICER HALSTEAD: On the right side, the camera and the Trocar. And then you couldn't see before of the adhesions?

THE WITNESS: Yes.

And then I did the same thing on the left and I could not see. In the middle, I saw --

MR. WHITE: Wait. I want to slow down for a second.

BY MR. WHITE:

Q. Did you take the Trocar out of the right

side at that point or did you leave it in or did you suture it up and then go to the left?

A. The Trocar is small, it's five millimeters, I did not suture it up at that time. I think I dictated I took it out.

Q. Took it out and used it on the left side?

A. I don't remember if it was the same one or a different one.

MR. WHITE: Sorry.

HEARING OFFICER HALSTEAD: That's okay. That's why I want it step by step so we can all be on the same page.

Then you did it on the?

THE WITNESS: On the left. And I also couldn't see.

So in the middle, I could see, but it looked like there was an injury to the bowel just below the Trocar, so opened the abdomen at that point to see what -- whether it was an injury of the abdomen, whether the laparoscopy was going to be possible or not.

HEARING OFFICER HALSTEAD: Okay. Thank you. That's helpful. I appreciate it.

Is that helpful to you, Mr. White?

MR. WHITE: Yes.

HEARING OFFICER HALSTEAD: Thank you.

MS. BYRD: Ms. Halstead, it's 11:40.

BY MR. WHITE:

Q. Real quick, the only question I have, though, is you did try to still repair the hernia on the third try in the midline, you were attempting to do that, but that's when you noticed there was a bowel injury?

A. I was attempting to obtain a laparoscopic view of the left inguinal hernia in order to see if I could proceed laparoscopically.

I think I've said several times that I've been able to do that in patients who have had a lot of surgery previously because this is what I do every day.

Q. Please just answer the question, though.

MS. DAEHNKE: She was.

HEARING OFFICER HALSTEAD: And that's for me to deicide.

MR. WHITE: Please advise counsel to --

HEARING OFFICER HALSTEAD: I just did. Are you done with your questions, Mr. White?

MR. WHITE: No. I have a few more, but we have to break at this point.

HEARING OFFICER HALSTEAD: Did you finish

your answer, Dr. Barber?

THE WITNESS: I think I did.

HEARING OFFICER HALSTEAD: Okay. Thank you.

We're going to off the record, and we will be back at 1:30.

(Lunch recess from 11:42 A.M. to 1:36 P.M.)

HEARING OFFICER HALSTEAD: We're back on the record In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D., case number 23-11660-1. Present are counsel for Dr. Barber and the IC as well as Dr. Barber, who remains under oath, and when we took a break for lunch was subject to cross-examination by the IC attorney, Mr. White.

Go ahead, Mr. White.

BY MR. WHITE:

Q. We maybe left off around here, but I just want to make sure we have this question answered.

What would it take for you abort a laparoscopic surgery?

A. Any circumstance in which I think that the surgery was no longer safe, if they were bleeding or a bowel problem or anything untoward like that. I'm not -- and sometimes when it's -- you're looking for

-- trying to get in for a very long time that at some point that you give up.

Q. How much time -- we might have mentioned this yesterday, how much had elapsed from when you started going in on the right side until you realized you had perforated his bowel and had to abort the original surgery?

A. I don't know the exact time. I don't think it was very long, though.

Q. Okay. You had testified also that there was bleeding, a lot of bleeding, so how come you didn't consider going to an open surgery then?

A. I didn't see bleeding until I opened.

Q. Okay.

HEARING OFFICER HALSTEAD: Can you define "opened," what that --

THE WITNESS: When I did a laparotomy, when I made a larger incision. The incisions I made at the beginning were only five millimeters, which is about a quarter of an inch.

HEARING OFFICER HALSTEAD: Okay. I just wanted to make sure I understood what you meant.

BY MR. WHITE:

Q. How big was the incision for the laparotomy?

A. I don't know how many inches.
Q. Not inches, but -- or millimeters?
A. I don't know. It was large enough for me to see. I think I did a laparotomy at first, which is usually about six centimeters, and I think I enlarged it in order to see better. I don't remember.
Q. Okay.
A. I would just be making something up, and I'm not going to do that.
Q. Okay. And you didn't put it your records?
A. It's not part of the record, no.
Q. Okay. You testified that you assumed the Trocar -- this was yesterday -- that you had placed inside Patient A was the cause of the bowel injury; correct?
A. Yes.
Q. But you would agree with me that there would be no Trocar injury of the bowel if you had gone into open surgery at some point?
A. Yes.
Q. I want to get this clear from yesterday too. Was there -- I think -- maybe you just said this too.
There was no bleeding that you noticed

until you went in in the laparotomy; is that correct?

A. That is my recollection.

Q. Then you said there was lots of bleeding; correct?

A. I said that. And my recollection is that when I moved things in order to clear the sides of the abdominal wall of adhesions, bowel, and omentum that things bled more than usual.

Q. And you also mentioned a friable bowel?

A. Yes.

Q. I think that's spelled F-R-I-A-B-L-E; is that correct?

A. I think so.

Q. And it can also be -- you can have other organs that are friable; is that correct?

A. Yes.

Q. And what does it mean?

A. It means the tissue is sensitive to touch and movement.

Q. Touch and movement.

Did you also say yesterday it kind of tears more easily?

A. I may have said that yesterday. I don't remember.

Q. Does it look different than that a healthy bowel?

A. Not necessarily.

Q. Not color?

A. Often it's more of an experience than a prediction.

Q. So it reacts differently to touch, is that what you mean?

A. Yes.

Q. What does it do? Maybe you can tell us what a normal bowel would do and then maybe what a friable bowel would do when you touch it.

A. A normal bowel would -- doesn't show that you have touched it, whereas a friable bowel may bleed. In general when you touch the bowel, it doesn't bleed.

But a friable bowel seems to be more responsive to manipulation.

Q. And, if you know, can you have just part of your bowel be friable?

A. Absolutely.

Q. Okay. I guess to clarify, you can have just part of a bowel, maybe, say, a foot of the bowel could be friable and the rest of it could be healthy?

A. Yes. You could have much less than a foot be abnormal, even as small as an inch or half an inch.

It is not a blanket condition of the abdominal cavity.

Q. And how is a friable bowel discovered? Is it just through touching and sight and watching blood come out as you touch it, or can you see it in a scan of some sort?

A. It's not predictable by scan.

Q. I think you also testified that that was the reason you did -- the friable bowel was the reason that you did sutures and backed it up with staples?

A. Yes.

Q. I think today you mentioned "belt and suspenders," is that what you used, the term?

A. Yes.

Q. Is that because the friable bowel just does not accept sutures very well?

A. I can or it cannot. In this case, it did not.

Q. It did not.

What was happening?

A. When you put a needle in, the needles are

shaped -- you could use a 9 cutting needle to sew the bowel, and it makes very small holes -- we have different needles that have different sized holes -- and so I used the -- the suture that is usually used on the bowel and the shape of the needle is so it will not have a bigger hole than you needed, whereas there are some situations you need a bigger hole for bigger stitches and things like that.

But in the case of sewing the bowel, the standard needle is SH, because when tying a knot, generally the hold does not become any larger. In this patient's case when I tied a knot, the hold became larger in closing them, actually the needle holes, small things would bleed that wouldn't usually bleed.

It made me feel that the usual way of closing the bowel with interrupted sutures may not be enough. That's why I chose to put the stapler line on there too.

Q. Did the staple line remain in there?

A. It remained in there. Yes, it was there.

Q. For a little bit, at least for a few days; right?

A. The staple line is made of -- the staples are made of metal, and they remained in the patient

when I closed.

Q. Did you staple the bowel?

A. Yes, I did.

Q. Okay. And so those staples remained inside as opposed to what the sutures did?

A. They --

Q. I mean, did they remain around the bowel, did they secure the bowel?

HEARING OFFICER HALSTEAD: Are you asking if the staples held?

MR. WHITE: Yeah. Yeah.

THE WITNESS: Thank you. I didn't understand.

Well, they did at the time of surgery, the time when I touched the bowel afterwards and manipulated to see if they were -- if it was -- it didn't leak when that was done.

BY MR. WHITE:

Q. So, taken all together as far as the friable bowel goes, you said that it's -- oh, I'm going to ask you this first. I'm sorry.

Did you -- did it ever cross your mind to maybe try and do a resection of that friable bowel and figure out where -- you had said it could be a partial friable bowel, did you ever consider maybe

looking to see where there might be healthy bowel and get that out of there?

A. I absolutely considered it, but this man already had a short bowel. I mean, I didn't want to shorten it anymore.

Yes, I considered that. That's part of my decision-making process in order to just -- instead of just taking things out and putting them back together. But I have proven that sewing it wasn't very happy, so I chose to do what I did because I thought that would cause the least amount of harm.

Q. So considering this friable bowel, and it sounds like it's kind of serious -- is it? -- having a friable bowel.

A. It can be.

Q. Is it something that can be treated with medication or is it something that has to be taken out eventually?

A. It doesn't have to be taken out.

Q. No?

A. No.

Q. Will it present a problem later on to the patient? Could it?

A. You asked me two questions.

Q. Could a friable -- having friable bowel

result in a problem for the patient later on in the future?

A. That alone, no, but that combined with other factors, perhaps.

Q. What other factors?

A. Infection, need for manipulation, structure.

Q. How would it react to -- how would the piece, if it's friable, react to being part of an adhesion?

A. I don't really follow your question.

MS. DAEHNKE: I'm going to object to the --

BY MR. WHITE:

Q. Could it tear more easily if it was part of the scarring of the abdominal wall?

A. I don't know the answer to that question.

Q. Okay. We have this friable bowel, it's one of the concerns you had to -- there was a lot of bleeding; right?

A. Yes.

Q. It was also the reason that you did not continue with -- one of reasons that you did not continue with the hernia surgery; correct?

A. Yes.

Q. And, as you stated, it tears more easily, it bleeds?
A. "It"?
Q. The part of the bowel that's friable?
A. I'm sorry. Can you restate your question?
Q. Yeah. I'm sorry. It's a bad question.
A. I got lost.
Q. It's okay.
To kind of sum it all up, your determination was that Patient A had a friable bowel and that's why it didn't accept sutures, it bled to the touch when you manipulated it; right?
A. Yes.
Q. It didn't accept the sutures --
A. Excuse me. Can I?
Q. Yeah.
A. When you say "it didn't accept the sutures," I don't really agree with that.
Q. Okay. Would you put it in medical terms for me?
A. The sutures that I put in had -- it had larger holes than I would like from the needle. It did not reject -- I think of acceptance and rejecting in that way. It didn't reject. The sutures that I placed were not as effective as I

would have liked them to be, so I reinforced it with staples.

Does that answer your question?

Q. Yes. Thank you.

Nowhere in the records do you mention friable bowel, any of the records that we've reviewed; correct?

A. I don't remember that. I don't remember that being said.

Q. Yeah, there's no reference to them.

You didn't speak with the patient about this friable bowel either, did you?

A. I don't recall whether I did or not.

Q. If you did, you didn't write it down?

A. I don't write everything I say down.

Q. And --

A. I recall discussing his surgery with him, but I don't recall exactly what I said.

Could I have said that? Absolutely. And I think I would not say it in the word "friable," because that's not something that a layperson, we have demonstrated, knows, and so I would have not have said it in that word. I mean, that's not my custom and practice.

Q. Sure.

Would you write it down like that, though, in your medical records?

A. Not necessarily, no.

Q. Either way, you didn't write it down?

And you just told me you can't predict it with a scan.

HEARING OFFICER HALSTEAD: She didn't answer. She shook her head but she didn't answer.

MR. WHITE: I'm sorry.

BY MR. WHITE:

Q. You didn't write it down?

A. I did not write down "friable" in my operative note.

Q. And you just testified a moment ago that it's not predictable by any kind of scan?

A. That's correct.

Q. So there is no way for Patient A to know that part of his bowel is unhealthy and friable, is there?

MS. DAEHNKE: Objection. That's argumentative, it's not seeking an answer, it's an improper question.

HEARING OFFICER HALSTEAD: Overruled.

Go ahead.

MR. WHITE: You overrulled?

HEARING OFFICER HALSTEAD: I did.

MR. WHITE: Thank you.

THE WITNESS: I'm sorry. I got lost in the back and forth, I apologize. What is the question again?

BY MR. WHITE:

Q. Based on the fact that the only way to find out that somebody has a friable bowel is by manipulation and seeing it, having it opened up, this patient, it's not predictable by any kind of scan, and you didn't write it down in the medical records at all, there's no way that Patient A can be aware that he has a friable bowel?

A. He had a friable bowel. Does he have one now? I don't know. Can a friable bowel heal? Absolutely.

Q. That's not answering my question.

He does not know --

A. You said "doesn't" --

Q. He probably doesn't know --

HEARING OFFICER HALSTEAD: Okay.

MS. DAEHNKE: It's arguing with the witness.

HEARING OFFICER HALSTEAD: She's answering your question, so she can finish. She's saying --

well, she's saying two things, I don't want to speak for her, but let her finish her answer and then you can follow up.

MR. WHITE: Okay.

THE WITNESS: I believe that you asked me if there is any way I could tell the patient if he has a friable bowel. When you say something like that, to me, that means in the present. And I have no idea whether he has that in the present.

People with a friable bowel on whom I have operated on several times for various reasons have had one condition at one time and a different condition at another time.

So does he have a friable bowel right now? I don't know.

BY MR. WHITE:

Q. Thank you.

I wasn't asking if he has it right now, but there's no way to know -- let's go back to February of 2019, there's no way for Patient A to know that you discovered that he had a friable bowel?

MS. DAEHNKE: Objection. It misstates her prior testimony.

HEARING OFFICER HALSTEAD: Overrulled.

Go ahead.

THE WITNESS: I recall talking to the patient and his woman friend about my findings in surgery. Whether I said friable bowel, I think I did not say that because I don't think that makes sense to most people.

BY MR. WHITE:

Q. You recall the conversation that you had with him?

A. Yes, I did.

Q. About the bowel?

A. I don't remember the specifics of the conversation, I believe I said that before. But I think I probably expressed to them the reason why I stopped the surgery, and that was certainly a part of it, that I did not want to injure the bowel further because it's sensitive, I think those are the words that I probably would have used, rather than "friable," that's something that is more of a medical term, surgical term, if you will.

Q. And -- one moment.

I think I have some of this wording wrong, but I want to make sure. You testified yesterday that the adhesions were very bloody?

A. Yes.

Q. Is that because of the short bowel syndrome?

A. Not necessarily, but perhaps.

Q. And he was missing clotting -- what do you call that? -- missing clotting.

A. He could have been missing clotting factors.

Q. Okay. Why do you suppose that could be?

A. Because of my experience in operating on people that have malnourishments, that they often bleed more than -- even with normal laboratory tests, they often bleed more.

Q. He was also anemic; right?

A. Very slightly.

Q. I'm going to jump over to the consent form with just one question.

Yesterday you testified that the consent form you have is very general. Do remember saying that?

A. I don't remember saying that I have, but I think that the surgery center has.

Q. Oh, okay.

A. It's not my consent form.

Q. It's not your consent form?

A. No. It's one I sign.

Q. Do you have any say in changing that consent form if you don't agree that it's specific enough?

A. I can't change the form.

Q. No?

A. No. It's a general form that you sign before you operate, no.

Q. How many other surgeons are at the surgery center?

A. General surgeons? There are a lot of different surgeons.

Q. General surgeons?

A. Probably about four.

Q. Four.

Could you change just yours or would that not be allowed, your consent form?

A. It's a surgery center consent form, not my consent form, and it's not been my habit and practice to change their consent form.

Q. Are you concerned every time that you use that consent form since it's too general?

MS. DAEHNKE: Objection. That mischaracterizes her had testimony.

HEARING OFFICER HALSTEAD: She can take issue with the question if she doesn't agree.

THE WITNESS: When you say "too general," it's me judging it as such, and I have never judged that it is too general.

BY MR. WHITE:

Q. Do you have any idea who writes those consent forms?

A. Probably the attorneys for the surgery center.

Q. The attorneys or anyone else that may not be a medical doctor, they don't have influence over how you treat your patients, do they?

MS. DAEHNKE: Object to relevance and --

THE WITNESS: What was the question? I'm sorry.

BY MR. WHITE:

Q. For instance, was this form --

A. Do the attorneys affect the way I --

Q. Treat your patients? Do they have any affect on the treatment of your patients?

A. I would say no.

Q. Except that you're not completely comfortable with this consent form and you can't change it --

MS. DAEHNKE: Once again, I object. She didn't testify to that. You're mischaracterizing

her testimony from yesterday and from today.

THE WITNESS: I didn't say I was uncomfortable with the consent form.

BY MR. WHITE:

Q. It's general?

A. And I didn't say that gave me discomfort.

Q. Okay. But you're using it as a defense; correct?

HEARING OFFICER HALSTEAD: I didn't rule on the objection because, as I said before, if she doesn't agree with that question then she can correct it, which she has done, but . . .

Go on. You may continue with that.

MS. DAEHNKE: I am going to assert another objection in that he's now arguing with Dr. Barber.

HEARING OFFICER HALSTEAD: Well, I think he's trying to make a point. Whether or not he's able to make that point is another question.

MS. DAEHNKE: That's true. Fair point.

BY MR. WHITE:

Q. Yesterday you stated during direct examination with your attorney that the consent form was general?

A. Yes.

Q. Why did you say that?

A. Because that is my judgment of the language.

Q. Would you make it more specific if you had the opportunity?

A. No.

Q. Why not?

A. It's not necessary.

Q. So on the one hand, you say that it's general and that's that reason it's missing some factors; right?

MS. DAEHNKE: Object. It mischaracterizes her testimony.

HEARING OFFICER HALSTEAD: Well, he's asking if she agrees or not. She can disagree.

THE WITNESS: I disagree with that. I think a general consent is helpful.

MR. WHITE: Give me a moment.

HEARING OFFICER HALSTEAD: I don't want to rush you, Mr. White, but it's two o'clock.

MR. WHITE: I'll just mark where I am and we can get Dr. Baskies on.

HEARING OFFICER HALSTEAD: How much more do you have? It is something -- do you want the extra time, is what I'm asking, or do you want to wrap up?

MR. WHITE: She's going to have to do redirect. Maybe we take Dr. Baskies now.

MS. DAEHNKE: We could. I --

MR. WHITE: It's five o'clock in New York.

MS. DAEHNKE: Yeah.

From what you've done, I have very little redirect.

HEARING OFFICER HALSTEAD: If you're going to be another five minutes or so, then I will just say finish up. But if you want more time to consider, then we can switch up.

MR. WHITE: I'd like a little more time than five minutes, sure.

HEARING OFFICER HALSTEAD: Okay. We're going to put a pin in the cross-examination and we are going to call Dr. Baskies out of order. And I believe we need to go off the record for a couple of minutes to accommodate that.

(Recess from 4:02 P.M. to 4:17 P.M.)

(Dr. Baskies joined the hearing via Zoom.)

HEARING OFFICER HALSTEAD: We're back on the record In the Matter of Charges and Complaint Against Annabel Barber, M.D, case number 23-11660-1. We ceased in the middle of cross-examination of

Dr. Barber so that we could accommodate Dr. Barber's witness, Dr. Baskies, in his appearance which was arranged to be called in via Zoom.

At this time, we have Dr. Baskies by video on Zoom, and we have, right now, Ms. Daehnke in the seat on video to question him.

Then, Dr. Baskies, can you please raise your right hand to be sworn.

(The oath was administered.)

HEARING OFFICER HALSTEAD: Thank you.

Go ahead, Ms. Daehnke, your witness.

DIRECT EXAMINATION

BY MS. DAEHNKE:

Q. I apologize about my voice. If you don't hear what I say, please let me know. I know it's hard to understand.

Where are you right now?

A. That's a great question. I'm in New Jersey.

Q. Doctor, I know that you have a family event that you have made arrangements to be here by video, so thank you very much.

I'm going to try to go through some things quickly. If I'm too quick, please stop me because I see there is a little bit of time delay.

Could you tell me, what is your profession?

A. I'm a board-certified general and urological surgeon.

Q. How long have you been board-certified?

A. Since 1983.

Q. And tell me just what, overall, you being a general surgeon involves?

A. So general surgery training requires four years of college, four years of medical school, a five-year residency. And then in addition to my five-year residency in general surgery, I had two years of advance cancer surgery which is a subspecialty of general surgery.

But general surgery encompasses surgery of the abdominal organs, as well as the peripheral vascularity and the chest and the neck. It is surgical approaches to the need (inaudible) to be treated in a certain manner if and when medical therapy doesn't work.

It's a very complex area of specialty because you have to know when to be able to operate in different regions of to body literally from the neck all the way down to the toes.

Q. Thank you, Doctor?

And you went to Boston University for undergrad?

A. I went to undergrad at Boston University, and my medical school training at Boston University Medical Center. I did my fellowship at the National Cancer Institute.

MS. DAEHNKE: Just for the record, Dr. Baskies' CV is Exhibit 9, Barber 130 through 144.

BY MS. DAEHNKE:

Q. Just for the record, Dr. Baskies, you forwarded your updated CV to me last night. I have your old CV -- the Board counsel and I have your old CV, which is, I believe, fairly current, but I can ask you to update it in moment.

A. Okay. It's not that different than the one that you do have.

Q. Okay. Let me ask a question now for everyone who's here. What is updated about -- your old CV that we had in this case, older CV, what have you updated?

A. Just that I'm chairman of a charity located in New York City, actually it's an international charity. And I believe I was recertified in 2024. So that would probably be the most significant update to the CV.

Q. Recertified in what?
A. In general surgery.
Q. Okay. And I -- well, I also got an invitation in the mail to an award that you received just recently. What was that?
A. I've received several awards. I received some recognition from the American Cancer Society, I was an honoree last year, and I was made chairman of a charity also that raises funds for cancer research.
Q. And your CV is very long and your work, if you can briefly tell us, your work with cancer surgery you said it involves a lot of areas.
Specifically, what are you doing now with regard to research and involvement with cancer?
A. So one of my areas of -- one of the things that I do a lot of is take care of patients who are medically indigent, they don't have insurance. I do volunteer work at a clinic that specializes in that area.
I have special areas interest, which is cancer surgery, and that involves breast surgery, colon surgery, any abdominal place of malignancy, as well as lung surgery for lung cancer.
My background is such that I not only have

my general surgery training, bit I can do complex cancer surgeries. Things like hernias are relatively simple operations for me, but over the years I not only do the simple operations but a lot of very complex surgical procedures like pancreatectomy, et cetera.

Q. Just with cancer patients, you said hernia, have you also done bowel surgery on cancer patients?

A. Yes. Absolutely.

Q. Okay. And I'm just asking this question out of order. What does friable bowel mean?

A. Friable bowel means very delicate, or when you touch an organ and it's friable, it doesn't have the integrity or the same strength, if you will, of normal tissue.

Q. And the term "friable" can apply to organs for -- various organs?

A. Yes. If someone is using the term "friable," it usually means that it is not -- what they are touching is -- doesn't have the same integrity that it would -- it's thinned out oftentimes, and so just touching it can -- not damage it, but it's thinned out.

Friable in the simplist terms would be

thinned out. Instead of being a certain thickness, it would be thin.

Q. Okay. And could it be easy to bleed or in this case with Patient A, Dr. Barber said she was using a regular needle to try the repair and it was making bigger holes with the needle, so that's when she did the stapling.

Would friable describe the holes around the needle, would that be accurate?

A. Bowel has a certain number of layers and a certain amount of thickness. If it's thinned out and we put a stich into it, then the stich will make a bigger hole than the needle itself. And so, yes, that's -- when tissue loses integrity and thins out, then it's not as strong as it would have been under normal circumstances.

If you can imagine a piece of paper or a piece of cardboard, that would be, say, normal integrity, but if something thinned out like paper and you put a stich into it, it can tear. That is a very loose analogy of what I'm trying to say, but, yes, I think you get the picture.

Q. Okay. And Dr. Barber did not use the term "friable" anywhere in her medical records.

Is that a term you would expect to see

either in a medical chart or would that be a term you would use to talk to a patient to describe the situation?

A. It depends on the patient's level of understanding of what I'm trying to say. I would probably explain what I mean by friable, try to explain it to the patient.

Q. Do you think it would be necessary to use the term "friable," in your opinion?

A. No. That wouldn't be something I would normally use in talking to a layperson. Another physician would understand it because it's a very commonly used term, doctor to doctor, but doctor to patient, if I was using that, I would immediately stop and say: Do you understand what I mean by friable?

I wouldn't expect them to understand that.

Q. All right. Thanks, Doctor.

And because I know it's after 5:00 there, were a little pressed for time, in looking at your CV what -- can I just ask you, the surgery that Dr. Barber, you were retained to look at the records in this case and formulate an opinion as to whether Dr. Barber breached the standard of care, violated the Medical Practice Act, both with her surgery and

her documentation, and -- is that fair?

A. Yes.

Q. Okay. And that was some time ago?

A. It was, yes.

Q. Okay. Have we not, in fact, had three separate hearings that you've been either here in Reno to testify for or waiting in the wings to testify for this same Patient A?

A. That's correct.

Q. And so, Doctor, I sent you the records and you reviewed them for the first time quite a while ago, a number of years ago.

Did you, in your review of the records -- and I'm sorry I jumped over your CV and your wonderful qualifications. I may ask a couple more -- did you develop an opinion as to whether or not Dr. Barber breached the standard of care as a general surgeon or --

MR. WHITE: I have an objection.

MS. DAEHNKE: I'm going to finish my sentence.

MR. WHITE: No you're not because I'm -- the objection is she's vouching for the witness now at this point: His wonderful CV.

HEARING OFFICER HALSTEAD: Okay. Just so

both counsel's clear, I'm not taking any questions as evidence -- counsel's questions are evidence, and I'm not a jury, so I think she's just being friendly with the witness.

His CV will speak for itself.

MS. DAEHNKE: I was trying to explain to Dr. Baskies why I'm not going through his CV, which is very impressive.

MR. WHITE: Again, vouching for the witness.

HEARING OFFICER HALSTEAD: Right. The CV will speak for itself.

BY MS. DAEHNKE:

Q. Dr. Baskies, do you need me to restate? I'll restate.

In your review of the medical records in this case that you reviewed some time ago and, again, each time this has been set for hearing, did you develop an opinion as to whether or not Dr. Barber breached the standard of care or violated the Medical Practice Act either with regard to the surgery that she performed on Patient A and the indications therefor and the manner in which she did it or in her medical recordkeeping?

A. I did formulate opinions.

Q. What are those opinions?
A. After going through the extensive records that I was sent, I think there was no evidence at all that she breached the standard of care, and then I felt that her medical recordkeeping was excellent.
Q. Dr. Baskies, let me address the medical recordkeeping in this case first.
Let me ask you about the February 22, 2019, operative report, the dictated operative report. Do you have the paper copy, can you locate that?
A. I have it.
HEARING OFFICER HALSTEAD: Can you identify it for the record?
MS. DAEHNKE: It's Barber 000079 to 000080.
BY MS. DAEHNKE:
Q. Doctor, do you have that operative report in front of you?
A. I do.
HEARING OFFICER HALSTEAD: It's respondent's Exhibit 5, and the page numbers?
MS. DAEHNKE: Respondent's Exhibit 5, and the page numbers are Barber 00079 to 00080.
HEARING OFFICER HALSTEAD: Thank you.

BY MS. DAEHNKE:

Q. Doctor, first of all, did you review this operative report?

A. I did.

Q. All right. And you're aware that the Board's expert, Dr. Spoerke, is critical of this operative report?

A. Yes.

Q. Okay. And in your review of this operative report, what is your opinion of this report.

MR. WHITE: Objection. Calls for narrative.

THE WITNESS: I think you have to look at it from the --

HEARING OFFICER HALSTEAD: Wait. There's an objection.

THE WITNESS: -- point of where the surgery was done, first of all.

MS. DAEHNKE: Hold on, Doctor. The Board attorney has objected. I don't know what the objection is.

MR. WHITE: Calls for narrative.

HEARING OFFICER HALSTEAD: Overruled.

BY MS. DAEHNKE:

Q. Please continue.

A. First of all, you have to look at it from the point of view of where the surgery was done. This was done at an outpatient center. And I just -- as you know, I've operated throughout my career at outpatient centers as well as in hospitals, and they -- the mode of which the patients are taken is completely different in a surgery center than it is in a hospital, and that is beyond the control of Dr. Barber. I'll tell you why that's important in a moment.

At the top, Las Vegas Surgery Center, this wasn't done at a university hospital where they have electronic health records. This was probably dictated into either a Dictaphone or by telephone, which is what most surgery centers do. You are not in real control over the quality of the person doing -- who is taking off the dictation. In fact, you don't even know, when you do your dictation, how good that transcriptionist did and whether or not it went through because they don't tell you in real time. You only find out later on if there are gaps in the dictation or if the transcriptionist understood what you said.

So, typically, what you will seen in a surgery center dictation note are gaps and mistakes in wording, which is what you see here. Not that that's great, it would be better if it wasn't, that that's the real word that we live in a surgery center situation.

So she clearly says what the pre-operative and post-operative diagnoses are, she stated what the procedure was that was performed, and she goes through who the surgeon was, herself, who the assistant was, who the anesthesia was, who all of this was, et cetera.

And then if you go through the notes, you'll see that there were some words that were probably not -- that were taken off in the dictation, and you will also see that there were gaps in the dictation. She would have no way of knowing that when the dictation was being done because it's being done remotely, and it's not an electronic record at all. It's done by a human being taking off what she thinks she hears but may not be accurate.

This is typically, unfortunately, what you see in a dictated operative note that is transcribed remotely.

If there is a problem with that, it's not doctor -- if there is a problem with the gaps or with the wording, it's not Dr. Barber that did that, it's the transcriptionist.

If the Board has a problem with somebody here, they should go after the transcriptionist, in my opinion, not Dr. Barber. She dictated an operative note and I can understand it, even though there are mistakes made by the transcriptionist, and even though there are gaps in what the transcriptionist was unable to transcribe.

And I think it's very important for the Board to understand that this -- Dr. Barber dictated a note and she had no way of knowing the transcriptionist makes mistakes and that she had gaps that the transcriptionist was unable to take the transcription from.

Q. Dr. Baskies, those gaps, and it looks in parentheses there might be a timestamp, what does that indicate to you, the gaps, the blanks, the slashes?

A. It indicates to me that the transcriptionist couldn't understand what was transcribed -- or wasn't sure of what he or she was taking off.

Again, it's very important to know that this is not -- this isn't something that you correct in real time or can do anything about in real time. In other words, you're dictating into like a meeting or on the telephone, and someone on the other end who you don't even know is taking off the dictation. It's not an electronic process.

MR. WHITE: I'm going to object to this at this point.

THE WITNESS: If you were at hospital, for instance --

HEARING OFFICER HALSTEAD: Let him finish.

MR. WHITE: All right.

THE WITNESS: -- (inaudible) hospital has electronic health records. This is not the situation in a surgery center.

I want to let the Board know, I work with -- I help direct the safety standards within the State of New Jersey, so I'm very familiar with this issue. And it's an issue in every surgery center.

My advice is find out, if the Board was really interested, how often this occurs. But I can tell you from my own experience, I've seen it hundreds of times in my own operative notes where

the transcriptionist had a problem.

MR. WHITE: The objection was to lack of personal knowledge. He can't relate what he is saying or what he is experiencing in his own practice to this. Also, it did call for a narrative, and it's nonresponsive to the question.

The question was: What are the gaps?

And he went into all -- if the Board has concern and everything else. Of course the Board has concern about medical records, that's a given. As I did object to calls for a narrative, it did.

HEARING OFFICER HALSTEAD: It did.

MR. WHITE: It provoked a narrative.

HEARING OFFICER HALSTEAD: I note your objection. A narrative at this point is getting us through and I will take all your other concerns as to weight.

MR. WHITE: Okay. Thank you.

MS. DAEHNKE: Do I need to respond?

HEARING OFFICER HALSTEAD: No. You can continue.

BY MS. DAEHNKE:

Q. Thank you, Dr. Baskies.

Let me -- can you turn to the second page of the operative report. It's 79, the first

page, and then 80 is the second page.

Do you -- what -- is that Dr. Barber signature?

A. There is a signature there, yes.

Q. Underneath that, do you see -- there's a -- it says "job," what -- in your experience, what is that on the operative report, what does that indicate?

A. Every dictation when it's taken remotely has a job number. They may be using an outside service to do this, et cetera. So it's a job number that identifies the job itself, so it's given a number.

Q. Okay. And then over in the same line with the capital D and a colon, what does that indicate to you, in your experience?

A. "D" means the date that it was dictated, and "T" is the date it was transcribed. Even though Dr. Barber dictated this on the 22nd, it wasn't transcribed until the next day.

Q. All right. And then, just flipping back to the first page -- well, actually, let me just ask you a couple follow-ups.

Could you tell us a little bit more about your experience with surgery centers, like Las Vegas

Surgery Center, are those ambulatory surgery centers?

A. Yes. Ambulatory surgery centers kind of came into being in the United States probably in the early 90s. Up until then, they didn't exist.

I'm intimately familiar with surgery centers, as I said, because I was asked to help with the safety and guidelines for surgery centers in the State of New Jersey. I was a part owner of a surgery center, for full disclosure purposes, and I know how they work.

Suffice to say, the surgery centers themselves will oftentimes have -- you'll dictate on a particular day and it will be transcribed sometimes, if on a Friday, it may not even be transcribed until Monday.

Q. Thank you, Doctor.

In your review of this operative report of February 22, 2019, for Patient A, do you have an opinion as to whether the pertinent information is contained in this operative report?

A. It is. The pertinent information is there.

Q. And what --

MR. WHITE: Objection. Vague. What is

pertinent?

HEARING OFFICER HALSTEAD: He -- actually, he went over that earlier in the questioning, and he is just reiterating the same thing that he testified to earlier.

MS. DAEHNKE: I'm going to ask what he believes is pertinent.

HEARING OFFICER HALSTEAD: Go ahead.

BY MS. DAEHNKE:

Q. What is the pertinent information that needs to be contained in an operative report?

A. Well, it depends on the operative note, obviously, what the situation includes. You want to identify what the pre- and post-operative diagnosis was, what happened during surgery and in the narrative portion of the operative report itself. You need all the details that are at the top that she has in this operative note, and then you start by saying, you know, how the patient was positioned, for instance, and then what was done in terms of access to the abdominal cavity and what was spotted during that procedure.

Q. In your opinion reviewing this note with the gaps in the transcription, is this an acceptable operative report in this case?

A. Yes. I understood exactly what happened from the operative note, and so that is what you want to see in the narrative, even though the transcriptionist obviously made mistakes, which are beyond control of Dr. Barber.

Q. Do you -- Dr. Spoerke testified yesterday that, of course, the creation, the dictation of an operative report is the duty of the surgeon.

Do you agree with that?

A. The creation of the operative note is an obligation of the surgeon, yes.

Q. Okay. And he testified that the surgeon could go into the EMR and make any corrections to the operative report before signing?

MR. WHITE: Objection. Misstates the evidence from yesterday. He did not talk about going into an EMR. He talked about --

MS. DAEHNKE: He sure did.

MR. WHITE: No. He talked about going into his computer.

HEARING OFFICER HALSTEAD: I recall the testimony, and I understand that this is not an EMR record. If you're going to make -- I don't know what point you're getting at, but maybe ask a more direct question.

I think your point is you can't go into an EMR and correct this record. Is that your point?

MS. DAEHNKE: It is.

HEARING OFFICER HALSTEAD: That's understood.

BY MS. DAEHNKE:

Q. So, Doctor, with the gaps and it looks like timestamps, from what you just testified, Dr. Barber would not -- and your understanding from what you've done and what you've seen, the surgeon would not know that there were gaps for this transcription?

A. That's correct.

EMR stands for electronic medical records, that's what it is, when the electronic medical record on the computer. In other words, it's there and you -- if the hospital will allow it, if the hospital system will allow it to be done, you can make changes.

My hospital system won't allow you to make any changes in medical records at all. Theoretically, it's possible, but it depends on the hospital.

But this not an electronic health record, this is a human being who is transcribing as best

they could, and it's got nothing to -- electronic health records manipulation or change doesn't apply here.

Q. Doctor, have you ever had a transcriptionist call you about something they could not understand in a dictated operative report?

A. No. That is not typically what's done because -- and the reason is is that in the real world, transcriptionists are doing it remote, sometimes from their home, and they don't even know who it is that did the dictation. They have no way -- that is not what happens.

No one calls you to tell you that I don't understand what you were saying. They go on to the next one, et cetera, many times.

Q. Then, Doctor, your review of the operative report, was it sufficient to give you an understanding as to how Dr. Barber proceeded with the surgery and what happened?

A. Yes.

Q. What's your understanding? First, do you believe Dr. Barber met the standard of care in performing this procedure on Patient A by attempting laparoscopic repair, possible open, is that plan sound?

A. Yes. She -- yes, it was within the standard of care to attempt a laparoscopic approach in this particular case. Yes.

Q. Could you tell me why?

A. Well, laparoscopic hernia repairs are very commonly done in the United States. There are about a million and a half annual repairs done -- a million and a half hernia repairs done annually in the United States. Probably about half of them are done under those circumstances.

Previous surgery -- and this is something that I think the Board really needs to understand -- is not a contraindication to doing laparoscopic hernia repair. It is not a contraindication. In fact -- and I' provided with two treatments, if you will, on this particular topic -- even in a patient who has dialated bowel from a bowel obstruction, laparoscopic surgery is done under those circumstances for patients who even have bowel obstruction.

Anybody that says, for instance, that this shouldn't have been done laparoscopically does not -- I'm afraid is not -- doesn't understand the literature. To ignore the experience of hundreds of surgeons in the United States who clearly do

laparoscopic surgery like myself over the years on patients who have had previous surgeries.

So there were no contraindications. In fact, it would have been in the patient's best interest to try to do this laparoscopically.

That's why I've concluded that making that decision try to do this laparoscopically was within the standard of care.

Q. Doctor, let me just back up a little bit. In your review of the records, you saw that Dr. Barber ordered a CT scan?

A. She did order a CT scan, yes.

Q. Was the created -- in your mind, could that give the surgeon helpful information about the planned procedure?

A. Absolutely. In terms of trying to create a roadmap and chain of any contraindications to proceeding with laparoscopic surgery, it makes absolute sense to do that, and it's good medical practice to have done that.

Q. Did you review the CT scan and the CT report?

A. I did.

Q. Did you see anything -- what was your evaluation of the CT scan?

A. The CT scan showed no bowel obstruction. It showed a relatively innocuous abdomen from the point of profusion that was going to be conducted in this case.

Q. Did you -- again, moving back from the operative report, did you also review the other workup that Patient A went through in anticipation of surgery?

A. I did, yes.

Q. Was that appropriate?

A. Yes, it was.

First of all, there was a CAT scan ordered -- this is from memory, I didn't make a list of things what were done -- she performed a preoperative evaluation, I mean, it's a multi-page -- and I would encourage the Board to look at that note -- complete documentation of the patient's history, including the family history, and it isn't just about the hernia. It's a very extensive pre-operative note. And in addition to that, she even sent the patient to medical clearance prior to surgery.

She did a CAT scan, she did a complete evaluation of the patient, and she sent the patient for medical evaluation by another physician. So it

was an excellent pre-operative workup.

Q. And the evaluation, are you talking about by the cardiologist?

A. Yes. And there was a note from the cardiologist that the patient was cleared for surgery.

Q. And in your review of the records, did you also see that various labs were performed?

A. Yes.

Q. Were any of the results of the labs a contraindication to proceeding with surgery laparoscopically with Patient A?

A. No, there was nothing in the lab testing that contraindicated surgery. There was no contraindications based on the labs.

Q. Did you note that part of Dr. Barber's plan was to prescribe Juven for the patient prior to surgery?

A. Yes.

Q. Dr. Barber testified today that two weeks is usual, but a month of Juven would be fine for this patient.

Do you agree or disagree with that?

A. Well, enteral nutrition prior to surgery is commonly used in many patients. I commonly will

prescribe Ensure or Juven or any of those, many of which you can buy at Costco. Protein helps healing.

I mean, it's not a requirement, but it shows good medical judgment in terms of let's get this patient into maximum physical condition, and certainly improves the healing process by doing that, even in a person who isn't malnourished.

HEARING OFFICER HALSTEAD: Ms. Daehnke, may I?

MS. DAEHNKE: Yes.

HEARING OFFICER HALSTEAD: The issue is the surgical decisions by continuing the high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has extensive surgical history and scarring in his abdomen, which is contradicted by medical literature.

So the line of questioning you've gone down for the last few minutes isn't -- I know that you both discussed it, but it doesn't go to the actual allegation in the Complaint, so it's not something that's helping me.

MS. DAEHNKE: Thank you for that. All right. I thought it was important, Dr. Spoerke's opinion.

HEARING OFFICER HALSTEAD: Well, there's

no complaint about the pre-workup or the Juven. I mean, no one is taking issue with that.

MS. DAEHNKE: Thank you. I'll move on.

HEARING OFFICER HALSTEAD: Thank you.

BY MS. DAEHNKE:

Q. Doctor, we're going to move on, but please just tell me what you were going to say because I couldn't hear.

A. I didn't know whether I was supposed to hear Ms. Halstead's -- what she was saying. I wanted to make sure I am not missing something is all.

Q. No, you're good. The judge said that the preop is not at issue, it's not charged in the Complaint. We did talk about it, though, because it was discussed. We're going to move on.

Let me invite your attention, also for time-saving, do you think -- so the decision to proceed laparoscopically was -- met the standard of care. And what about the decision to continue the procedure in the fashion that you understood when occurred in this operative report -- I'll get to the charging in a minute -- do you think this procedure was -- it was appropriate to proceed the way Dr. Barber did?

A. Absolutely. There was no contraindication for a laparoscopic approach. We know that if -- and let me tell you why.

We know that the recovery rate for laparoscopic hernia repair is much better for patients, much quicker and much more efficient, the healing process is much better, and that's why laparoscopic surgery has become very poplar in the United States, because you don't have a big incision to heal and you don't require opiates after surgery, et cetera.

From that point of view, it makes a lot of sense to proceed with that approach.

Q. Okay. Let me -- and then the next question is whether she should have continued, but let me just read you the allegation so we can focus a little bit because I have a lot that I would like to ask you.

The allegation is Dr. Barber failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstance when she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has extensive surgical

history and surgical scarring in his abdomen, which is contraindicated by medical literature.

You got that?

A. I do.

Q. Do you have an opinion as to whether that allegation is true and accurate based upon your review of the records and your experience and training?

A. The last part -- let me talk about the last part of this thing. There was no contraindication. Whoever wrote that up didn't understand the medical literature, unfortunately, with all due respect. The medical literature shows that you can do laparoscopic hernia repair. And any laparoscopic surgery, in fact, in the abdomen in a patient who has had previous surgery.

That is an incorrect statement and anybody that is board-certified should know that, number one.

Number two, she didn't fail to use good judgment at all. She used good judgment because she tried to save this patient the problems that can occur with an open hernia repair. That's why we try to do laparoscopic surgery whenever possible to repair a hernia.

The third thing that is is that she -- the laparoscope wasn't inserted initially in a midline at all and there is no contraindication reporting a Trocar in the midline.

The first intent when we do laparoscopic anywhere -- and I should mention, laparoscopic inguinal hernia repair, which is a groin hernia, if the hernia is on the left side, the first approach is to go in from the right because that is where the scope is going to -- if you put the scope in on the left, you can't get your instrument in the right place. You have to go in on the opposite side, first of all.

If it's a left inguinal hernia, the first Trocar should be on the right side. If it was a right inguinal hernia, the first Trocar attempt -- insertion attempt would go in on the left side. That's the way we teach it, that's the way we do it.

If you can't get in on either side, then you only have the option of going in in another area. It could be in the midline, it could be in the upper abdomen, it could be anywhere, but you have to get the first Trocar in because that Trocar is the way to introduce the scope.

Q. Okay.

A. I don't know whether I made that clear enough.

Q. I think you made it clear.

Let me ask, if it's a left inguinal hernia, you put the scope -- the first entry is on the right, just explain the vision -- explain why, why you --

A. So the area that you're going to do -- you're going to eventually end up with three -- two or three or more Trocars into the abdominal cavity. I'm going to show it on my abdomen.

This is the left side of my abdomen, if I put a scope here to fix something in my groin, that scope will be in the way of the instrument that I want to put -- that I want to do the repair with. You want to put the scope in so you can visualize from the opposite side of what you're at then so then you can put your Trocar in here and do your surgery while you're looking, using this scope on the other side. If you have the scope in here, you can't get your instruments in the right place (indicating).

Anybody that knows how to do laparoscopic surgery understands that. It's a very basic -- it's the first thing I taught residents and medical

students when teaching these procedures.

If it's a left inguinal hernia, left groin hernia, you want to put the scope in through the Trocar on the opposite side, otherwise that scope will be in the way of your instruments that you are eventually going to put to do the repair.

It's a very, very basic and very, very -- you can't do it other any other way. It's very basic.

Q. Okay. Thank you, Dr. Baskies, that was helpful.

In this case, is that your understanding as to what Dr. Barber did?

A. It is.

Q. Okay. And then -- so the next inquiry is whether it was imprudent or improper or failure to use reasonable care by continuing the surgery after Dr. Barber put the first scope in -- or went in on the right and there was no visualization.

Was it imprudent to continue to go on the left, should she have converted to open?

A. Yes, it was, because then you could see -- your opposite side, if you can't get in or you have a problem and you suspect that you can't get in with the Trocar and you want to see what's going on on

that left side, if you can then put a different Trocar in somewhere else. It's a very common -- the access issue, it's a very common issue for people that have had previous surgery, but it is not a contraindication to proceed.

Q. I asked the question a little strangely.

Do you believe it was appropriate for Dr. Barber to go in on the left side instead of converting the surgery to open?

A. Yeah, it was prudent to do that. You still want to try to see if you can get enough bowel away from abdominal wall so that you can do the hernia repair in the abdominal wall.

Q. And what about does the fact that there was not visualization on the right indicate in any way the burden of the adhesions on the left or whether the left side would be adhesed as well?

A. No. With previous surgery, you can have adhesions just in one localized area of the abdomen. It could be just maybe -- it's an unpredictable thing where you're going to form adhesions.

I think it's very important to know that we constantly operate on patients who have previous abdomen surgeries. As long as you can get into the abdomen and create working space by insufflating it,

once you have your Trocar in, then you increase the pressure in the abdominal cavity by putting gas in so that the abdominal wall will go -- will enlarge and you get working apace.

The goal is to get that first Trocar in and once you got that, once you insufflate the abdomen, then the bowel, potentially, could fall away from the abdominal wall and then you get working space.

Now with that, the place that you expect the adhesions are, the surgeries that Patient A had would be in the pelvic in the lower abdomen, because the problem that the patient had as an infant, an omphalocele, which involved not the large bowel but the small bowel. So the small bowel was eviscerated from the abdominal cavity when Patient A was born.

But the place where you expect the least adhesions would be in the groin.

Q. And by "fall away," what do you mean by that?

A. If the -- so once the first Trocar is in, into the peritoneal cavity, then the next step is to insufflate the abdomen. You put carbon dioxide into the abdominal cavity.

Then the abdominal cavity and the

abdominal wall will then -- because you're putting it into the abdominal cavity -- expand; right? And in doing so, the bowel, if it is not stuck to the abdominal wall, in some places will fall, or in other words, will go back down. Then you can put another Trocar in and start to manipulate the adhesions and cut them.

That's what we do all time when we operate on patients who have had previous surgeries. It's something that I've done hundreds and hundreds of times.

Q. When you -- do you always insufflate the abdomen after you put the first Trocar in with laparoscopic surgeries for groin repairs?

A. Yes. Otherwise you can't create any working space.

Q. That's just something that's understood it's going to be done?

A. Yes.

Q. And Dr. Barber didn't state in her operative report that CO2 was used to insufflate.

Do you think that that's a breach in the standard of care?

A. No. It's not a breach in the standard of care because everybody knows in order to do the

surgery, that's what you have to do.

Not only that, but she never established in the note and probably never even got to the step where she would have insufflated.

Q. Okay. So it was appropriate for Dr. Barber, after going in the right to continue to see to go in on the left, she did not have to --

A. Yes.

Q. -- to open.

And then what about going in midline, do you think that that was inappropriate or appropriate?

A. No. There's nothing inappropriate about that at all. If you are trying to access, you're going to try different spots of the abdominal wall. There's nothing magic about the midline.

In terms of making a big deal out of that, I don't understand. Midline is the place where I commonly go in as my attempt to get my Trocar.

She's repairing a left inguinal hernia, the first place you are going to go with your Trocar is the right side. If you can't get in there, then you go to the left or the midline. You can go to either one.

You just want to get a spot where you can

get the Trocar in and then start to put your gas in, your carbon dioxide, so that you can get some working space, and then you can get another Trocar in and start to manipulate the adhesions. That's how it's done.

I'm not sure I've given enough of a description for the Board to understand, but that's how it's done.

Q. And that's how it's always done, that's custom and practice in the way these surgeries go?

A. Yes.

Q. And after she was in the left, you do not believe that the standard care or the Medical Practice Act mandated that she convert to open instead of going midline. Is that your opinion?

A. I don't understand the question.

Q. Do you have any opinion as to whether she could -- had to to meet the standard of care, convert to open after going in on the left or whether it was appropriate to go to midline?

A. It was appropriate to go to midline to try another side in the abdominal wall to get to the point needed. That was appropriate.

Q. I realize that you explained this and it's natural. I was trying to get this out for the

record, so thank you for your patience, Doctor.

Then Dr. Barber testified that when she got to the midline and then she recognized or realized or suspicion that there was an injury to the bowel.

Is that your understanding?

A. Yes.

Q. Okay. Then she did a mini laparotomy that she extended.

Is that appropriate?

A. Yes. She opened the abdomen and because she saw bleeding, decide that was needed.

Q. Is that exercising good medical judgment, reasonable care, and skill?

A. Yes.

And by the way, just so you know, I've been called in to help surgeons who have had bowel injury and with no previous surgeries in pointing the Trocar. And so it isn't something that you need -- a Trocar injury isn't something that are unique to people who have had previous surgery. Okay? I can't tell you the number of times that a gynecologist or another surgeon has asked me to help them because they went into a bleeding abdomen with no previous surgery and there was a Trocar injury.

Recognize -- unfortunately, Trocar injuries are a recognized complication of laparoscopic surgery.

Q. So it's a recognized risk, the procedure, and a known complication?

A. It's a known complication, yes. Even in a patient who has had no previous surgery.

Q. Now, is it your understanding that Dr. Barber did not repair the hernia during this procedure?

A. That's correct. I wouldn't have repair-- when you have this problem that occurs here, it is not appropriate if it's the hernia, you wouldn't do it, and there's a simple reason why.

Q. What?

A. The reason is is that the repair will be done with mesh, which is a foreign body. If you have injury to the bowel, you really shouldn't put a foreign body in because it will get infected.

When recognized, the injury, unfortunately, putting -- it would have been very poor judgment, I don't want to say the word "malpractice," but, I mean, you would not put mesh in, you would not do a hernia repair in a situation where you have a bowel injury. You wouldn't do it.

In fact, I would be critical of that. The fact that she didn't repair the hernia is exactly correct.

Q. In your review of the records, and particularly with regard to this operative report and the surgery, is there anything else that was significant to you in your review as to whether Dr. Barber met the standard of care and met the -- acted as a reasonable surgeon, using reasonable care, is there anything with regard to the surgery itself that was significant?

A. Not that I can think off the top of my head. I mean, I've got a very full understanding of the patient from the pre-operative evaluation.

I understood what she was dealing with here, and I didn't see anything else that I would comment in terms of the operative.

Q. Okay. Thanks, Doctor.

Let me, then, turn to the short op note and the H and P from the surgery center. It's one page, and for the record, I'm looking at Barber Exhibit 5, 000071.

Doctor, you have that in front of you?

A. I do.

Q. Can you tell me, what is this?

A. This is a one-page note that contains a history and physical as well as a brief operative note. This is exactly what you see in an outpatient surgery center associated with a one-day or same-day surgery. What we call a "surgical note," and it's meant to be brief.

In fact, the history and physical portion is a supplement to the initial evaluation. When patients come in for outpatient surgery, they have to have a recent history and physical that is complete. The reason that these are short is it's meant to be an interim note. If there's something that happens between the time of the initial evaluation with a full H and P, then you note that on the second, a change in medication, for instance, change in the physical exam.

This is designed to be a supplement to the full evaluation.

Q. And we will talk about that in a second.

The full H and P, the full evaluation was done December 27, 2018?

A. Correct.

Q. It had been done two months before?

A. Correct.

Q. And this would update that?

A. That's why it's a short version of that.

Every surgery centers -- and I've been in a lot of them over the last 45 years -- have a one-page note that's meant to be a supplement to -- I'm talking something that a nurse can look at, for instance, it's not meant to be a full history and physical by no means. It's meant to just be kind of a synopsis or an interim note.

Let's say the patient got started on another medication, you would put that in here. And so it's change that then occurred between the time when you did your evaluation and the time that the patient's in for this one procedure.

It's very important to understand that. Every surgery center has a one-page note just like this.

Q. It looks like, on left side of this document, is the H and P. Is that accurate?

A. Yes. On the left side is the history -- what is a brief history, and on the right side is the brief operative note.

Q. On the top, the right is brief op note, and then down, as you continue down on the right side, what else does this document entail or encompass?

A. It is a brief synopsis of the post-op orders. It says, "See op order sheet," so this is one page that has all the operative notes, all the post-op orders. And then a discharge note, which is also brief.

But, again, patients usually will go home with a list of things, dos and don'ts, et cetera.

Q. And -- all right. Going back to the left side, let me direct your attention to the description in the top, "Past medical surgical history."

A. Yes.

Q. Is that accurate -- is that sufficient information for this form to meet the standard of care in regard to recordkeeping?

A. Yeah. In fact, oftentimes what most people do is not even write there, see H and P, history and physical, especially if there's a lot of stuff going on. Patients could have diabetes, hypertension, et cetera, et cetera, there's no room to put that in. Oftentimes as an update, see history and physical.

But, yeah, this is clearly the pertinent things that was on her mind and understood that this patient has had previous abdominal wall

reconstruction.

Q. For a chief complaint, it says "left inguinal hernia." Dr. Spoerke testified that if there is no room on this, that the doctor, Dr. Barber should have written smaller and more legibly.

Do you agree with that or not?

A. Someone actually said that?

Q. Dr. Spoerke said that yesterday.

A. With all due respect to Dr. Spoerke, I think that's an absurd statement. I don't mean to insult the man, but that is a ridiculous statement.

You have a full history and physical that was done that described everything that was needed to know about this patient. And why would you want to write small so you couldn't read what's there when you have it all there?

The chief complaint, why is the patient there, it's a left inguinal hernia. Let's be real here.

Q. Is it necessary to document where a patient has a reducible or incarcerated hernia, in your opinion?

A. If it's incarcerated, yeah, I would write "incarcerated," but if it's not, I would just write "left inguinal hernia."

Whether it's incarcerated or not, that's why the patient is there.

Q. So -- all right. Doctor, is in your review of this and your training and experience in your review of this and working in ambulatory surgery centers, would there be anything else necessary for Dr. Barber to add about this patient in order to meet the standard of care and to comply with the Medical Practice Act?

A. Look, I would be very critical if this was the only medical documentation regarding this patient. But it's very clear that there is a full history and physical that was done that elaborated all the things that are necessary here.

The things that are on here are meant to be brief, it's designed to be brief, but anyone who wants to know anymore about the patient, it's clearly in Dr. Barber's note.

And if you become critical about not having additional things in these notes, I believe is -- for want of a better term, a plan starts with an author.

Q. On the op report where it says "Significant findings," it says, "adhesions, small bowel injury repair."

A. Yes.

Q. Is that adequate in your mind?

A. If -- again, this is a brief operative note. It's not -- there's no -- the narrative, there's no room for narrative here. It's designed for telling -- to look at or see what happened or the pertinent things that occurred. And it's very clear that there is a pre-op diagnosis, a post-op diagnosis, which is saying procedure was an attempted laparoscopic procedure with laparotomy with repair of bowel. That's really what we've done here. That's what occurred.

So if I was -- look, I've been a chief of surgery, I've had 35 interns that reported to me. I reviewed all the complications for those people. This is exactly what I want to see: What were the pertinent things that happened during this case.

She lists them there. And then what were the significant findings? Well, there were adhesions, there was a small bowel injury. That's exactly the significant findings.

Then it goes on to say, "There was no specimen removed," et cetera, "blood loss was 200ccs." Then complications. She's not hiding the fact that there was a complication. There was a

complication: small bowel injury and repair.

And so the essence of what was done there, the -- it's all in this one note. She is not hiding anything, she clearly states what happened. It's a recognized complication of laparoscopic surgery, and it's there.

There's nothing wrong with this record.

Q. The 200ccs of blood, Dr. Barber testified that is a significant amount of blood.

Do you agree with that?

A. It's 200ccs of blood. More than a hundred, less than 300, but -- I'm not trying to make light of it, but, yeah, that's significant blood loss. Yes. It's about a unit.

Q. Is that another indication not to proceed with further repair and take the patient --

A. Blood loss and a small bowel enterotomy, those two things alone, it's not a good idea to fix the hernia. That would be not a good idea.

Once that's occurred, the hernia repair is done, it's over.

HEARING OFFICER HALSTEAD: Ms. Daehnke, we need to take a small break. We'll go off the record and be back at 3:35.

(Recess from 3:25 P.M. to 3:36 P.M.)

HEARING OFFICER HALSTEAD: We're back on the record In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D, case number 23-11660-1. Counsel are present as is Dr. Barber. Dr. Baskies remains present via Zoom.

Dr. Baskies, I remind you that you remain under oath.

We took a break during direct examination by Ms. Daehnke.

Ms. Daehnke, your witness.

MS. DAEHNKE: Thank you, Your Honor.

BY MS. DAEHNKE:

Q. Dr. Baskies, could I invite your attention to the H and P that you mentioned previously, December, 2018, H and P.

A. Okay.

Q. For the record, I'm using the copy that is respondent's 5, starting at page 72 going to 75.

Doctor, you were talking about this full H and P, but when you were explaining the question with regard to the allegations against Dr. Barber's recordkeeping, do you believe that this H and P is a complete H and P, a legible H and P, and that the standard of care so far as recordkeeping, documentation met the requirements of the Medical

Practice Act?

A. It certainly did, yeah. I mean, it's about as complete a history and physical as you would expect to see on anybody. It even talks about allergies, all of the details in the history et cetera. Very complete.

Q. I'm sorry. I didn't catch all of that. What did you say?

A. It even mentions his allergies. He's allergic to latex, he has a latex allergy. It's methodical, it's very detailed, and it is exactly what you would expect to see.

Q. And you referenced that the short op note and the H and P that we were looking at for the ambulatory surgery centers is to supplement this H and P; is that correct?

A. Yes. It's -- that's why it's so short, it's a one-page, check off-type of history and physical that was approved by the Las Vegas Surgery Center, and this is -- I assume this is the same document that every patient that goes to that surgery center gets filled out. That's what they want.

Q. The prior exhibit not this one?

A. Right. Yes.

Q. Doctor, in reviewing this H and P done at UNLV medicine, is it your understanding -- well, what's your understanding as to where Dr. Barber's employed?

A. I believe she's employed by UNLV. I don't know -- and she has a title there, professor of surgery, I believe.

Q. All right. Is there anything that you feel needed to be added to this H and P in order for Dr. Barber to meet the standard of care?

A. No. I think very it's very complete. I mean, she goes through why the patient is in the office, history of present illness, a complete review of systems. It's goes -- the past medical history is all there, the past surgical history is all there, the family history is there, the social history is there. The objective findings, it calls out how much he weighs, how much the patient weighs, and how tall the patient is, his blood pressure. Then goes through the physical examination and then the assessment and plan.

I mean, it's exactly what you see in a well-done history and physical, yeah.

Q. Let me ask you real quick. The first time -- well, when I asked you to review in this case,

you understood that you were going to get paid for your time; correct?

A. Yes.

Q. And you were ready to go the first time and when the hearing was dismissed, you had to cancel a plane ticket, a non-refundable plane ticket; is that correct?

MR. WHITE: Objection. Relevance.

THE WITNESS: That's correct.

HEARING OFFICER HALSTEAD: What is the relevance?

BY MS. DAEHNKE:

Q. And you charged --

HEARING OFFICER HALSTEAD: There's been an objection as to relevance.

MS. DAEHNKE: The relevance is that I anticipate, like a Board attorney did last week, asking an expert if he was paid for his time. It's quick.

HEARING OFFICER HALSTEAD: But what does that have to do with the plane ticket?

MS. DAEHNKE: Well, he would charge Dr. Barber for his time and cost and expenses.

HEARING OFFICER HALSTEAD: That's fine.

BY MS. DAEHNKE:

Q. Did you charge Dr. Barber for your non-refundable plane ticket?

A. I believe I did, yes.

Q. And when you came out here in June last summer to testify and the hearing had been terminated, you were here and came to the Medical Board the day that you were scheduled to testify; correct?

A. Yes.

Q. Okay. Because we were not sure what was going to happen, you were already on your way?

MR. WHITE: Objection. Leading. And you've been doing it all afternoon.

THE WITNESS: Yes.

HEARING OFFICER HALSTEAD: Okay. So --

BY MS. DAEHNKE:

Q. Did you?

HEARING OFFICER HALSTEAD: -- an objection just needs to state the objection and the legal basis therefor, and I realize it's leading but she's just trying to finish up and get us out of here timely.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: This line of

questioning, I understand how experts work.

MS. DAEHNKE: All right.

BY MS. DAEHNKE:

Q. And, Doctor, you charged Dr. Barber for your air fare and time; is that correct?

A. Correct.

Q. And you will be submitting a reasonable invoice for this appearance as well; right?

A. Yes.

Q. Thank you.

A. For my time, yes.

Q. Yes, for your time.

Thank you, Doctor.

CROSS-EXAMINATION

BY MR. WHITE:

Q. Good afternoon, Dr. Baskies. You understand I have the opportunity now to question you, do you understand that?

A. Yes.

Q. Okay. My name is Don White, I'm an attorney for the Investigative Committee.

Mr. Daehnke was just referring to the hearing that was suspended roughly back in June of last year and in reference to your traveling out here to attend that.

Did she provide you a transcript from that hearing?

A. No.

Q. No.

Did you discuss this matter with Ms. Daehnke?

A. I discussed the matter with Ms. Daehnke, yes.

Q. Okay. How many times have you spoken with Ms. Daehnke?

A. Well, I spoke to her one time prior to today that I can recollect.

Q. Without telling us anything that was said, have you spoken with Dr. Barber?

A. I have spoken to Dr. Barber, yes.

Q. How many times?

A. Once that I can recollect. And that was the -- that was when I met her for the first time, I think, when the hearing was cancelled.

Q. Thank you.

Have you ever testified for Dr. Barber in anything else before?

A. Not that I can remember.

Q. Have you testified for any other cases of Ms. Daehnke's?

A. I believe I have, yes.
Q. You have. Okay.
Can you recall how many times you have testified for a case Ms. Daehnke has handled?
A. I believe once. That I can recollect, one.
Q. One other time?
A. That I can recollect, yes.
Q. Okay. And it was just touched upon, you are getting paid to be here today; correct?
A. Yes, I'm being compensated for my time.
Q. How much are you getting paid?
A. I charge $450 per hour for my time.
Q. Have you ever testified as an expert in administrative hearings such as this?
A. Mr. White, this is the first time I've ever time before a board, yes. No, never before. This is my first time, yes.
Q. An administrative hearing.
Would that also be the same thing for a civil hearing, have you ever testified in a civil hearing?
A. You mean in a malpractice case, yeah.
Q. Sure. Yeah.
A. Yes.

Q. How many times?
A. I can't give you a number. I mean, this year that I can recollect, once.
Q. Okay. And do you it mostly for plaintiffs or defense?
A. Within the last year, it's been about 50/50.
Q. Okay. And you can correct me, I don't have the updated version of your CV, so you can correct me if I'm wrong in these statements I'm about to make in these questions.
You're no longer performing surgery; correct?
A. That's correct.
Q. When did you stop performing surgeries?
A. The last time that I performed an operation was about three years. I've had other obligations with the American College of Surgeons, the Commission on Cancer, and other things.
For accreditation purposes, they require me to leave town on a frequent basis. And so I had to juggle my time so much, I really couldn't devote my time to -- I didn't want to leave town after operating on people.
I see patients in the office and still

refer them to people that I know that are good surgeons.

Q. Okay. And that has to do with -- I missed the beginning, did you say because you're chair on different boards?

A. Well, I'm past chair of the national board of the American Cancer Society, I'm currently chair of a foundation that creatins dollars for cancer research. In addition to that, I'm doing work for the American College of Surgeons. I do accreditations of hospitals, as well as breast cancer centers, so those accreditations require me to leave where I practiced. Because the college asked me to do that and I do a lot of them, I was unable to continue to operate. And then I have other obligations in addition.

I decided at that point that I could see patients in the office, but not have to do the surgery because it just wouldn't work for me. I just couldn't emotionally operate on people and then leave town.

Q. Okay. You're not completely retired?

A. No, I'm not retired at all. If you ask my wife, she'd like me to retire, but, no, I'm not retired.

Q. Okay. Are you also a professor?
A. I'm a professor of surgery at Rowlan School of Medicine in New Jersey.
Q. You had said before -- I'm just confused. I'll go back to your testimony in civil hearings.
You had said in the last year, 50/50 for defense and plaintiff, but you had mentioned you'd only done it once. Have you done it more than once?
A. No. You asked me, I think, how many -- I interpreted it to be how many times have I testified at trial. That's how I interpreted your question. And I can remember once this year that I can recollect that I testified in court.
Q. Okay. That clears it up. Thank you.
This may be one of those questions, you can correct me, according to your CV, you did not recertify with the American Board of Surgery in 2022 when you should have?
A. No. I have an extension because I took my boards in 2012, earlier than I needed to, they gave me an extension through 2024. I was recertified in 2024.
I've been certified about five occasions.
Q. Okay. And despite your lengthy CV and many accomplishments, it doesn't mention you have

done anything involving hernias?

A. You mean am I overqualified to do hernias, is that what you're asking me?

Q. Have you ever done surgery on a hernia?

A. Yes. In fact, I've probably performed somewhere around 2,000 hernia repairs.

Q. Okay. But you didn't mention it here. That's all.

A. No. That wouldn't be on my CV, the number of operations that I've done. No, it's -- hernia surgery are relatively -- something that I've done for my entire career. I've averaged between 40 and 50 of them a year for 40 years, so if you do the math, it comes out to around 2,000 or so.

Q. What about bowels?

A. Bowel surgery?

Q. Yes.

A. If I had to estimate how many bowel procedures I've performed, it's probably over a 1,000.

Q. Is it mostly for cancer or are you repairing perforated bowels?

A. Well, the bowel surgeries I've performed have been on an emergency basis for perforation as well as elective procedures like for diverticulitis

or Chron's disease or ulcerative colitis, et cetera, so it's very -- I'd have to sit down and start to think about how many there were. Perforations for stab wounds or gunshot wounds.

Suffice it to say, it's a lot. I mean, yeah, trauma, I've come to the emergency rooms for almost my entire career just about, and so I have more-than-passing acquaintance with problems of the intestines, yeah.

Q. Did you do mostly open or laparoscopically?

A. For what?

Q. A bowel surgery or a hernia surgery?

A. So inguinal hernia repairs did not begin to be done in the United States until about, roughly speaking, late 90s, early 2000s. I happen to have done the first laparoscopic gallbladder procedure in New Jersey in 1990. I'm trying to think back to when we seen our first laparoscopic hernia repairs. It really wasn't until the early 2000s.

If you proportion it out, probably about 30 percent were done laparoscopically, 70 percent open, somewhere around there depending on the year.

Q. Thank you.

You're not licensed in Nevada; correct?

A. No, I do not hold a medical license in Nevada.

Q. And so it would be fair to say that you are not familiar with the definition of malpractice no Nevada?

MS. DAEHNKE: Object. That's --

THE WITNESS: It's fair to say that I'm familiar with the diagnosis and definition of standard of care, and I think that I understand that.

Malpractice is something that when you see, you know. It's kind of like pornography.

BY MR. WHITE:

Q. I'm familiar with that Supreme Court Case, yeah.

Also fair to say you're not familiar with the definition of maintaining proper medical records in the State of Nevada?

MS. DAEHNKE: I'm going to object.

THE WITNESS: Definition means --

MS. DAEHNKE: I just read --

THE WITNESS: What do you mean by that?

HEARING OFFICER HALSTEAD: There's been an objection in the record, and the objection was he's familiar with it -- well, that's really the answer

for him.

MR. WHITE: I think the objection was that she just read it to him.

HEARING OFFICER HALSTEAD: Yeah, but that's not a legal objection.

MS. DAEHNKE: Sure. And it's late.

HEARING OFFICER HALSTEAD: You can continue, Mr. White. I just want to make sure the record reflected what happened.

BY MR. WHITE:

Q. You're not -- it's fair to say you're not familiar with the statute regarding maintaining proper medical records in Nevada?

A. I believe I read the statute before. I mean, I can't recite it.

Q. No, I'm not asking you to recite it. It's okay.

You had testified earlier on direct examination that it was not necessary to write down that Patient A in this case -- that's how we refer to him, by the way -- had a friable bowel.

Do you remember that?

A. Well, it depends. The question -- what's the question?

Q. The question is --

A. It depends on the situation as to whether I would use that term and when I would use it.

Q. Correct.

A. So I'm not sure what the question is.

Q. Just earlier, though, you said it wasn't necessary to put in the record; right?

A. If thought there was -- if I -- it depends on the situation. It depends if it was relevant or not, if I felt it relevant.

But the question that I was asked before, Mr. White, was when would I use the term, and it would be -- I mean, I wouldn't necessarily use that term with a patient unless I properly explained it, because I wouldn't assume that patient understood what that meant.

That's what I recollect talking about.

Q. Sure.

And I think you said you would explain it to them, what is going on?

A. It depends. It depends on who I'm talking to. If I'm talking to you, I might assume that you would understood the term "friable."

Q. I'm sorry. Let me stop you there.

A. If I were talking to another physician, I might assume that they understood that term. If I'm

talking to a patient, I may or may not, it depends on the patient and what the circumstances were.

Q. How would you write it in your record if you discovered that a patient of yours had friable bowel?

A. It depends on what situation you're talking about. It's a general question.

Q. So you're not going to answer my question? You can't answer my question as to how you would write that? Would you write it in layman's terms?

HEARING OFFICER HALSTEAD: Why don't you relate it to this patient.

THE WITNESS: It depends. I don't understand your question, it's very general.

BY MR. WHITE:

Q. Okay. This patient, it was determined from Dr. Barber, had friable bowel. How would you have written it in the operative report that they had friable bowel? Or would you not --

A. It depends. Well, it depends on whether I felt it was relevant or not to state that. It depends.

Q. Would it be relevant if you were asked a question regarding that the holes were too big for sutures because of the friable bowel situation with

this patient, Patient A. Would you write that in your report?

A. Well, again, it depends on what my findings were and whether I thought it was relevant.

Q. Well, isn't that the definition of relevant, if you have a situation where you can't even get sutures to stick into the bowel?

A. It depends on the situation, what the diagnosis is, what the setting is, what bowel are we talking about, whether he had -- and whether or not it has relevance to the procedure.

So it's a generalism, I can't answer that question because you haven't given me a situation that -- to use it in. You're just asking a general question and how I would use it, when I would use it. It would just depend on the situation whether I thought it was of importance.

Q. I gave you the situation, it's this situation that you've read the records?

A. I read the records, yes.

MS. DAEHNKE: I object to this entire line of questioning. And incomprehensible, not relevant, and based upon testimony that was given yesterday that Dr. Baskies didn't hear.

HEARING OFFICER HALSTEAD: I think it's a

fair question. I think it's just -- the issue is how it's being articulated and how it's being responded to.

With the clarification that in this situation with this particular patient, how would he have noted the issue that Dr. Barber described as being friable, would that have been noted and how that would have been noted is a fair question.

MR. WHITE: Ditto. I --

MS. DAEHNKE: Well, can Dr. Baskies answer that question because that's articulated.

Can you answer that, Doctor?

THE WITNESS: I don't know what the question is. I'm sorry.

BY MR. WHITE:

Q. In this situation, Patient A, what happened and what transpired in this exact matter, how would you have articulated it that there was a friable bowel in your operative notes?

A. Again, it depends on how friable, whether or not it was relevant, whether -- what bowel it was, what the condition was whether I would note it at all. It depends.

What is in the narrative report is not -- is based on what the individual surgeon feels is

relevant to that particular procedure.

Q. Doctor, I just realized this isn't a fair question because there is nothing about friable bowel in the records you reviewed because Dr. Barber didn't include it.

I just realized it's not a very fair question to you.

MS. DAEHNKE: I move to strike that because you know --

BY MR. WHITE:

Q. Would you agree there's no -- you would have to agree that there's no way to predict friable bowel?

HEARING OFFICER HALSTEAD: Just for the record, it's not a question and I'm not -- again, I'm not concerned with either counsel's statements or questions, I'm concerned with the evidence and the answers.

Are you moving on to a different line of questioning?

MR. WHITE: I am, yes. Well, there's still some stuff about friable bowel.

HEARING OFFICER HALSTEAD: That's fine. Go ahead.

BY MR. WHITE:

Q. You would agree, Doctor, that there's no way to predict friable bowel through any kind of scan; right?

A. It depends on the diagnosis and what you mean by "friable." I'm not trying to be argumentative, I'm just trying to tell you that the term, it's a very general term. What it means from one person to another is very different.

Q. Thank you for that answer.

I'm going to refer you back to the op report, operative report, which is NSBME 115, but it's also a different one from what I think is in front of you.

MR. WHITE: I'm going to need some help with that.

MS. DAEHNKE: It's page 79.

HEARING OFFICER HALSTEAD: Exhibit 5, 79 through 80.

MR. WHITE: Thank you.

HEARING OFFICER HALSTEAD: Oh, it's Exhibit 5, page 72.

MR. WHITE: Thank you.

BY MR. WHITE:

Q. Doctor, I don't want to misquote, but you

had said something about records are different and expect to be different for ambulatory centers, surgery centers versus a hospital; correct?

A. Well, that is not really what I said. What I said is that the surgery center usually will -- any surgery center that I know of and having had intimate relationships with surgery centers will have a one-page note like this, as opposed to a full history and physical that is done in an office setting.

It's meant to be different. One is meant to be short and brief and designed to be that way because it's a short procedure, usually.

And that history and physical for a surgery center is exactly what you see here, it's a very short document, it's designed that way, and it's designed to be short as opposed to an office dictation that has a lot more detail in it.

You can't possibly put all the details in the one short form that they give you at the surgery center because it's not designed that way.

Q. From your testimony, we can assume that the patient should not expect the same quality of surgery and the same quality of records --

A. No.

Q. -- if they go to a surgery center?
A. No. It's nothing to do with that, Mr. White, I think you probably realize that.
Look, a history and physical for a surgery should have an additional -- the document that's here from Dr. Barber. The history and physical that you fill out in a surgery center is designed to be a short form history and physical that's a check-off. And so that's why we do a supplemental, that's considered to be supplemental. There's no way you can put all of that information in this one form. That's why we do a complete history and physical prior to surgery, which is exactly what's called for in this particular case in which Dr. Barber did.
Q. You said refer to the operative reports --
A. I think if you have a problem with the history and physical, to be honest with you, Mr. White, you should go after the surgery center. They produce this document.
MS. DAEHNKE: Doctor --
HEARING OFFICER HALSTEAD: Stop.
Which are you referring to?
MR. WHITE: I'm looking at the operative report.
MS. DAEHNKE: He's looking at something

different.

HEARING OFFICER HALSTEAD: Dr. Baskies, I want to make sure that you're on the same page. Mr. White, I know that he's referencing --

MR. WHITE: Yeah. No, I'm on the wrong page.

HEARING OFFICER HALSTEAD: Okay.

MS. DAEHNKE: Um-hum.

HEARING OFFICER HALSTEAD: Which page are --

MR. WHITE: It's 79. I thought we said 79, I guess.

HEARING OFFICER HALSTEAD: You want to be on --

MR. WHITE: Page 79.

HEARING OFFICER HALSTEAD: Okay. So he was meaning to reference the operative report on Exhibit 5, page 79 of respondent's exhibits. And what you were referring to just now is Exhibit 5, page 71 of respondent's exhibits.

Perhaps you could turn to page 79, and we can start from the position that you're both on the same literal page.

BY MR. WHITE:

Q. Sorry. Are you on page 79 now, Doctor?

MS. DAEHNKE: He can't hear us now.

Doctor, you can't hear anything?

HEARING OFFICER HALSTEAD: Can you hear me, Dr. Baskies?

THE WITNESS: Can you hear me?

HEARING OFFICER HALSTEAD: Yes.

THE WITNESS: Okay.

(Zoom technical difficulties.)

HEARING OFFICER HALSTEAD: So, Dr. Baskies, did you hear me when I was speaking earlier? This is the Hearing Officer, Ms. Halstead.

THE WITNESS: No, I didn't hear you, anything that you said.

HEARING OFFICER HALSTEAD: Okay. When you were testifying, you where referencing respondent's exhibit -- I've turned the page since then. You were addressing respondent's Exhibit 5, page 71, and Mr. White was meaning to reference respondent's exhibit page 79, and so you weren't on the same literal page of what he was trying to ask you about.

THE WITNESS: Okay.

HEARING OFFICER HALSTEAD: If you could turn to page 79 of Exhibit 5 of respondent's exhibits. Now that you are both where he intends you to be, he would like to ask his questions again

in context.

THE WITNESS: Thank you for the clarification. Sorry about that.

MR. WHITE: No, I'm sorry. It was my fault for turning you to the wrong page, Doctor.

BY MR. WHITE:

Q. Now that we're both on the same literal page, I think you had stated earlier, I don't want to put words in your mouth, that there was just a difference in a report like this that comes out of a surgery center versus a report that comes out of a hospital. Correct me if I'm wrong.

A. I think you paraphrased what I was trying to tell you.

In a hospital setting, generally speaking, EMR, the electronic medical records, allows a surgeon in real time to be able to see the words that one is dictating. So it's kind of like you're using word processing in front of your eyes, you can make mistakes with spelling or whatever, you do it.

In a surgery center, they don't have that. It's a different standard of care. In a surgery center, a surgeon has no control over the quality of the dictation in the sense that when you're dictating, it goes through, usually, at least in

this case, it clearly went to an outside source because you can see that the person's initials are on this thing, and so Dr. Barber when she's done with the dictation doesn't know that this person, whoever it is, is taking off the dictation and may not have understood what she said, and there may actually be technical glitches in the -- if you're using a telephone especially, there might have been, and that's exactly what happened here.

Dr. Barber has no way of knowing what the quality of her dictation is when she does it, that's what I'm trying to get at in this case, because it's not electronic. Okay? That's all I'm saying.

Q. So the quality of --

A. It's a human being, another human being using a machine that is dictating into a phone, usually.

Q. So while the quality of surgery could be that same, it's safe to assume, though, that the quality of the medical records not as good as a hospital?

A. No, that's not in case. It depends on the quality of the person on the other end of the phone. But Dr. Barber has no way of knowing that that person made a mistake when she did the transcription

or that there were gaps in it. She had no way of knowing that.

At the end of the dictation, she puts down the phone and you have to assume that the person -- that person didn't call her to tell her that she didn't understand what was said, whatever. That's why hospitals have gone to that but most surgeons don't know.

But, again, Dr. Barber is not in charge of the surgery center, she is just working there. I've been in this situation and I can tell you, it's the real world where you're depending on somebody to take off your dictation, but they don't tell you -- two days later that this thing was transcribed, but that is not Dr. Barber's fault.

Q. So she's not in charge of -- what you just said, she's not in charge of the surgery center, she just works there, but you have to agree that she is responsible for her medical records; correct?

A. The contention is -- responsibility is to deal with this patient at the end of this operation in this case. You talk to the company that the surgery center hires to do it correctly, that's all I can tell you.

Q. So, then, it's your testimony, and I think

it happened before too, you said this -- I'm paraphrasing, but you said this earlier on direct examination, it's your testimony that you have no opportunity to correct these operative reports such as this one here that we're looking at because it's been transcribed by a human being?

A. In real time, you don't. But, again, this thing is transcribed two days later and you don't even know -- you won't see it again until you come to the surgery center again, whenever that is.

The surgery center doesn't call you and tell you that there's a problem, but that's the surgery center that has that responsibility to tell you that there were an issue with the quality of the transcription.

To hold her responsible for a transcription with obvious mistakes or failed to transcribe something, I think it's unusual, to be honest with you.

Q. Well, Doctor, you wouldn't -- you have a lot of experience, you have been doing this a very long time. You wouldn't sign a record like this one that we're looking at on page 79 containing gaps and other -- I'm going to use your words, "obvious mistakes."

You wouldn't sign that record, would you?

A. It depends. I mean, if I thought there was enough of a problem, it depends on whether or not I had enough information on there to do that.

But at that point, you're altering the medical records. I mean, if it becomes an issue, then it could look like you changed a record, and you can't re-dictate it because it was two days before. This is dated on the day that she did the surgery. She's kind of stuck with dictation the way it is.

If you want to put in additional things there, where are you going to write it? I mean, it's awful. But Dr. Barber didn't create the problem; it was created for her by the transcriptionist.

Q. So there is no opportunity to correct it?

A. Well, you -- if you -- there's no way to re-dictate because then it's not medically accurate.

So the transcriptionist has now left these two gaps in it and there's also some words in here that are not correct, what's she going to do, cross it out and write it again?

As long as I understand what I did at the time, then isn't the medical record -- it's not --

the responsibility of doing this accurately was on the end of the transcriptionist, not from Dr. Barber.

Dr. Barber dictated an operative note and was not told there was a problem when doing the dictation. And so at that point in time, that's the medical record that was created for her, even though she dictated them in a different way.

I mean, to hold her responsible for a faulty transcription, I think, it's unfair. That's all I can tell you. She can't re-dictate because it's already -- could be filed. By the time you found out that there's a problem, then you better remember exactly what you did four or five days before. It's a real-world problem.

Q. I'll move on from that.

You would agree that you cannot predict adhesions through any kind of scans; correct?

A. You can -- it depends on what you mean by "predict adhesions." If you have somebody who has had previous (inaudible) of a small bowel obstruction, previous surgery that created small bowel obstruction -- just follow where I'm going here.

If you see somebody that has had previous

surgery and dilated bowel and is obstructing, then you can -- you see the secondary effect of the adhesions. If you (inaudible) see any secondary effect of the presence of adhesions and --

HEARING OFFICER HALSTEAD: I'm having --

THE WITNESS: (Inaudible) what adhesions are?

HEARING OFFICER HALSTEAD: I'm having trouble understanding him. I don't know if it was the static or what, but what he just said was hard for me to understand.

MR. WHITE: Okay.

BY MR. WHITE:

Q. Would you repeat your answer, Dr. Baskies. I'm sorry. Something about secondary effect or something.

MS. DAEHNKE: You're cutting out.

THE WITNESS: Generally speaking, it's the second effects of the presence of adhesions that you see, not the adhesions themselves, generally.

BY MR. WHITE:

Q. Would you agree that one of the best ways to see adhesions would be through a laparoscope?

A. You can see the adhesions visually and you can with a laparoscope, yes. There's no best way to

see adhesions.

Q. What other ways?

A. Either through the laparoscope or with the naked eye with the abdomen open. Those are the two ways that you can see adhesions.

Q. Okay. Let me stop you there.

There was no open surgery except for the -- for when the perforation of the bowel occurred. Otherwise, there was no -- I'm just saying as far as the way this case manifested itself, the best way to see it was through the scope; right?

A. Hold on one second. It's dark here. I'm going to turn on the light.

THE REPORTER: His feed is crackling.

HEARING OFFICER HALSTEAD: It's crackly, yeah.

THE WITNESS: Could you repeat your question, please?

BY MR. WHITE:

Q. There was no open surgery either -- I'm being told that if you slow down just a little bit it will be easier for the computer to pick up your voice and we won't have any problems.

MS. DAEHNKE: We won't have any transcription problems.

MR. WHITE: Yeah.

BY MR. WHITE:

Q. You would agree that you can see adhesions best through a scope; right?

A. There's a problem, Mr. White, I have. What do you mean by "best"? You can see adhesions visually if the abdomen is open or can see them, potentially, through the laparoscope.

There's no better or best here -- or worst. Those are the two ways that you can visually identify the presence of adhesions.

Q. Either open or -- open surgery, you will see them and with a laparoscope, you'll see them?

A. The possibility of seeing adhesions can be done either with a laparoscope or with open surgery, depending on the circumstances.

Q. Okay. So you would agree that when you have no visualization and you're seeing bowel -- and I'm referring specifically to the first try on the right side -- that there is scars and adhesions there that you're looking at; correct?

MS. DAEHNKE: Object to the form.

THE WITNESS: It depends, again --

MS. DAEHNKE: -- (inaudible) in the record. I object to the --

THE WITNESS: -- what you're talking about.

MR. WHITE: There was an objection. Sorry. Hold on one second.

MS. DAEHNKE: I object to the form. It mischaracterizes evidence, the facts and the evidence in this case, and it's already been (inaudible).

HEARING OFFICER HALSTEAD: I will have the transcript. Again, the question isn't evidence, and if the expert disagrees, he can clarify in his answer.

MR. WHITE: Can I ask him again?

HEARING OFFICER HALSTEAD: Yes.

BY MR. WHITE:

Q. What I want to ask you, you would agree that no visualization -- and I'm referring specifically to the first attempt on the right-side Trocar -- and you see bowel is indicative of scarring and adhesions; is that correct?

A. It could be. It could be from something else other than adhesions. But, yes, it could be that. It depends on what case you're talking about.

Q. It depends on what case I'm talking about. I'm talking about this case. I couldn't hear you

right.

Did you say it depends on what case?

MS. DAEHNKE: Yeah.

THE WITNESS: Well, the question was very general, and I'm saying it depends on what happened.

If you're talking about this case, it most likely would be that the bowel is close to the abdominal wall, it may not even be adhesed to the abdominal wall, it may be close to the abdominal wall. It doesn't necessarily indicate that there are adhesions elsewhere. It may be that there are adhesions just when you're looking. And it also may be even the bowel is close to the abdominal wall not but not adhesed, not stuck to it.

Q. Earlier you said that somebody who would go in to do a left inguinal hernia surgery laparoscopically from the left knows nothing about laparoscopic surgery.

Do you remember saying that?

A. No. I don't believe, Mr. White, that is an accurate characterization.

Q. I beg to differ.

A. I said that --

HEARING OFFICER HALSTEAD: The record will reflect that. He gets to answer your question.

MS. DAEHNKE: Go ahead, Doctor.

BY MR. WHITE:

Q. You realize that Dr. Barber --

MS. DAEHNKE: Wait.

Q. -- switched from the right side --

MS. DAEHNKE: Can --

Q. -- to the left side. You understand that?

MS. DAEHNKE: Can --

HEARING OFFICER HALSTEAD: I -- he didn't get to finish answering his question.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: Unless you want to withdraw the question?

MR. WHITE: No.

HEARING OFFICER HALSTEAD: Then let him answer, please.

MR. WHITE: Okay.

BY MR. WHITE:

Q. Address the first question.

A. What I said is the -- and excuse me, for the Board, if I said something that (inaudible), but if you have a left inguinal hernia, the first attempt to see if you can get into the abdomen should be on the right side, and the reason for that is, optimally, you want to try to put the scope in

from the other side so that you can see where you want to do the surgery on the left side.

If you can't get in on the right side, your next attempt can be on the left so that you can see if you can get the bowels -- if the bowels were to where the hernia is reasonably or if the bowel is in the hernia, then you can at least get an idea as to where you can put another Trocar.

The first attempt should be on the right side because you can see where you can get your scope in and not have to scope in the way of your instruments, which is going to be working on the left side. That's the way you see.

If you can't get in on that right side for whatever reason, technical or whatever, it is permissible to go in on the left side to see if you can get in at all. And then if you can get in, then you try to figure out where to put your instrument Trocar.

The first Trocar is meant to be just a way where you scope, not for an instrument, for where you scope. And by going in on the left side, you can then get an idea of how sensitive this may or may not be. And if you can't get in on the left side, then you try to go in with precision.

The optimal place to put the first Trocar is the opposite of where the hernia is. I don't know that I can be any more explicit than that. That's how we teach it, that's how it is done. If you look at any video that might be on the internet, whatever, you will see that that's how it's done, because you've got to get another instrument in, either one or two more instruments in. You then try to figure out, with a person who has had past previous surgery, where you're going to do it.

But it's not contraindicated to try multiple places to get your Trocar in. That's exactly what you have to do, you have to try that.

Q. And --

A. Especially if you --

Q. And make sure -- sorry.

A. -- are --

Q. We're talking over each other.

HEARING OFFICER HALSTEAD: Let him finish and then you can clarify. I know it's a long answer.

THE WITNESS: -- an experienced laparoscopic surgeon.

BY MR. WHITE:

Q. And to make sure we are talking about the

same thing, when you say it's okay to go with your Trocar in the other side, meaning the left side now which is right near the hernia, are you talking about the camera still also to look?

A. You're going to -- optimally, either -- because you try to go in on the opposite side so the scope doesn't get in way of where you are going to put your instruments. But if you can't get in on that side, then you try the opposite side, and then you can see where you're going to insufflate, and by insufflating, the bowel will, hopefully, give you more working space and then you can go back, possibly, to the opposite side again and see where you're going.

Once you get the scope in and you insufflate, then you can figure out what it looks like in the abdomen. That's what we do when you operate on people. And if you've done any laparoscopic surgeries, this is exactly the problems you face and that you try to get around.

Q. Thank you, Doctor.

You had said earlier, I think, it's appropriate to go into the midline even though there's no visualization on the third try and you just can just see bowel?

A. If you try -- if you can't get in on either side, then you try a different location than the abdomen. And the reason is that if you have had previous surgeries that usually a space that you can get into, that you can insufflate the abdomen, in other words, blow up the abdominal wall so that you can get some working space.

So you try once, you try twice, and then you try a third time. That's exactly what you see in circumstances like this. It is appropriate to go into the another area of the abdomen other than in the groin areas because you're trying to get working space, you're trying to insufflate the abdomen, and you're trying to see what's going on.

Q. So you wouldn't be a believer in the theory that a person who was born with an omphalocele, someone who was born with that, and then also had two-thirds of their bowels removed later in life, you wouldn't subscribe to the theory that most of the scar tissue is going to be right in the midline?

A. No, I wouldn't subscribe to at all. Look, if you can get into the abdomen, that's all I can tell you about that. And, no, that wouldn't deter me offering a patient a better option in terms of

recovery.

If you've ever had a hernia repair and had it laparoscopically and you need another one, you want to have another laparoscopic surgery. It's a much easier post-operative recovery to avoid opening it -- I mean, there's a whole bunch of advantages that are associated with laparoscopic care.

Q. Thank you.

Earlier, you mentioned that you would have stopped the surgery for the hernia because mesh is a foreign body and it's used in a hernia repair, and that's the reason that you would have stopped the hernia surgery.

Do you remember that?

A. If I had a problem during surgery that resulted in bleeding and enterotomy, in other words, a bowel, a hole in the bowel, it would be generally contraindicated to put mesh into the -- for the repair. You just don't do it. You have to back down and repair the hernia another day. This is exactly what you see.

I would be critical, unless there was some overriding reason for proceeding under those circumstances with the repair of the hernia, you have to come back and find another day for that.

It's not right do that, generally speaking.

She made the right decision, not putting mesh in under the circumstances such as this.

Q. Would it surprise you to find out that Dr. Barber did not mention that as a reason for stopping the surgery on the hernia?

A. Well, I think any reasonable surgeon who is reviewing the case would realize why the hernia wasn't -- why she didn't put mesh in. I mean, I think you would have to be a dummy not to realize why she didn't proceed with the hernia repair, especially if you were in medicine.

In fact, the opposite is true. If she went ahead and did the hernia repair and put mesh under those circumstances, you are going to have to wonder why she did that. It wouldn't be the right thing to do.

Q. Thank you. Give me one second here.

Could you turn back to page 71, please?

HEARING OFFICER HALSTEAD: Respondent's Exhibit 5, page 71.

MR. WHITE: Thank you.

THE WITNESS: Mr. White, I just wanted to elaborate on the answer I gave you, by the way, about the mesh, so that the Board understands.

Mesh can get infected, and if you have bowel that is perforated you -- you're taking a -- it's no longer -- if you get -- the potential for infection is very high, and then you've got another problem on your hands.

The better part of valor is not proceed with the hernial repair.

BY MR. WHITE:

Q. Thank you.

Doctor, if you see where it says, "History of present illness," upper left, could you read that for me, what was written in there?

A. "Pain and bulge in left groin."

Q. Okay. You can read that as "left"?

A. "Pain and," with the little "and" sign, "bugle in left groin."

Q. Okay. And how about right after "omphalocele," just below it, past medical and surgical history?

A. "Born with omphalocele abdominal wall reconstruction."

Q. Very good.

Please turn to the next page, page 72. Earlier, you had mentioned that you, for lack of a better term, commended Dr. Barber for writing -- or

for noticing that there is a latex allergy.

Do you remember that?

A. There -- it says, "Allergy to latex," yes.

Q. Would it surprise you to know that she didn't actually do that part, her medial assistant did?

A. So is that wrong?

Q. I'm just saying would that surprise you to know that?

A. I mean, are we -- if her medical assistant did that, kudos to the medical assistant, yeah.

Q. And I have another question for you regarding that spot right there. It says, "Chief complaint, new patient," you're okay with just writing "hernia," and not put an L or left or anything, you're okay with that?

A. Well, if the patient said -- she gets it, usually, from the patient, and if this is what the patient came in said, I have a hernia, and didn't say which side, it's okay. I mean, that's what this states this is, patient has a hernia.

The chief complaint of the patient, what I do is -- if my medical assistant does it, tell me what's bothering you most, what's your chief complaint, the patient has a hernia, that's why I'm

here. May have been left or right, now you can figure it out, now you do your physical exam, yeah.

So that's the chief complaint, the hernia.

Q. Doctor, who is responsible for that doctor's records ultimately to be accurate, complete, legible, and timely?

A. What do you mean by that? Which record are you talking about?

Q. Who is responsible -- is Dr. Barber responsible for her records to be timely, legible, accurate, and complete?

A. I think that it's -- that Dr. Barber is responsible for providing the best records that she can do.

Q. Would the fact that there were now three holes or wounds or whatever you want to call them that Dr. Barber did to gain entry by Trocar, would that affect the healing process that we're trying to help out, I guess, for lack of a better term -- I'm getting tired. I'm sorry.

You're trying it laparoscopically -- I've heard a lot of testimony from everyone here that laparoscopic surgery is -- it promotes quicker healing, return to work, whatever you're doing, would the fact that there were now three attempts at

laparoscopic surgery, would that affect it and slow that down and really just kind of cancel out what you were trying to do?

A. That's a great question. I think what you have to realize is that the size of the hole in the case from laparotomy is a small, very small, four- or five-millimeter hole that has no affect, no reasonable affect on post-operative healing.

That's the reason why laparoscopic surgery, even for bowel, when we do bowel resection, it becomes very popular because we don't have to make a big incision to do it.

You're talking about -- I don't know whether the Board can appreciate these things, but you talk about four or five millimeters for the hole to get entrance to not have no affect, no significant affect on healing, no.

Q. Is it your belief that laparoscopic surgery in this situation with all the -- now we know there's some scar tissue in there after the scope was in there, is it still your testimony that that was the correct way to go versus an open surgery after at least one attempt?

A. I do, yes. I mean, we know from the literature even, even if you don't want to believe

me, there's documented literature that backs this statement up, that backs up my position, which is that laparoscopic surgery, even in cases more significant than this, where adhesions have caused small bowel obstructions, the patients do a lot better that way than making an incision, a big incision, and putting the patient through a big operation.

So to answer your question, absolutely yes, my own experience as well as medical literature. I presented to Ms. Daehnke a while back and you might want to look at the papers that I gave you that back up what I sent to you.

Q. You have to agree, though, that if --

HEARING OFFICER HALSTEAD: Mr. White, I'm sorry. Can you just hold that question. I need a small comfort break. I know we're almost done, but --

MR. WHITE: I am almost done.

HEARING OFFICER HALSTEAD: -- we're going to take a minute off the record.

(Recess from 4:43 P.M. to 4:47 P.M.)

HEARING OFFICER HALSTEAD: We're back on the record In the Matter of Charges and Complaint Against Annabel Elizabeth Barber, M.D., case number

23-11660-1. We took a small break. We were in the middle of cross-examination. Dr. Baskies, who remains on Zoom, counsel and Dr. Barber are present.

Dr. Baskies, I remind you that you remain under oath.

Mr. White?

MR. WHITE: Thank you. I only have a few more questions. Maybe two.

BY MR. WHITE:

Q. Dr. Baskies, you may agree that this was a pretty horrible outcome, that this patient had to return three days later from this original surgery to have his -- and he was leaking some fecal matter from his midline incision.

Would you agree that that's traumatic for the patient?

A. I don't think there's any question the patient had a recognized complication of surgery, of this surgical procedure. It's a recognized complication that is not indicative of malpractice, and it was not feculent material, it was small bowel material, which is very different from feculent stool.

So with all due respect, that is not a correct characterization and it's a big difference

between small bowel and large bowel content.

So, yes, the patient had a complication of surgery that is a recognized complication.

Q. Okay. And then you may or may not agree, but it's -- this could have avoided by going to an open surgery, by not having the Trocar perforate the bowel.

Would you agree with that?

A. Well, just so you know, you can get into the bowel with an open procedure too, and I have been called in to fix that situation. Either way, you can get into the bowel.

At the end of the day, what you're asking, I guess, is this malpractice or could another option have been chosen? And another option could have chosen, but it could have gotten us in trouble that way too.

Q. Sure. And I didn't say there was zero chance of perforating the bowel if you did an open surgery. But you certainly could have seen a lot more with an open surgery than you could with a laparoscope in this patient.

You would have to agree with that; right?

A. I would agree that either one of them has potential complications associated with them. The

recovery rate and the smoothness of surgery with laparoscopic hernia repair is far better than it is with an open procedure.

So this is a recognized complication of the surgery, and that's all I can tell you. It's not indicative of malpractice.

Q. That's to be determinated later. But I --

MS. DAEHNKE: I'm going to move to strike that.

MR. WHITE: I have nothing further.

HEARING OFFICER HALSTEAD: Okay. I have a question, if I may, so both counsel can follow up on it, and then after that, I would like Dr. Baskies to stay on and we can determine a time to come back when you can do redirect and we can finish with Dr. Barber, and we can do it all by Zoom.

MS. DAEHNKE: Okay.

THE WITNESS: Just so you know, I missed my granddaughters' prom tonight because of this.

MS. DAEHNKE: I appreciate it.

THE WITNESS: Hopefully we can make a better time to work.

HEARING OFFICER HALSTEAD: I want you to stay on so that we can coordinate a time with you that will work and won't conflict with anymore

family or other obligations that you have. But before we coordinate that, I have a question I would like to ask you.

THE WITNESS: Okay.

HEARING OFFICER HALSTEAD: I don't want anyone to read into this question, but it's something that hasn't been addressed that I'm curious about.

Are you able to tell from the medical records which Trocar entry caused the injury to the bowel?

THE WITNESS: I'm pretty sure it was the midline, the third -- a third attempt.

HEARING OFFICER HALSTEAD: Okay. Thank you.

Is there anything in particular that you base that on?

THE WITNESS: The -- if there had been a problem with the first or second, you would have seen evidence of it through the Trocar.

HEARING OFFICER HALSTEAD: And I don't know the scope of the visual when the camera goes in from the entries that were made on the left and the right, so you wouldn't know the status of midline adhesion unless you entered from the midline, or

would you be able to see that from cameras on the right or the left?

THE WITNESS: The camera could have been inserted from either of the first two. You could have gotten an idea as to whether or not the midline would have -- but there's nothing magic about the midline. You could have -- from previous surgery, you can have adhesions anywhere, but there was no indication that the patient had significant adhesions from any of the -- the CAT scan that was done preoperatively, there's nothing on it that shows bowel obstruction.

All I'm saying is that adhesions could be anywhere in the abdomen. There's nothing magic about it having been in the midline.

HEARING OFFICER HALSTEAD: Thank you.

That's why I'm trying to clarify. If you go in and have no visual on the left, and you go in and have no visual on the right, then you wouldn't know about midline unless you entered; correct?

THE WITNESS: That's correct.

HEARING OFFICER HALSTEAD: Any questions based upon the questions I just asked?

MR. WHITE: I don't.

MS. DAEHNKE: No.

HEARING OFFICER HALSTEAD: Let's all look at our calendars and determine a time that Dr. Baskies can come back that's convenient for him.

I want to stay on the record so that date can be on the record.

MS. DAEHNKE: I have only one question.

HEARING OFFICER HALSTEAD: I'm told, Dr. Baskies, that Dr. Barber's counsel only has one question. I'll have her ask it now and then we can actually be concluded with you.

THE WITNESS: Okay.

REDIRECT EXAMINATION

BY MS. DAEHNKE:

Q. My question, the world "friable," that Mr. White was asking you about, does friable tissue include tissue that's easily torn, crumbly, or bleeds excessively?

A. That's a reasonable definition that some people would use. It could also -- there's other things that apply to friable, the term "in doubt," in other words, delicate, those are all synonymous with that terminology, yeah.

Q. In the operative report, did you understand that the tissue that Dr. Barber encountered, the bowel tissue bled easily?

A. I got that impression, yeah. That there was bleeding, yes.

Q. The laparotomy was continued up and a great deal of bleeding occurred when opening the tissue, chest, the fascia, and epigastrium?

A. Okay. Yes.

Q. Could that be a description of bowel that is friable?

A. Yes. When bowel becomes delicate or in doubt, it tends to bleed more, that's correct.

Q. Thanks, Dr. Baskies.

MS. DAEHNKE: I don't have anything further.

MR. WHITE: I don't have any follow-up, if you were going to ask me.

HEARING OFFICER HALSTEAD: Thank you, Dr. Baskies. We don't need to reconvene, after all, so thank you for your time today.

THE WITNESS: Thank you.

HEARING OFFICER HALSTEAD: We can be off the record, but I want to place on the record when we are going to reconvene.

(Off-the-record discussion.)

HEARING OFFICER HALSTEAD: We're back on the record. We went off the record to discuss when

this matter will be continued to, case number 23-11660-1, In the Matter of Charges and Complaint Against Annabel Elizabeth Barber M.D.

This matter will be continued to accommodate the continued cross-examination and redirect of Dr. Barber, which I'm told is the only remaining witness.

This matter will be continued to April 10th at three o'clock and will be conducted by Zoom, per the agreement of all the interested parties.

Anything further we need to put on the record before we adjourn?

MR. WHITE: We'll do closings too?

HEARING OFFICER HALSTEAD: Correct.

MS. DAEHNKE: No questions on behalf of the respondent.

HEARING OFFICER HALSTEAD: Okay. All right. We're back off the record. Thank you, everyone.

(Hearing adjourned at 5:07 P.M.)

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

I, BRANDI ANN VIANNEY SMITH, do hereby certify:

That I was present on April 4, 2025, for the hearing at the Nevada State Board of Medical Examiners, and took stenotype notes of the proceedings entitled herein, and thereafter transcribed the same into typewriting as herein appears.

That the foregoing transcript is a full, true, and correct transcription of my stenotype notes of said proceedings consisting of 252 pages, inclusive.

DATED: At Reno, Nevada, this 17th day of April, 2025.

/s/ Brandi Ann Vianney Smith

_____

BRANDI ANN VIANNEY SMITH

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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. 23-11660-1
ANNABEL ELIZABETH BARBER, M.D.	)	
Respondent.	)	

TRANSCRIPT OF HEARING PROCEEDINGS

Held at the Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, Nevada/Las Vegas, Nevada

Via Zoom Conferencing

Thursday, April 10, 2025

REPORTED BY:
NICOLE J. HANSEN
NV. CCR NO. 446
CAL. CSR 13909
RPR, CRR, RMR

APPEARANCES:

The Hearing Officer:

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Also Present:

PATIENT A.

PATIENT A'S FAMILY MEMBER

IAN CUMINGS, ESQ.

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RENO, NEVADA; THURSDAY, APRIL 10, 2025; 3:00 P.M.

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HEARING OFFICER HALSTEAD: So we're back on the record in the charges and complaint against Annabel Elizabeth Barber, M.D. It's Case Number 23-11660-1.

Can the parties please state their appearances.

MR. WHITE: Don White, on behalf of the IC, Senior Deputy General Counsel.

MS. DAEHNKE: Patricia Daehnke for Dr. Annabel Barber.

HEARING OFFICER HALSTEAD: And then I note Dr. Barber is present as well, and we were concluding the remainder of this hearing by Zoom. I have a bird in my office. I don't know if everyone can hear that. I'm going to have my assistant come take him out.

MS. DAEHNKE: Can't hear it.

HEARING OFFICER HALSTEAD: Okay. We're going to continue this hearing by Zoom, and that's by consent of all of the parties. Where we left off was cross-examination of Dr. Barber.

Dr. Barber, you were sworn at the time, but because so much time has passed and just to make sure the record is sufficient in that regard, I'm going to have

you be re-sworn at this time. So if you could raise your right hand.

(The respondent was sworn.)

HEARING OFFICER HALSTEAD: Thank you. With that, I'm going to take just a two-second break. Give me a moment here and then we'll commence with cross-examination. Sorry about that, everyone. Go ahead, Mr. White.

MR. WHITE: Thank you. Just looking for I actually needed that little bit of break. I'm looking for the informed consent. I think that's where we ended off. I wrote down a note that we had left off there, so just checking my notes. One second. Sorry about this.

HEARING OFFICER HALSTEAD: Do you want me to indicate in general what the subject was where we left off?

MR. WHITE: I think if you can, yeah. Do you have it?

HEARING OFFICER HALSTEAD: You had been questioning about the friable -- about the bowel being friable, and then you had asked about whether the hernia surgery had been continued. And the last note I have is about how the patient how Patient A was slightly anemic.

MR. WHITE: Okay. Thank you.

And, Dr. Barber, do you have a binder in

front of you?

THE WITNESS: The binders that you sent from Reno did not come yet, so I have the exhibits in other forms.

MR. WHITE: Okay. So if I refer to them, you'll be able to --

MS. DAEHNKE: He has one of your bound books.

MR. WHITE: What's that?

THE WITNESS: I have one of your bound books.

MR. WHITE: Okay. Sorry guys. I'm really trying to look for this one thing and I will find it in a second, I'm sure.

CONTINUED CROSS-EXAMINATION

BY MR. WHITE:

Q Dr. Barber, before I think we left off also talking a little bit about the consent form and you don't have power over how that's worded; is that correct?

A That is correct.

Q That is done by the Las Vegas Surgery Center?

A Yes.

Q Do you recall you had said that you spoke with Patient A about possible open surgery too, right?

A I believe that I did.

Q And is that reflected in the consent form

also?

A I don't recall.

Q Okay. I'm trying to find that. I think it is, but when you testified the other day, I think it was probably just probably going back to Thursday, you said no one advised you that it wasn't safe to go from right to left. Do you remember saying that?

MS. DAEHNKE: I can't hear you don. Could you possibly --

MR. WHITE: Sorry.

MS. DAEHNKE: Oh, much better.

Q (BY MR. WHITE:) Much better? Okay. So do you recall when you testified on Thursday that you said no one advised you that it wasn't safe to go from right to left for repairing the left inguinal hernia? Do you recall that?

A I don't recall that question.

Q It wasn't a question. It was an answer you gave to your attorney when you were on direct examination.

HEARING OFFICER HALSTEAD: Sorry. Mr. White, we literally can only see the top of your head.

MR. WHITE: Oh, I'm sorry.

HEARING OFFICER HALSTEAD: And it's distracting.

MR. WHITE: Sorry about that. Is that better?

HEARING OFFICER HALSTEAD: Yeah, but when you look down, I don't know if you can adjust your camera. I know you tried earlier.

MR. WHITE: The camera won't adjust but I can adjust the screen where it's on top of. Okay?

HEARING OFFICER HALSTEAD: Okay.

MR. WHITE: I'm not a really good Zoomer, I guess. I don't do a lot of them. I'll get better.

HEARING OFFICER HALSTEAD: Okay. And can you repeat the question, please?

Q (BY MR. WHITE:) Yeah. So you had testified on Thursday when you were answering questions to your attorney that no one advised you that it wasn't safe to go from right to left for repairing the left inguinal hernia. Do you recall that?

A I don't recall that exact those exact words, but looking to do a left inguinal hernia to enter the abdomen from the right is not ill-advised. Perhaps that was something that I might have said.

Q And you were the lead surgeon?

A Yes.

Q And you were teaching -- you had a resident there that you were teaching too; correct?

A Yes.

Q And that was Max Vest?

A Yes.

Q And you wouldn't -- you're not implying that you would be looking for advice or anything from someone else in the room as the lead surgeon, would you?

A No.

Q And you weren't waiting for Max to tell you what to do, Max Vest to tell you what to do, right?

A No.

Q Okay. And I don't know. I'm just asking questions because I wouldn't know. Maybe a resident does have some power to try and tell you what to do. That may be part of the teaching experience. Is it?

A This resident was an intern, and no. That was not part of it.

Q Okay. You had testified there was a general consent form. It's a general consent form, right?

A Yes.

Q And it's not something you can change?

MS. DAEHNKE: Asked and answered.

THE WITNESS: I cannot change it. I have to use the consent form they have in the surgery center.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: I didn't get to

rule, so I'm on mute. If there is an objection, then I need to unmute and respond, and so we need to have time to do that. I don't see any reason the answer can't stand, especially I imagine we'll re-cover a little bit just because of the time lapse, but I don't anticipate we'll do that very much.

Q (BY MR. WHITE:) Yeah. Let me say I'll do my best not to re-ask questions. I've tried to figure out where I was on the questioning from last Thursday and Friday a little bit of Friday, I think, and hopefully I won't repeat myself. It might be there might be a few questions that get through because it's been so long.

And then you testified on Thursday that you did not repair his hernia because he had unexpected problems and was not in as good as shape as you had originally thought. Do you remember saying that?

A Something such as that.

Q Paraphrasing? Yeah. And it was also difficult to stop the bleeding. Do you recall that?

A Yes.

Q What bleeding were you talking about? From the adhesions or the bleeding from the perforated bowel or both?

A I don't recall.

Q And you also testified that the nurses and

the anesthesia doctor said patient was hemodynamically stable. You recall that, right?

A Yes.

Q What does hemodynamically stable mean?

A That your blood pressure is neither high nor low but it's staying normal. It's a dynamic statement in that not just one reading but over time, they're not large fluxes.

Q Okay. Did you look at anything else besides just the blood pressure?

A The patient's pulse, the patient's respiratory rate if they're not being ventilated.

Q Was he?

A He was -- I believe that I talked about his hemodynamic stability both when I was commenting on his time in the operating room and also in the recovery room. So I think I commented on both of those states, and I believe that he was hemodynamically stable during both of those. In the operating room, he was being ventilated, and in the recovery room, he was breathing on his own.

Q Okay. Thank you. And this was your reasoning for why it was safe to discharge him; correct?

A One of them.

MS. DAEHNKE: Object. That's not a charging document.

MR. WHITE: I know, but we can still talk about it.

MS. DAEHNKE: Sure.

HEARING OFFICER HALSTEAD: Yeah, but I mean with that caveat, you can continue. I understand that's not part of the charge and won't be considered as such.

MS. DAEHNKE: Thank you.

THE WITNESS: I apologize. Will you please repeat the question?

Q (BY MR. WHITE:) I think you answered, but I said: And this was your reasoning for why it was safe to discharge Patient A?

A I believe it was one of the reasons. It was not just the sole reason, but one of it.

Q What were the other ones?

A That the patient's pain was under control, he was able to drink, and that he had been determined by other professionals the nurses and the anesthesiologist to be suitable for discharge.

Q Were those nurses and the anesthesiologist aware of the friable bowel?

A I think they're aware of the operative findings in general. That specifically, I don't know. I don't recall discussing that with them, but I don't know that using the term "friable bowel" would mean anything

to them, so I don't think I mentioned that to them. But I know that the operation in general was discussed with the staff taking care of the patient.

Q What would they understand if they don't understand friable bowel?

A That he bled easily.

Q But from where? That doesn't tell us anything; correct?

A I think if you're in the profession, it does mean things if you bled easily. It means things that don't usually bleed bled easily.

Q So it's your testimony here then that a nurse and anesthesiologist that have been trained wouldn't understand what a friable bowel is?

A I wouldn't necessarily think that.

Q Okay.

A They may. They may not.

Q Okay. Would you at least explain to them that the bowel is having -- you're having trouble getting the sutures because the holes are too big?

A I think that my testimony is a little bit mischaracterized by that in that sometimes I didn't have trouble putting the stitches in. I put the stitches in, but they didn't hold in the position I would expect them to. So that is a little bit different from what you

said, I think.

Q Okay. So let me stop you for a second then. So they wouldn't -- the bowel wouldn't retain the --

MS. DAEHNKE: Let her answer the question.

HEARING OFFICER HALSTEAD: You're going to have to be careful about talking over each other, especially since we're on Zoom. It's already hard to record.

MS. DAEHNKE: I guess I was objecting in that counsel interrupted the witness in the middle of her answer to his question and started asking another question. If we're trying to make a good record, that doesn't seem --

MR. WHITE: I think I don't really have an answer for that speaking objection except that it's my witness, so I can actually do things like that when I feel necessary.

HEARING OFFICER HALSTEAD: Well, I think okay. Stop. The witness gets to answer her question. If it's nonresponsive, then you can note that it's nonresponsive and ask for an instruction from me.

Dr. Barber, did you finish answering the question?

THE WITNESS: I'm not sure.

Q (BY MR. WHITE:) So the bowel had trouble

retaining the sutures. Would that be a way to term that?

A No. The --

Q Holding? Doctor, what's the difference between retaining and holding?

MS. DAEHNKE: Same objection. The witness was trying to answer the question and he interrupted again.

HEARING OFFICER HALSTEAD: Yeah. She said no, and she started to respond and then you changed the question, Mr. White. So I think that she was probably going to answer what you asked, but you need to please just if nothing else because it's harder on Zoom and we need to record this. Again, if she's not being responsive, I'll give an instruction or you can follow up with your next question, but please let her finish.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: Thank you. Do you want -- What was the last question, Mr. White? I think it was the difference between retaining the stitches and --

MR. WHITE: And holding.

HEARING OFFICER HALSTEAD: -- and holding the stitches.

THE WITNESS: I would like to say that stitches were not rejected. They didn't go anywhere.

When I tied them, generally, it doesn't -- the bowel will close and stay closed. It closed, but I think I testified earlier that when you -- the needle holes which are usually invisible in a normal bowel were -- you could see the actual track of the needle.

So did they hold? Yes, they held. They were there. They didn't go anywhere. They were still there, but I was not sure that they were adequate, and that's why I stapled the bowel as well.

HEARING OFFICER HALSTEAD: I understand that, but I believe -- and Mr. White, correct me if I'm wrong. The question was if there's a difference between the stitches, holding or the stitches being retained. Did I phrase that right?

MR. WHITE: Yes.

THE WITNESS: May I speak?

HEARING OFFICER HALSTEAD: Yes.

THE WITNESS: Okay. Retained -- to retain, if something is not retained, it means it's gone away. They didn't go anywhere. They were still there, and they were on the bowel where I placed them but they were not serving the purpose that I completely wanted and so I felt they needed to be reinforced.

Q (BY MR. WHITE:) Were --

A Is that clear?

Q Yes. Thank you. Were those holes that were larger than you would have liked to have seen? Was there any matter coming out of those?

A I don't think so.

Q I think I might have asked this, but the other day -- but I can't remember, so bear with me. Did you discuss this friable bowel with the patient?

A I believe I testified and I think the record will show that I discussed the patient -- my findings with the patient and his girlfriend or wife, whomever was there with him. And do I remember using the word "friable"? No, I don't. Could I have done that? Yes, I could. Do I recall specific words? No, I don't.

Q Let me ask the questions, please. Thank you. Did you -- and you didn't note it anywhere in your medical records that he had a friable bowel?

A I don't think that that was the word described in any of the documents that I made.

Q And you also didn't document that you spoke with your team meaning the anesthesiologist or the nurses either; correct?

A When are you speaking of?

Q Before discharge.

A That's not the usual practice. The usual practice --

Q And you didn't note it in your records?
A That is not a usual practice.
Q And I think you had said that Dr. Gomez, who was the anesthesiologist, expressed no concern about discharging the patient; right?
A That is correct.
Q And but it's not his call, correct? It's your call.
A It's a joint decision.
Q On either Thursday or Friday -- I think it might have been Thursday -- you didn't know what CPT stood for. Do you remember saying that?
A Yes.
Q Do you know what it stands for now?
A No.
Q No? Is it correct procedural terminology?
A It may be.
Q You also testified a little bit about there's rules at the ambulatory center or Las Vegas Surgery Center, which is an ambulatory center, that determine if the patient can have surgery there, right?
A Yes.
Q Okay. And who makes those rules? Hold on. Sorry. Hold that thought. Okay. If you know, who makes those rules?

A I think that they are put forth by the surgery center. The ambulatory surgery center gets guidelines from the governing bodies of ambulatory surgery companies or units and then they make their own and specific to that. I think I mentioned earlier that the Las Vegas Surgery Center was owned more than 55 percent by HCA, and I think that they have a good influence on the documents that are within the chart.

Q Are they medical professionals?

A They are medical professions within the company. Yes.

Q In the HCA?

A Yes.

Q What's HCA mean?

A I think it's an acronym for Hospital Corporation of America.

Q Okay. And then who makes those decisions based on those rules?

A Can you clarify your question?

Q So you have a set of rules that govern whether you can have a patient -- give a patient surgery. Right?

A At an ambulatory care center? Is that what you're referring to?

Q Yeah. And those rules are the same all the

time?

A Yes.

Q And who makes the decisions based on those rules? Do you?

A Well, no. There are some patients that are deemed appropriate or inappropriate, and they -- on every patient when it's -- when the surgeries were scheduled, the staff would fill out forms based on the patient's history and that they're provided -- they would ask the surgeon's office who was scheduling the surgery and a number of questions to see if the patient was fit for ambulatory surgery. That is then reviewed by the medical director of the ambulatory surgery center. All of the cases are reviewed prior to occurring and after approval, then and only then is a surgery performed.

Q Okay. And you have to submit something that says what you're going to do to these people that approve or disapprove?

A Yes.

Q And are those people, the ones that approve or disapprove, are they medical professionals?

A Yes.

Q You had also testified last week that you checked on page 107 which is Exhibit 5 -- excuse me -- Exhibit 4. IC's Exhibit 4. You had checked: WNL on all

of these boxes. Do you recall that?

A I remember that.

Q And I think you said -- I put it in in quotes in my notes here -- "normal looking man." So you had said that last week that he was a normal looking man. Is that correct?

A Yes.

Q And you also said you didn't shine a light in his eyes, so you weren't going to say that if you didn't do it. Do you remember that?

A Yes.

Q And then why check WNL if you haven't done any of those things?

A I didn't say that I did those things. HEENT exam does not say that I looked at his pupils. It doesn't say anything about that.

Q I know you didn't write anything after that. I understand that. There's nothing there. But why check within normal limits if you didn't check?

A That's -- I looked at his head, his eyes, his ears, his nose and his throat. They looked normal. I didn't say I shined a light in his eyes. Our expert witness said that you had to say you shined the light in their eyes and I was refuting that. That's all.

Q Right. I'm not saying you did shine the

light in his eyes. I'm saying you didn't.

A That is correct.

Q And you also said you wouldn't put it down if you didn't shine the lights in his eyes, right?

A Yes.

Q You should be able to understand how confusing this could be for other providers who read those records and rely on them, right?

A No.

Q No?

A No.

Q So you look at this and you go within normal limits. They might assume that you did other things, right?

A No.

Q And you don't write what vitals you're checking or not checking on this, do you?

A I don't think that the vital signs are on this form.

Q Okay. And you don't see this is potentially dangerous for future -- for this patient if later on in the future, if another provider looks at this, you don't feel that this is inadequate and dangerous for somebody else to look at?

A I do not.

Q Okay. I've been trying to find it. You said you reviewed the CT scan that you ordered, right?

A Yes.

Q Where did you write down did you document that you reviewed it?

A I think that that is in three places in the chart.

Q In the chart?

A Yeah.

Q And did you document the results?

A I don't recall.

Q Now you remember here on page 107 that you also testified last week that you wrote for some reason you didn't check it as within normal limits but you did have a look at his testicles and wrote two arrows that are down, right?

A Yes.

Q And those arrows designate that both of them have descended; is that right?

A Yes.

Q Okay. So let me understand this. So you didn't take a look -- you didn't take the time to look into his eyes with a light, but you took time to look at his testicles, right?

A I wasn't operating on his eyes.

Q And do you see the right side of the page there it says complications?

A Yes.

Q Why not write down anything about his bowel other than it's injured? Why not write that it's not very healthy at the moment?

A Because that wasn't a complication of the surgery.

Q It wasn't?

A That his bowel was not healthy to start with? No, it wasn't a complication of surgery. The complication of the surgery was that his small bowel was injured, and that I commented that it was repaired.

Q Okay. But you didn't write anything down -- you didn't feel it was necessary to write anything down about the sutures or anything like that we've just discussed?

A There's a brief operative note.

Q Yes, it is. You testified last week also that based on -- and this was with regards to the records and the transcriptionist. Do you recall some of that testimony?

A Yes.

Q Okay. And do you recall saying that the transcriptionist never called you and never has, right?

A Not that I recall.

Q Okay. And but you did testify, I think, that it's your responsibility. You know that, right, for your records to be timely, legible, accurate and complete?

A Yes.

Q And you also said you don't specifically remember signing the operations report which is contained in pages 115 and 116 of Exhibit 4 of the IC. Do you recall that?

A Yes.

Q And, I mean, that's -- you don't really don't remember signing it at all?

A I really don't.

Q I think you said something to the effect of you recall not seeing operations report operative report -- excuse me -- until the IC filed this case against you?

A No, that's not really true. I think that I didn't look at it in detail until then. I obviously signed it before that.

Q But you don't remember signing it, is what you just said, so --

A I don't remember when I signed it.

Q So it wouldn't be your testimony that this is the first time you're seeing it when we filed the case against you when the IC filed that case, right?

A That was the first time I looked at it in detail.

Q And would that have been -- would that have been -- maybe give you a little timeline. Would that have been after you received the allegation letter?

A I don't recall.

Q So maybe not when the IC filed the formal complaint that we're here for. Was it when you just found out that there was a case against you from the letter?

A I don't recall.

Q Did you look at your medical records that you sent in response to the letter?

A Yes.

Q So maybe did you look at it? Did you look at it then maybe?

A Well, I believe that I did.

Q Operative report?

A Yes.

Q Okay. And in this operative report, they have no indication of writing anything down about friable bowel, right? You'd agree with that?

A I began to describe that when I opened the abdominal cavity and talked about freeing up the bowel that a lot of bleeding was encountered or happened, and

so I think that it indirectly says something such as that but it doesn't say that exactly. Those words are not there, and we discussed that last week.

Q Okay. And did you indicate in here that there were bloody adhesions like we discussed last week?

A I don't think those exact words were used. I think we can all agree that there -- those exact words are not in this document.

Q And what about you had testified that the procedure was bloodier than you wanted or he lost more blood than you wanted. Do you recall that?

A Yes.

Q Yeah. And so and there's no -- see where it says estimated blood loss 200 cc's but there's nothing of note there saying that that's more than you'd want?

A That's not something that we say.

Q Okay. You probably wouldn't sign this now as you're sitting here, would you, this op report?

A Maybe not. At the time, there was not a way to correct it. I think we discussed that as well.

Q Yeah. And that is your testimony. There's no way to correct it, right?

A There's no way to correct what?

Q Your operative report before you sign it.

A At that time, I think as I explained to this

committee last week, there was not; that there were no electronic medical records. It was not on a computer sent to me with a correctable form.

Q You talked last week about with your attorney you testified that there was a timeout in this just like most surgeries, right?

A All surgeries have time outs in them now.

Q And can you point to me on page 107 here where you wrote timeout? Did you do that? Timeout procedure was performed?

A You mean point it out on the record? I don't understand what you're asking.

Q No, I see it. Okay. Timeout procedure was performed. Right?

A Yes.

Q Do you normally not write a time?

A No.

Q Do you remember taking some time to go through this op report last week with your attorney and make some corrections and edit?

A I don't know what you're asking me.

Q Really?

A Really.

Q Do you recall going through this for quite a time, quite a bit of time going through this operative

report last week with your attorney on direct examination and making corrections?

A I remember us talking about it. Making corrections, I think that's not -- I don't really understand exactly what you're saying like that. I think we tried to clarify it if that answers your question.

Q Yeah. Like, you know, for instance, where it says middle of that paragraph somewhere: We did easily and had multiple suture ligations of bleeding vessels. Like we did easily. So I think you kind of filled in some blanks there?

A I recall that.

Q Yeah. And also the blanks that are actual blanks with numbers next to them, I think you tried to determine what should be there, right?

HEARING OFFICER HALSTEAD: Well, and just sorry to interrupt. Just for the record, you're skipping between documents, and the record is not reflecting that. So you were talking about Exhibit 4, page 107. And then when you asked if she went through the document and made corrections -- your words -- you were referencing -- correct me if I'm wrong -- Exhibit 4, IC Exhibit 4, pages 115 through 116. Correct?

MR. WHITE: Yeah. I haven't moved from that. I mentioned that before a few minutes ago when I said

please, you know, I'm going to refer to that now. But sorry if it was confusing. Yeah. I'm still referring to 115 and 116.

HEARING OFFICER HALSTEAD: Okay. So when you said you did the timeout procedure and that's noted, where is that noted?

MR. WHITE: It is on the third line of the very end. It says time and then dash, and then out is on the fourth line.

HEARING OFFICER HALSTEAD: Okay.

MR. WHITE: Do you see that?

HEARING OFFICER HALSTEAD: So for my own purposes when I go back and look at this transcript, you didn't go back to the other document then. You stayed focused on 115 through 116.

MR. WHITE: Correct. Yes.

HEARING OFFICER HALSTEAD: Okay. Thank you.

MR. WHITE: Apologize if that was confusing.

HEARING OFFICER HALSTEAD: It might have been me, but thank you for clarifying that.

Q (BY MR. WHITE:) Certainly. So it's appreciated that you were like editing and correcting and trying to fill in some blanks. So would you like to sign it again with today's date, Dr. Barber, the operative report?

MS. DAEHNKE: Objection. That's not seeking an answer.

HEARING OFFICER HALSTEAD: Sustained. I think that's argumentative.

Q (BY MR. WHITE:) I only have a few more questions. So Patient A had bleeding adhesions, a friable bowel that wasn't holding sutures very well. He had lost more blood than wanted and he's anemic, yet you discharged him based on the approval of the nurses and the anesthesiologist. Is that all correct?

A It's partially correct in that the patient was exhibiting appropriate recovery and he was not hemodynamically unstable. If he were dangerously anemic, he would have been tachycardic with an increased heart rate and his blood pressure may be low. Neither of those were true, so he was discharged.

Q If you could remember, did Dr. Vest express any concerns to you that about how this treatment went?

A I don't recall.

Q And how about regarding your medical records for Patient A? Did he voice any concerns about that?

A I don't recall.

Q Do you discuss these things when you're teaching somebody, an intern?

A These things? Which things?

Q Your medical records, how the maybe I guess the question should be: Do you have a debriefing of any sort with students after surgery?

A A resident is not a student. They're a physician. And while they're learning, they're not a student per se. We, in medicine, we refer to medical students are people who don't have a medical degree. Dr. Vest was a physician, and he was -- do I speak with them about the surgery that we're doing, going to do during, before, during and after the operation? Absolutely. Yes.

Q Okay. What did you discuss with Dr. Vest after this one?

A I don't recall the exact. I don't recall our discussion.

Q And it's not written down anywhere?

A No. There's no reason to write that down. That's what I do every day.

Q Was there any discussion about whether this should have been switched to an open surgery with Dr. Vest?

A I don't recall any discussion about that one way or the other.

Q And you, I guess for lack of a better term, instructed him because you're like you're the instructor.

You're the lead surgeon. Did he ask any questions about whether or express any concern about not being able to review the medical records and edit them and make those changes before you sign them? And I'm referring to the operative report.

A He doesn't have anything to do with that.

Q He doesn't? He doesn't look at them at all?

A I don't know that he does.

MR. WHITE: That's all I have. Pass the witness. Thank you.

HEARING OFFICER HALSTEAD: Thank you, Mr. White.

Ms. Daehnke, redirect?

MS. DAEHNKE: May I have a moment?

HEARING OFFICER HALSTEAD: Yes.

REDIRECT EXAMINATION

BY MS. DAEHNKE:

Q Thank you, Your Honor. Dr. Barber, just really a couple of questions. Mr. White was asking you in the beginning about no one telling you to go from right to left and you didn't recall that. Can you just tell me really quickly the order from left to right to midline and when you saw the injury and why you proceeded?

A Well, I think again, just wanted to make clear from the beginning, the plan is to put in -- to make three incisions and to do that all safely. And so that was the plan.

So I started first on the right, and I couldn't see very well because of bowel being in the way and not going out of the way with insufflation. And then I went on the left and again had the same result and made a third incision that with intention of clearing off the bowel as I usually do in this sort of case of the abdominal wall in order to see the two areas that I had opened before. So I intended to expose those areas and put the trochars in again and where I would be able to see the area that needed to be operated on. So I'm sorry. I think --

Q Just trying to track. So after you went midline?

A Midline.

Q That's when --

A That's when I went in through the midline, I saw an area of bowel when I went into the peritoneum that it looked like the bowel, I injured it at that time. I had just injured it, it appeared.

Q And you just -- okay. That's what I was -- all right. That's what I thought needed to be clear.

And you testified last week that you believe that was from the trochar?

A Yes.

Q And then thank you. So Dr. Vasquez and you may have said this too, but Vest had said when you're doing a lot of hernia -- laparoscopic hernia repair, you would normally under any circumstances use three or four ports and with a camera. Is that -- Can you tell me just about that? Tell me what that means and what --

MR. WHITE: Before you do though, objection, leading. This is just redirect. You're not allowed to ask leading questions.

MS. DAEHNKE: Well --

HEARING OFFICER HALSTEAD: I'll rule on it. I didn't find it to be leading. She just prefaced the question and asked her to explain.

THE WITNESS: Okay. To successfully do laparoscopic hernia repair, you need at least three ports. And the ports are trochars. Those words are used interchangeably, and that's important to know. And so to put them in, you have to have a camera in order to see safely and --

Q (BY MS. DAEHNKE:) Could you raise your hands so we can see them?

A Oh. Sorry. A camera -- so with a trochar

with a camera in it at first, and then through that, it is a hollow tube and we put carbon dioxide in. And then you need to find enough space in order to see the abdominal wall to put a second trochar and a third trochar. That was the purpose of the explorations that I did and the incisions that I made, and that was intentional to have three incisions from the beginning, and that's the way that surgery is done.

Q And from those trochars or ports, there's a camera that displays it on a screen that you and the others can visualize: Dr. Vest, the nurse, anesthesiologist?

A Anyone that's interested can watch the TV.

Q And then you did testify to I think when Mr. White --

MR. WHITE: Objection, leading. I already see where this is going.

MS. DAEHNKE: Where Mr. White was going last week about the size of the incisions that you made for the ports, and he asked you whether you would then sew them up. When would you -- I didn't understand. Your answers to his questions, I think, need to be clarified. What happens with the incisions after you put the trochar through the ports?

THE WITNESS: So the trochar that I put in --

HEARING OFFICER HALSTEAD: I'm sorry, Dr. Barber. Just for the record, there was an objection. The question wasn't finished. I'm not sure what the objection was to be frank, but it --

MR. WHITE: It was leading, Ms. Halstead.

HEARING OFFICER HALSTEAD: Okay. She can -- so it's been a week, so she can preface her questions to say this is the preface of my question. Here's the question.

MR. WHITE: Okay. I'll just make like an ongoing objection, but I'll just stop and then we'll just get through this.

HEARING OFFICER HALSTEAD: Okay. Thank you, Mr. White.

MR. WHITE: Thank you.

HEARING OFFICER HALSTEAD: And I'm sorry to interrupt, Dr. Barber. I don't know if you need the question repeated. I'll defer to you.

THE WITNESS: I think I understand. I think you asked whether I close the trochar sites before I put another trochar in. And so no, I would not close a trochar site, an incision there because I had planned to use it later.

MS. DAEHNKE: Okay.

THE WITNESS: Does that help?

Q (BY MS. DAEHNKE:) Yeah. Thank you. Mr. White was asking you questions about discharge which the objections for the record given it wasn't a charge that's been made.

In your review of the medical record that was produced obtained by the Board and produced from Las Vegas Surgery Center, do you see the information, other information other than what Mr. White was asking you about that showed the patient was safe for discharge?

A I think that in the record that the patient had again, I think though he had lost some blood, he seemed to have tolerated that very well and that his blood pressure was okay, his pain was under control, he was able to drink liquids, and so I thought it was safe for him to go.

Q And who would monitor the patient in the recovery room?

A Several nurses as well as the anesthesiologist is really sort of in charge of the recovery room and in charge of that process in that the nurses take orders primarily from the anesthesiologist and sometimes they ask me, but the anesthesiologist actually can trump me in the care of the patient in the recovery room.

Q I'm sorry. The anesthesiologist can?

A Can trump me. Yes.

Q And what's the reason that the anesthesiologist is in charge of that postop period?

A Well, in that they are expert in knowing what drugs were used and how long do they last and what are symptoms, the side effects of the drugs versus the surgery. And they were there in the surgery and kind of know sort of how the patient was during the operation if things changed or not. A big thing is if the patient is stable or is there a change.

Q Thank you. You -- I mean I think it was a tad obvious, but since we're on Zoom, when Mr. White was asking you about the arrows down showing distended testes and asking why you didn't document or look in his eyes and you said you were operating on his groin, is that because -- why is that? Is that the area you would see his testes in the groin or why did you?

A That the fact that the testes were both descended -- he had had a congenital problem, so you worry about other congenital problems and undescended testicles are one of those. And the groin is the area I was concerned about, so I wanted to make sure a normal testicle -- that they were both in the scrotal sac to start with. Sometimes in fixing a hernia, a testicle can go up into the abdominal cavity, so I wanted to make sure

that this is at a starting point. This is where we are today.

MS. DAEHNKE: Thanks, Dr. Barber. I don't have any further questions.

MR. WHITE: I think I just have one follow-up if that's okay.

HEARING OFFICER HALSTEAD: Go ahead, Mr. White.

MR. WHITE: Thank you.

RECROSS EXAMINATION

BY MR. WHITE:

Q You had just testified a few questions ago to that the whole team makes the call like the anesthesiologist has some say in whether a patient's discharged; also the nurses because they're monitoring it, right?

A Yes.

Q But ultimately, it's your call. You could tell the team that you're not discharging if you don't feel the surgery is completely done or maybe it doesn't -- there's still some healing that needs to happen, right?

A We don't expect healing in the recovery room.

Q You don't expect healing to start at all?

A In the few hours there, not in a noticeable fashion. You don't expect healing in an hour or two.

Q Maybe healing is a bad word. If you don't feel the surgery is complete or there's some complications that you wanted to keep an eye on, you have the final say, right, to as to whether to discharge or not?

MS. DAEHNKE: Object to form. It doesn't make medical sense.

HEARING OFFICER HALSTEAD: I understood it. You can answer, Dr. Barber.

THE WITNESS: My choice from the surgery center would be to either discharge the patient or ask the patient to go to a hospital. I did not think the patient warranted hospitalization at that time, so I thought that he could be discharged with close follow-up.

Q (BY MR. WHITE:) Okay. And I thank you for that answer, but at the same time, the question though is you have the final say as to whether to discharge a patient or not, right?

A If the anesthesiologist felt or the nurses felt like the patient should be hospitalized, they would be hospitalized. They could overrule me.

Q Okay. But all things being equal, everything else is hemodynamically stable. If you feel the surgery

has some complications that you want to keep an eye on, you don't have to discharge them, right?

A I think I stated the patient can be discharged from the surgery center and either go home or be transferred to a hospital. I did not think the patient needed to be hospitalized.

Q Okay. But not -- if you can answer it for me in a non-passive voice. Like do you make those decisions or you said they can be discharged or can you answer it in more in an active voice? Do you have say in that?

A I have say but I do not have the final say. I think I just answered that.

MR. WHITE: Okay. That's all I have. Thank you.

HEARING OFFICER HALSTEAD: Thank you. Anything, Ms. Daehnke?

MS. DAEHNKE: No, thank you, Your Honor.

HEARING OFFICER HALSTEAD: Okay. Any further witnesses for the defense?

MS. DAEHNKE: There are not.

HEARING OFFICER HALSTEAD: Anything further from the parties before we move to closing argument?

MR. WHITE: I don't have anything.

MS. DAEHNKE: If plaintiff's case is done and defense is in, I do have a motion.

HEARING OFFICER HALSTEAD: So both parties are resting their case. Is that my understanding?

MS. DAEHNKE: Defense rests.

MR. WHITE: Yes.

HEARING OFFICER HALSTEAD: Okay.

Ms. Daehnke?

MR. WHITE: What is this? I didn't hear what she said.

HEARING OFFICER HALSTEAD: She said she wanted to make a couple of motions, so I'm not sure what she's going to say.

MR. WHITE: Okay.

MS. DAEHNKE: One second so it will be more efficient if I just get this. Yeah. With the permission of the hearing officer, I would move to strike Dr. Spoerke on behalf of Dr. Barber to strike his testimony in that he does not have the experience/ training in laparoscopic hernia repair to offer an opinion as to whether Dr. Barber violated the Medical Practice Act and committed malpractice.

Additionally, the foundation -- he had no foundation given that his own testimony, the decision and the pivotal inquiry as to whether or not in addition to the patient's condition and how is what the experience of the surgeon and the experience and training, and he

admitted that he did not consider and didn't consider when he made his first opinion, his second opinion or even between the time he testified in June and came last week. He had no idea if Dr. Barber had done one or hundreds of laparoscopic hernia repair. And therefore, I'd say there's no foundation and no experience and adequate training, and I would move to strike.

HEARING OFFICER HALSTEAD: It's denied.

MS. DAEHNKE: Thank you. And then the second -- may I move to my second and final?

HEARING OFFICER HALSTEAD: Yes.

MS. DAEHNKE: All right. And then on behalf of Dr. Barber, we would request dismissal of the charging document for failure of the prosecutor to meet the burden of proof based upon well, the charging document itself did not -- Dr. Spoerke did not prove by a preponderance of the evidence that there were violations.

A lot of his testimony was based on speculation or what is generally done, to wit: Well, doctors can just go and type in the computer and correct or he didn't know what the descending the arrows down meant. Dr. Vasquez and Dr. Barber do, so we would move and request dismissal of the charging document.

HEARING OFFICER HALSTEAD: That's denied as well.

MS. DAEHNKE: Thank you. That's it for me.

HEARING OFFICER HALSTEAD: Okay. Would the parties like to move to closing statements or would you like a couple of minutes to prepare?

MR. WHITE: I'm ready to go. What about you, Ms. Daehnke?

MS. DAEHNKE: Thank you. You know what? Let me just take a -- let me go to the restroom quickly.

HEARING OFFICER HALSTEAD: Okay. It's 4:04. So we'll come back at --

MS. DAEHNKE: I only need three minutes.

MR. WHITE: 4:15.

HEARING OFFICER HALSTEAD: 4:15 might be too long. Let's come back at 4:10.

MR. WHITE: Okay.

MS. DAEHNKE: Okay. Thank you.

(Recess.)

HEARING OFFICER HALSTEAD: We're back on the record in Case Number 23-11660-1 in the charges and complaint against Annabel Elizabeth Barber, M.D. Counsel and Dr. Barber remain on the Zoom call. Both parties have rested their sides of the proceeding and we were going to move to closing arguments.

Anything further before we do that?

Ms. Daehnke, I saw your lips move, but I

didn't hear you.

MR. WHITE: One second. Sorry.

HEARING OFFICER HALSTEAD: I can't hear you. You're not on mute, but I can't hear you.

MR. WHITE: You can't hear me?

HEARING OFFICER HALSTEAD: I can hear you, Mr. White. I can't hear Ms. Daehnke.

MR. WHITE: Yeah. I can't either.

HEARING OFFICER HALSTEAD: You're on mute now.

MS. DAEHNKE: Is that okay?

HEARING OFFICER HALSTEAD: Yes. Now you're back. Anything further from you, Ms. Daehnke, before we move to closings?

MS. DAEHNKE: No, Your Honor.

HEARING OFFICER HALSTEAD: Okay. Mr. White?

MR. WHITE: Yeah. Sorry. Give me one second. Bring something up here. Okay. Thank you. Now what did I do with my glasses? There they are. Okay.

Thank you, everyone. On behalf of the Investigative Committee, I'd like to thank you, Hearing Officer Halstead, court reporter, opposing counsel, thank you and Dr. Barber and all of the witnesses for their time and consideration.

As I mentioned in my opening statement, we're

here to present evidence so the Board can determine if Dr. Barber violated the Medical Practice Act. This case is actually pretty simple. Dr. Barber is alleged to have committed malpractice which is demonstrated by but not limited to the respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery to a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature and that respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment, and care of Patient A by failing to correctly document her actions and patient's extensive medical history when she treated Patient A.

You heard testimony -- well, I think you read it, Ms. Halstead, because it was from the June 4th, 2024 hearing. You heard testimony from Monica Gustavson, who is our senior investigator for the Board, as I stated was at the last hearing on June 4th, 2024, which was the transcript was admitted as part of this hearing. Her role was mainly to describe her investigation of this matter and to lay a foundation for the IC's exhibits,

both of which she did thoroughly.

You heard at length from Dr. Spoerke, a peer review in this matter, and the following is kind of summary of his testimony. You heard his vast experience and qualifications. His CV is admitted into evidence for your reference, Ms. Halstead. He presented his opinion with regards to the count of malpractice. You heard Dr. Spoerke state that Dr. Barber diagnosed Patient A with a left inguinal hernia. That was a correct diagnosis.

Respondent then attempted laparoscopic surgery despite Patient A's multiple prior bowel surgeries resulting in vast amounts of scar tissue. Dr. Spoerke testified that respondent attempted laparoscopic surgery from the right side with no visualization as stated in her own records, and Dr. Spoerke then testified that respondent then attempted laparoscopic surgery from the left side, also no visualization after the first attempt with -- sorry -- with attempting that from the right side after having no visualization from the left side, in Dr. Spoerke's opinion, this was where the malpractice starts.

Dr. Spoerke testified that it was once again malpractice to attempt a third laparoscopic surgery at the midline or not the laparoscopic surgery but the third entrance at the midline because people with Patient A's

medical history of their bowels are extremely likely to have a large amount of scarring and adhesions at the midline and that's what he testified to multiple times which increase the likelihood of bowel perforation. Patient A also has short bowel syndrome of which respondent was aware.

The midline surgery is what led to Patient A's perforated bowel. Respondent should have recognized with all of her experience that the midline laparoscopic surgery was going to show the same high amount of scar tissue not allow her to see and repair Patient A's hernia and could and did leave to respondent perforating Patient A's bowel.

Dr. Spoerke testified extensively about Patient A's history and how it led to short bowel syndrome starting with his own omphalocele repair as an infant and further opined as stated above that Patient A's medical history concerning his bowels resulted in a large amount of scarring adhesions and short bowel syndrome.

He describes to you why he thought Dr. Barber had no visualization when she first attempted to go into the patient's abdomen via laparoscopy. There was way too much scar tissue. Patient A, with his history of surgeries starting when he was an infant, resulting in

vast amounts of scar tissue in the midline, and Dr. Barber even admitted in her records that she could only see Patient A's bowel when she tried to go in the right side.

Patient A also had those adhesions. As described by Dr. Barber herself, they were bloody. So it was extremely likely his bowels were attached to his abdominal wall because of all of the scarring, particularly at the midline, and it's exactly -- the midline is exactly where the bowel was perforated and required further surgeries, and that's not in dispute. That was even told to us that it was at the midline that Dr. Barber thought the bowel was perforated.

Dr. Spoerke did say that the first attempt at laparoscopic surgery was probably okay. He was okay with that in his opinion as this peer reviewer but that the second and third attempt and particularly the midline is malpractice.

He also said that open surgery presents less of a risk for bowel perforation in this case because the doctor can see more, as he stated, of the abdominal cavity and the area they are trying to repair like the left inguinal hernia in this case. Dr. Barber, on the other hand, said that she discussed open surgery with Patient A but despite having no visualization in her

first attempt with laparoscopic surgery, she refused to deviate from her plan of doing laparoscopic surgery and did not attempt to do open surgery.

Dr. Barber also testified that a doctor cannot predict the amount of scarring slash adhesions -- that's used interchangeably -- that they might discover in a patient but also offers no explanation as to why she did not switch to open surgery after her first attempt to find the left inguinal hernia. One can infer that's because she realized she had perforated Patient A's bowel and had to abort the left inguinal surgery hernia surgery.

Though not charged as malpractice, and we've discussed this, Dr. Barber felt it was okay to discharge Patient A even though he was anemic, had heavy bleeding, a friable bowel that would not retain or hold sutures.

Next, Dr. Spoerke opined as to why he believes Dr. Barber failed to maintain proper medical records for Patient A's initial visit on 12-27-18 with respondent, and that is Exhibit 4, pages 1 through 7 through 107 through 111. The record just mentions the hernia. It does not mention surgical scars or the laterality or type of hernia: Right versus left, inguinal versus ventral. None of that was written down. Respondent's physical exam makes no mention of the type

of hernia, left or right, inguinal or ventral, makes no mention of surgical scars. It simply states a hernia is present is, and that is on Exhibit 4, Exhibit 4, page 111.

On the date of the surgery on February 22nd, 2019, Patient A was admitted to Las Vegas Surgery Center for a surgery. Required history and physical note lists the abdominal exam as within normal limits or -- I'm sorry -- WNL was checked off, and that's short for within normal limits, but it doesn't mention any previous surgical scars and simply describes a left inguinal hernia. And that's on page 107 in the IC's Exhibit 4.

The informed consent provided by Dr. Barber and signed by Patient A on the day of surgery on 2-22-19 for Patient A showed no indication that respondent discussed risks and benefits of laparoscopic versus open surgery. There's just nothing in there about that. And Dr. Barber, her answer to that is that she's not in charge of making that -- sorry. She's not in charge of writing or approving the what do you call it? Sorry. The informed consent form.

There was essentially no indication in the records to specify about the perforated bowel except that there was one. Nothing really explanation. And her explanation, Dr. Barber's explanation for that is that

she has no way of changing those records, the operative note or the -- excuse me -- the operative report. She really doesn't remember signing it.

Dr. Spoerke also described in depth how important and easy it is to review your medical records from a dictation company and also accept it or and make those changes before you sign it. Dr. Barber on the other hand spent about an hour of testimony reviewing her medical records with her attorney editing them and blaming others and meaning the dictation company and the MA's for improper medical records despite admitting that the accuracy and completeness of her medical records are her responsibility.

But it didn't stop there. She also stunningly admitted she had not seen the operative report until sometime after this case was either filed or at some point, but it wasn't during the -- after the surgery when she signed it. She had not really seen the operative report until she was asked to respond to this case, yet she signed it on the same day as the surgery or just the day after as it looks.

Dr. Barber really didn't have an answer for when if any time she would abort a laparoscopic surgery and switch to an open surgery. Dr. Barber's expert witness, Dr. Vasquez, has a pretty difficult time

answering the IC's questions on cross-examination. They weren't particularly difficult questions, however, Dr. Vasquez did not clearly answer many of the questions. He, however, testified that Dr. Barber's treatment of Patient A was not malpractice and her medical records were sufficient. He also said that there is no opportunity to correct or edit your medical records once they are dictated and sent back. And maybe that's something that should be changed. I don't know. Yeah. And then Dr. Barber even said today that she probably wouldn't sign. When asked if she would sign that operative report today, she said: Probably not.

MS. DAEHNKE: I object to all of that. This is closing.

MR. WHITE: I'm doing closing argument.

HEARING OFFICER HALSTEAD: Yeah. So, Ms. Daehnke, you're echoing pretty bad. It is closing. I know what the transcript said and I'm very familiar with the testimony that was today so, you know, the transcript is going to speak for itself, and I recall how she testified to that.

MR. WHITE: Sum it up now. As counsel for the IC, I submit that the IC has met it burden and proven malpractice and failure to maintain proper medical records by a preponderance of the evidence which is the

standard. So on behalf of the Investigative Committee, we ask the Board to consider the record that was presented here and render the appropriate findings and discipline. Thank you.

HEARING OFFICER HALSTEAD: Thank you, Mr. White.

Ms. Daehnke, it's your turn for closing.

MS. DAEHNKE: Thank you.

HEARING OFFICER HALSTEAD: You're echoing though.

MS. DAEHNKE: We need to fix this.

MS. DAEHNKE: Is that better?

MR. WHITE: Yes.

HEARING OFFICER HALSTEAD: It is better.

MS. DAEHNKE: Apologize. I don't know what. Thank you. And thank you, Hearing Officer, our court reporter, Mr. White, witnesses. Thank you for your time on behalf of Dr. Barber. We've been it seems like we've been here for a very long time, and I do not want to repeat because Mr. White did read the two counts into the record.

On behalf of Dr. Barber, supported by a well-qualified expert, Dr. Vasquez, she did not breach the standard of care. And in closing and in the testimony and the questions asked, it does appear that the nature

of a laparoscopic hernia repair is either intentionally or possibly not intentionally misunderstood. There's not three -- there was not three procedures. You need to put ports in to do laparoscopic surgery, and that's what Dr. Barber did.

Dr. Vasquez testified about both the standard of care from his 40 years. He's a general surgeon. This is what he does. He's also a cancer surgeon, and he was too modest and we had no time to go into his extensive CV. I mean, he's on the American Cancer -- he's done so much and so many surgeries, and he answers the questions that he was asked trying to understand what the questions were, and he believes that Dr. Barber did everything correctly and including the documentation.

Mr. White took him through that short op short H&P. Dr. Vasquez can read it. And maybe this is a generational issue in that and/or an experience issue in that Dr. Spoerke has only seen possibly a couple of these quick op short H&P's. Dr. Spoerke's answer as to what his criticisms were for Dr. Barber on that short one sheet that is meant to be an update even by Dr. Spoerke's standards and only to note anything new from the time of the H&P, maybe he hasn't seen it, but his answer when presented with the question: You know that this is a short form. It's meant to be a short op note and a short

H&P was: Oh, well, then Dr. Barber should write smaller and make her writing more legible. Operating in the real word. This is a form that the ambulatory surgery center has, and Dr. Vasquez could read it. Dr. Vasquez could read that little indication the little sign that was a left. Dr. Vasquez knew what that was. He's been practicing longer than Dr. Barber. Perhaps the older surgeons who have done so much of this surgery know what these signs mean. Dr. Spoerke didn't, not unsurprisingly.

The arrows showing the testes down, this hypercritical about you should have -- the surgeons knew what was being what was called for. And according to Dr. Vasquez, there was all of the needed information. Dr. Vasquez was -- he said he would be critical if that was the only H&P and the only op note but it wasn't. We have the December 27th operative report that was supplemented by the subsequent. It's meant to be a short note, a short H&P, a short op note and a short discharge and with follow-up.

And Dr. Barber specifically in several places in the record said the patient was to follow up with her in two days. A couple things. Specific things. I was going to go through a lot more, but for the time, I'm going to be quick hopefully. Dr. Spoerke alleged that

the op report did not indicate that there was a bowel injury. On the February 26th, 2019 operative report, it states: However, there was a suspicion of entering through the small bowel so mini laparotomy was done. Small injury was confirmed.

That same operative report documented her placement of the trochars, documented the incisions and documented the repair of the small bowel. The idea that the word -- now I've even forgotten the word. The word that means bleeding tissue -- friable -- that Dr. Barber in describing yes, it was friable, Dr. Barber didn't say she documented it was friable. I Googled when we were in Reno when Mr. White was asking Dr. Vasquez about the term "friable," and friable is tissue that can easily bleed. It just comes up on good old Dr. Google.

This picky nonrealistic no common sense from Dr. Spoerke, and maybe I guess really the answer as I think about it in my head and have been trying to figure out where he lives is he doesn't know any better because he doesn't have the experience. He doesn't have the experience in ambulatory surgery centers, and he certainly has repeated several times that he had five to ten laparoscopic hernia repairs. He said that in June and he said that last week.

Well, when a surgeon who is testifying

against another Board certified highly experienced highly awarded tenured profession -- tenured professor who teaches others, maybe he could go and look and see how many he actually did because people who say they've done five to ten trials or had five to ten of this or that really means they probably had three or four. Didn't even bother. Didn't bother to look at Dr. Barber's number of surgeries, didn't even bother to look up his supposed surgeries.

With regard to the December 27th H&P, that contains all of the information that was needed to work up the patient, and it was prudent to have the patient come in two months earlier so that all of the necessary testing that Dr. Barber ordered could be done.

Dr. Spoerke is critical because he didn't know why Dr. Barber would order Juven for the patient. Dr. Barber spent time talking about her knowledge of Juven. She did the original studies that led to the patent on Juven. To have Dr. Barber note that patient needs Juven when there's already the patient's history that he had some anemia, a past medical history of anemia, doctors who actually are in the field know why Juven would be given and it was appropriate. It was given to preop the patient. So Dr. Spoerke doesn't have a problem with the Dr. Barber ordering the Juven and

putting the patient on Juven. He just didn't know why. And so that's a violation of the Medical Practice Act. Dr. Barber said it was to optimize the short bowel to maximize healing in the short bowel because it makes the villi absorb. I mean, she knows this. And that was probably why I asked her to talk about her experience with Juven.

Everything in the December 27th, 2018 record discussed preoperative workup, the CT scan. The CT scan is noted in the record that Dr. Barber reviewed it. In fact, she was going to proceed with surgery after discussion with the patient only after the CT scan came back. Dr. Barber, Dr. Vasquez even Dr. Spoerke, I don't know that Dr. Spoerke looked at the CT, but they said there was nothing that would contraindicate proceeding laparoscopically. The CT scan could define the anatomy better, but there was -- and there was nothing there. She was looking. This is a prudent doctor.

With regard to the other documentation allegations, Dr. Vasquez found that everything was accurate, was accurate and adequate for and in fact, that the preoperative workup on December 27th was excellent, he said. And he does these surgeries. He does hundreds. Indeed he's not just a couple. He does this all the time. Both Dr. Barber and Dr. Vasquez are cancer

surgeons. They do tricky surgeries. They do bowel surgeries. Comparing five to ten possibly to hundreds, there's just no comparison. The patient had preoperative clearance.

And with regard to the discharge, it is a team effort. The patient's not going to be discharged. It only makes sense that the anesthesiologist is in charge of monitoring the patient right outside in the PACU, and that's the anesthesiologist because the anesthesiologist is the one who put the patient under, and the anesthesiologist together with the nursing staff right there are monitoring Patient A.

This gamesmanship absolutely defies the real way things work in medicine and the way things work in an ambulatory surgery center. Ambulatory surgery centers are different than hospitals.

MR. WHITE: I'm going to object to what was the gamesman -- who is being accused of gamesmanship?

HEARING OFFICER HALSTEAD: It's argument.

MR. WHITE: Okay.

HEARING OFFICER HALSTEAD: I'm not going to entertain that. But, Ms. Daehnke, I will tell you that you're going really fast.

MS. DAEHNKE: I apologize. Just a couple hopefully more things. A little slower.

With regard to Dr. Spoerke's criticisms of the short form op note and short form history and physical, the history of present illness with a pain and bulge in the left groin, that's accurate. Patient was born with omphalocele. Accurate. Had small bowel resection. Accurate.

Review of systems. Short bowel and anemia. Accurate. Accurate. Physical exam. Left inguinal hernia. Dr. Barber's impression: Left inguinal hernia. Dr. Spoerke said well, it should have said whether it was incarcerated or the word that means it's not incarcerated. Reducible. Dr. Vasquez said well, if it was incarcerated, it should have been documented.

This is picky, not real world, not common sense, and I query whether Dr. Spoerke actually understood what his role as a peer reviewer was in this case. In June, he testified he wasn't an expert which I might agree with that. Last week, he said -- unfortunately, my box got left in Reno. It didn't get sent, so I wrote down what he said as to his review as to what his role was in this, and I think he completely misjudges what his role is.

It seems to me what he did is he took records and then looked for things to point out that he didn't understand or that he thought could have been better. I

mean, well, the Board gave me this instruction. And he sent he had ten articles that supported his opinion that the standard of care was that Dr. Barber should have gone open, but he couldn't remember the names of the articles? He couldn't cite anything from the articles? Well, since we can't, Dr. Barber couldn't see the articles which that's been gone over, Dr. Spoerke couldn't even cite to it.

He did, however, he conceded surprisingly that the technique and skill and experience and comfort level of the surgeon when you make a determination to do a hernia repair open versus closed is paramount. He said that and yet possibly, the disconnect in this case is because he did not even bother to see how many laparoscopic hernia repair surgeries Dr. Barber did, did not last June, did not two years ago, did not last week. And I dare say if he was here today, he wouldn't have looked either. And that is pretty much Dr. Spoerke's opinion.

He lacks foundation and lacks experience and was just excited to tag Dr. Barber with everything including not saying left on one line and saying left on the same document where it says left doesn't say it two lines later. And yeah, when questioned, he said Dr. Barber should write smaller which I submit is not a

standard of care issue.

So on behalf of Dr. Barber -- oh, sorry. Just with regard to the dictation, Dr. Spoerke admitted well, no didn't admit. Dr. Spoerke said that generally, doctors can go on their computer and fix things and sign them. And I thought he was talking about EMR which it's established it's not at Las Vegas Surgery Center. Dr. Spoerke hasn't been at Las Vegas Surgery Center. He has no idea how Las Vegas Surgery Center -- excuse me -- how Las Vegas Surgery Center operates. There's no contrary evidence Dr. Barber didn't -- that the dictation wasn't the same day. Mr. White was talking about oh, she didn't even see it. She didn't see it the same day. Dr. Barber said she didn't look at the descriptions, in other words, the things that have been thought to be such a problem and the mistranscriptions.

She's not blaming anyone. It's just a fact. It's transcribed. There's the name of the transcriber. The transcription was the day after. And how is it presented to Dr. Barber? They don't give it to her on a screen. They put it with a stack of reports to sign in her inbox and she gets it when she's at the surgery center again. That's just the way it is. So Dr. Spoerke has no foundation for that criticism like most of his criticisms.

So on behalf of Dr. Barber, I would submit that Dr. Vasquez and Dr. Barber herself are well-qualified experts who have foundation and looked at the records. Vasquez has no problems with the records or with the procedure because he does the procedure. He knows how to do the procedure. And by the description that even today what was given of how things went, it's clear that either Dr. Spoerke has not articulated the way these procedures go on a normal basis or somehow either he doesn't know or he has not told Mr. White how the procedures go.

And so on behalf of Dr. Barber, I would submit that the evidence is in support that she should not be found to have violated the Medical Practice Act on either the decision to proceed with the procedure laparoscopically, the decision to discharge the patient, even though not charged, the decision to necessarily repair the bowel and do a repair of the hernia later because of the patient's bleeding, that that was prudent and certainly not a violation, and that the alleged dictation, the alleged errors in the records are not errors. They're errors from the dictation.

Dr. Barber wasn't blaming the transcriptionist. She was just telling it like it is at Las Vegas Surgery Center. There's no way she doesn't

have access to the tape. The transcriptionist didn't call her and say: Hey, Dr. Barber, did you see I noted on my tape that I can't understand this? So there was no way for that to correct it. And does she want to keep correct records? Of course she does.

We'd submit that the Board has failed to meet its burden of proof by a preponderance of the evidence based upon the more credible and competent evidence by Dr. Vasquez, Dr. Barber and the records themselves. Thank you.

HEARING OFFICER HALSTEAD: Thank you. Anything further before we close the proceedings?

MR. WHITE: No.

HEARING OFFICER HALSTEAD: Ms. Daehnke?

MS. DAEHNKE: Oh, nothing. Nothing from me, Hearing Officer.

HEARING OFFICER HALSTEAD: Okay. I appreciate everyone's time and the presentations that have been made. I know these hearings are a lot of work for everybody and they're particularly stressful for the participants and those involved, so I appreciate everyone's time and effort.

I will take this matter under submission. I have been warning everybody that I took over a caseload of a prior hearing officer, and I've been inundated with

cases and motions and things like that. I have a timeline by which this is supposed to be done. I think it's 30 days. I've heard the Board say it's 60.

MR. WHITE: It is 60.

HEARING OFFICER HALSTEAD: But I try for 30. So please do not expect something quickly from me because it's probably not going to happen. But I will get it out and it will be hopefully thorough and well reasoned and you will have a resolution probably just not as timely as you would like.

So with that, does either party have any concerns about me needing an extended timeline for ruling?

MR. WHITE: No. I just think that no, I have no concerns except -- and I know what you're talking about, Ms. Halstead. You have a lot of cases now, so it's probably not going to be June if we're already in April. So it might be on the September board meeting?

HEARING OFFICER HALSTEAD: That's what I anticipate.

MR. WHITE: Yeah. Okay.

HEARING OFFICER HALSTEAD: I'll do the best I can.

Ms. Daehnke?

MS. DAEHNKE: Did you take over Woodman's

caseload?

HEARING OFFICER HALSTEAD: I did.

MS. DAEHNKE: I figured. You know what? This is real life. We've got a lot of work to do. I don't see that there's any -- we're good. That's fine on behalf of Dr. Barber if you need to do a decision and take your time. Do we get a copy of the transcript, the court reporter transcript?

HEARING OFFICER HALSTEAD: I believe so. Mr. White?

MR. WHITE: I think I'll leave it up to Meg to answer. I think we do send it out, but I'll make sure.

MS. DAEHNKE: Great. Thank you so much. Thanks, Don.

MR. WHITE: I don't know how that works. Not really our -- it's proprietary. Not sure how that works with Veritext.

MR. WHITE: We provide it anyway?

MS. DAEHNKE: I think you kind of have to because it's a hearing.

MR. WHITE: Yes. Yes. We will provide it to both Hearing Officer and you, Ms. Daehnke.

MS. DAEHNKE: Was that Meg?

MR. WHITE: Yeah.

MS. DAEHNKE: Thanks, Meg. Hi, Meg.

MR. WHITE: She just walked out. Okay.

HEARING OFFICER HALSTEAD: Thank you, everyone. These matters are concluded and considered submitted.

(The hearing concluded at 4:46 p.m.)

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STATE OF NEVADA)
COUNTY OF WASHOE)

I, Nicole J. Hansen, Certified Court Reporter, State of Nevada, do hereby certify:

That said proceedings were taken before me remotely at the time and places therein set forth and were taken down by me in shorthand and thereafter transcribed into typewriting under my direction and supervision;

I further certify that I am neither counsel for, nor related to, any party to said proceedings, not in anywise interested in the outcome thereof.

In witness whereof, I have hereunto subscribed my name.

Dated: April 11, 2025

Nicole J. Hansen

Nicole J. Hansen
NV. CCR No. 446, RPR, CRR, RMR
CA. CSR 13,909

7

EXHIBIT 1

EXHIBIT 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

October 28, 2019

Annabel Barber, M.D.
1701 W. Charleston Blvd., Suite 490
Las Vegas, NV 89102

RE: BME CASE #: 19-19059
PATIENT: [redacted] DOB: [redacted]

Dear Dr. Barber:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges you provided substandard medical care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on or around February 22, 2019, for a hernia repair surgery.
2. The patient had undergone six previous surgeries, including the removal of two thirds of his small intestine, prior to presenting to you for surgery.
3. You disregarded the patient's requests that you enter through the groin for his hernia surgery and not touch his adhesions.
4. You entered through the patient's abdomen. By entering through the abdomen you perforated the remaining one third of the patient's small intestine, causing the small intestine's contents to spill into the patient's stomach cavity.
5. The contents of the intestines resulted in the patient suffering with near death sepsis, two blood transfusions, five additional surgical procedures, three fistulas, open wounds, total parenteral nutrition, migraine headaches and excruciating pain.

It is further alleged:

1. The patient is irreparably disabled and unable to work.
2. Due to the perforation you inflicted, you had to remove more of the patient's small intestines.
3. The patient only gave consent for you to enter through the groin during his hernia repair surgery, not through the abdomen. You did not adhere to proper consent from the patient nor did you consider the patient's pertinent medical history of six previous surgeries and adhesions.
4. Furthermore, you never repaired the hernia.
5. The patient has felt undue pain and his quality of life has suffered.

Received 11/18/2019

6. Therefore your care and treatment of the patient may have fallen below the standard of care.

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 the allegations noted above, as well as complete health care records for the aforesaid patient. Please provide 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.

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: **NAC 630.040; NAC 630.620 (2); NRS 630.301 (4),(8); NRS 630.306 (1)(f), (1)(g), (1)(p).**

Respectfully,

Monica C. Gustafson, CMBI
Senior Investigator

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

ORIGINAL

In the Matter of the Investigation of:	)
	)
	) Case No. 19-19059
Annabel Barber, M.D.	)
	)
License No. 8247	)
	)

ORDER TO PRODUCE MEDICAL RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

Annabel Barber, M.D.
1701 W. Charleston Blvd., Suite 490
Las Vegas, NV 89102

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records and imaging of [redacted], DOB: [redacted], from February 1, 2019 through the present date.
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records and imaging of [redacted], DOB: [redacted], from February 1, 2019 through the present date

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Monica C. Gustafson, Senior Investigator, Nevada State Board of Medical Examiners, 9600 Gateway Dr., Reno, Nevada 89521). Failure to comply and produce said records in the aforesaid manner may subject you to potential disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS

630.3062(1)(d); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this **28th** day of **October,** 2019.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

M. Neil Duxbury

M. Neil Duxbury, Chairman
Nevada State Board of Medical Examiners
Investigative Committee

UNLV | School of MEDICINE

November 15, 2019

RECEIVED
NOV 18 2019
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Investigation Division
Attn: Monica C. Gustafson, Senior Investigator
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

RE: BME CASE #:19-19059
PATIENT: [redacted] DOB: [redacted]

Dear Ms. Monica Gustafson,

Enclosed you will find my initial patient consult from 12/27/2018. He has a left inguinal hernia and an acquired short bowel syndrome. I began him on a "pre-hab program" for his bile with Juven which has been proven to increase absorption of nutrition by lengthening of the small bowel villi.

He was being followed by family medicine during the time prior to his surgery. He underwent Pre-op clearance by them prior to his planned procedure on 02/22/2019. On that date, he underwent laparoscopy converted to laparotomy and small bowel resection. He was sent home and was instructed to return to my office in 2 days' time. On 02/25/2019 he came to the emergency room and was found to have failure of his anastomosis. He was taken to the operating room and a small bowel resection was performed with anastomosis. His abdomen was left open. He underwent subsequent washout on 02/27/2019, 03/01/2019 and closure on 03/05/2019. He was treated with antibiotics and total parental nutrition. He was able to tolerate enough oral intake by the time of his discharge from University Medical Center on 03/15/2019. He saw me in the office for a post-op visit on 03/21/2019. At that time I spoke with him about Gattex which may have helped his symptoms of short bowel syndrome. He did not keep his follow up appointments with me.

In regards to this patients allegations, I discussed laparoscopic versus hernia repair with the patient. Both in the office and in the surgery center prior to his operation. I do not recall his requesting an open surgery. Based upon his cat scan which I reviewed prior to his surgery with him I felt that a laparoscopic surgery will be less painful with shortened healing time. Unfortunately, the patient suffered an injury to his small intestine during surgery. This was immediately recognized and a safe repair was done. Unfortunately, he was unable to heal this and required further surgery. As I have not seen the patient since March 2019, I am unable to say that he is irreparably disabled and unable to work. Mr. [redacted] signed consent at Las Vegas Surgery Center for laparoscopic possible open hernia repair prior to his procedure. I did not repair his hernia as he had bowel contents that were controlled during the operation in order to try to avoid infection.

It is unfortunate that this man suffered complications. However, I believe that I proceeded carefully and logically in his care. Please don't hesitate to contact me. Enclosed are his records.

Sincerely,

Annabel Barber, MD

1701 W Charleston Blvd · Suite 490 · Las Vegas, Nevada 89102

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 2

EXHIBIT 2

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 3

EXHIBIT 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

SECOND REQUEST

August 24, 2020

Lubna Javed, M.D.
Caring for Life Medical Group
10170 W. Tropicana Ave.
Las Vegas NV 89147

RE: BME CASE #: 19-19059
PATIENT: [redacted]; DOB: [redacted]

Dear Dr. Javed:

This is the **second request** for your statement of your treatment plan regarding the patient associated with this case. Please provide the requested **statement, a thorough written explanation of your of your treatment plan for the above named patient. We understand you are not the custodian of records; however you never provided the Board your statement of treatment, in your letter we received November 18, 2019.**

Be advised that your failure to produce and make available health care records to an authorized representative or Investigator of the Board, as prescribed by Nevada law is grounds for the Investigative Committee to initiate a Formal Complaint against you, which may result in disciplinary action or denial of licensure (NRS 629.061; 630.3062(4); 630.352).

You have not been named as a respondent in this case at this time. The Investigative Committee of the Board requires your records and a statement to help it investigate the care provided by others. Your providing the requested information is deemed a professional obligation of any physician active in or knowledgeable of patient care and treatment under investigation by the Board, and your assistance shall not be deemed to be cooperation subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Enclosed is a copy of the original letter sent to you October 28, 2019. Should you have any questions you may contact me at 775-324-9373. **Please reply to this request within 15 days.**

Thank you in advance for your attention to this matter.

Respectfully,

Monica C. Gustafson, CMBI
Senior Investigator
Nevada State Board of Medical Examiners

SPRING VALLEY HOSPITAL
MEDICAL CENTER
A Member of The Valley Health System

Advanced Wound Care and Hyperbaric Therapy Center

RECEIVED
SEP 28 2020
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

September 22, 2020

Monica C. Gustafson, CMBI
Senior Investigator
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Re: BME Case #: 19-19059
Patient: [redacted]; DOB: [redacted]

Dear Mrs. Gustafson,

This letter is to inform you patient [redacted]; DOB [redacted] was under our care at the Spring Valley Hospital Advanced Wound Care and Hyperbaric Center, and Spring Valley Hospital from March 28, 2019 – March 10, 2020. He was treated for a complicated surgical abdominal wound with fistulas. Mr. [redacted] was seen at our center on multiple visits and had follow up appointments with his surgeon during that time frame.

Any additional requests for the above mentioned patient, can be obtained from the Medical Records Office at Spring Valley Hospital at: 5380 S. Rainbow Blvd. Las Vegas, NV 89118.

If you have any other questions please feel free to reach out to me at 702.853.3853.

Respectfully,

Javed

Lubna Javed, M.D.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

October 28, 2019

Lubna Javed, M.D.
Caring for Life Medical Group
10170 W. Tropicana Ave.
Las Vegas NV 89147

RE: BME CASE #: 19-19059
PATIENT: [redacted]; DOB: [redacted]

Dear Dr. Javed:

Pursuant to Nevada Revised Statutes (NRS) 629.061, the Nevada State Board of Medical Examiners requests **copies of the health care records** of the above named patient, also including **any x-ray or other films** you produced in treating this patient. **Please also include a thorough, written explanation of your treatment plan for the patient.**

You have not been named as a respondent in this case at this time. However, the Investigative Committee of the Board requires your records and treatment plan to help it investigate the care provided by yourself and others. Nevada physicians are professionally obligated to comply with lawful requests by the Board. *See* NRS 630.3062(4).

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.

Please forward the records and treatment plan to the Investigative Committee of the Board **within 21 days**.

If you have any questions or we may be of assistance, please call me at (775) 324-9373.

Thank you in advance for your attention to this matter.

Respectfully,

Monica C. Gustafson, CMBI
Senior Investigator

Received Statement 9/28/2020

NSBME 082

SPRING VALLEY HOSPITAL
MEDICAL CENTER
A Member of The Valley Health System

RECEIVED
NOV 18 2019
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

November 12, 2019

Monica C. Gustafson, CMBI
Senior Investigator
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Re: BMI Case #19-19059
Patient: [redacted]; DOB: [redacted]

Dear Mrs. Gustafson,

This letter is to inform you of the Custodian of Records for patient [redacted]; DOB: [redacted] is at Spring Valley Hospital Medical Center.

Any request for the above mention patient can be obtained from the Medical Records Office at Spring Valley Hospital Medical Center located at 5400 S. Rainbow Blvd. Las Vegas, NV 89118.

If you have any questions please don't hesitate to call me at (702) 853-3853.

Sincerely,

Javed

Lubna Javed, MD

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

Nicholas Spoerke, MD, FACS

75 Pringle Way Suite 1002
Reno, NV 89502
nspoerke@westernsurgical.com

Employment

Partner, Western Surgical Group 2012 – present
Reno, NV

Fellowship

Surgical Critical Care 2011-2012
Oregon Health and Science University, Division of Trauma
Portland, OR

Residency

General Surgery Residency 2005-2011
Oregon Health and Science University

Trauma Research Resident 2008-2009
Oregon Health and Science University

Education

Doctorate of Medicine 2001-2005
New York Medical College
Valhalla, NY

Bachelor of Science- Cell and Molecular Biology 1997-2001
Northwestern University, Evanston, IL

Licensure and Certification

Fellow, American College of Surgeons	2013 – present
Board Certification, Surgical Critical Care	2012- present
American Board of Surgery Qualifying exam	passed 2011
Board Certification, American Board of Surgery	2012 - present
State Medical Licensure-Nevada	2012 - present
USMLE Step I, II, III	
Advanced Trauma Life Support Certification	2006-present
Advanced Cardiac Life Support Certification	2005-present

Appointments

Chair, Department of Surgery 2016 – 2018
Renown Regional Medical Center, Reno, NV

Medical Director, Surgical Critical Care 2017 – present
Renown Regional Medical Center, Reno, NV

Presentations

Gender Does Not Effect Mortality for Blood-Transfused Trauma Patients – **ACS Region X Committee on Trauma, 11/15/08**

The Use of Lyophilized Plasma for Resuscitation in a Swine Model of Severe Injury – **ACS Region X Committee on Trauma, 11/15/08**

The Use of Lyophilized Plasma for Resuscitation in a Swine Model of Severe Injury – **Pacific Coast Surgical Association, 2/15/09, San Francisco, CA**

The Presence of RBC Accelerates the Onset of Clot Formation in Polytrauma and Hemorrhagic Shock - **Portland Surgical Society, 5/29/09, Portland, OR**

Crystalloid Resuscitation Improves Survival in Trauma Patients Receiveing Low Ratios of FFP:PRBC – **Portland Surgical Society, 5/29/09, Portland, OR**

Crystalloid Resuscitation Improves Survival in Trauma Patients Receiving Low Ratios of FFP:PRBC – **Damage Control Resuscitation Consortium, 6/5/09, San Antonio, TX**

Lyophilized Plasma for Resuscitation in a Swine Model of Severe Injury – **Annual meeting of the OR/WA chapter of the American College of Surgeons, 6/15/09, Lake Chelan, WA**

Effects of Ethanol Intoxication and Gender on Blood Coagulation – **Annual meeting of the OR/WA chapter of the American College of Surgeons, 6/15/09, Lake Chelan, WA**

Lyophilized Plasma for Resuscitation in a Swine Model of Severe Injury – **United States Military Health Research Forum, 9/2/09, Kansas City, MO**

Effects of Ethanol Intoxication and Gender on Blood Coagulation – **Annual meeting of the American Association for the Surgery of Trauma (AAST), 10/3/09, Pittsburgh, PA**

Red Blood Cells Accelerate the Onset of Clot Formation in Polytrauma and Hemorrhagic Shock **– Annual meeting of the Eastern Association for the Surgery of Trauma (EAST), 1/17/2010, Phoenix, AZ**

Publications

Lin HJ, **Spoerke N**, Deveney C, Martindale R. Reconstruction of complex abdominal wall hernias using acellular human dermal matrix: a single institution experience. Am J Surgery 2009;197:599-603.

Spoerke N, Zink K, Cho SD, Differding J, Muller P, Karahan A, Sondeen J, Holcomb J, Schreiber M. Lyophilized plasma for resuscitation in a swine model of severe injury. *Arch Surg* 2009;144(9):829-34.

Spoerke N, Martindale R. Should the principle of "pay for performance" be applied to nutrition support? *Curr Gastroenterol Rep* 2009;11(4):332-5.

Spoerke N, Underwood S, Differding J, et al. Effects of ethanol intoxication and gender on blood coagulation. *J Trauma* 2010;68(5):1106-11.

Spoerke N, Van P, Differding J, et al. Red blood cells accelerate the onset of clot formation in polytrauma and hemorrhagic shock. *J Trauma* 2010; 69(5):1054-9.

Spoerke N, Trunkey D. *Emergency Department Thoracotomy*. Cameron's Current Surgical Therapy, 10th Ed, 2011, Elsevier.

Van P, Hamilton G, Kremenevskiy I, Sambasivan C, **Spoerke N**, Differding J, Watters J, Shreiber M. Lyophilized plasma reconstituted with ascorbic acid suppresses inflammation and oxidative DNA damage. *J Trauma* 2011;71:20-25.

Hamilton G, Van P, Differding J, Kremenevskiy I, **Spoerke N**, Sambasivan C, Watters J, Schreiber M. Lyophilized plasma with ascorbic acid decreases inflammation in hemorrhagic shock. *J Trauma* 2011;71:292-298.

Spoerke N, Michalek J, Schreiber M. Crystalloid resuscitation improves survival in trauma patients receiving low ratios of fresh frozen plasma to packed red blood cells. *J Trauma* 2011 71(2):S380-383.

Honors and Awards

Wilfred F. Ruggiero, MD, FACS Memorial Award and Scholarship 2005

Winner ACS Committee on Trauma Region X competition, 11/15/08, Seattle, WA

Winner Pacific Coast Surgical Association resident competition, 2/15/2009, San Francisco, CA

Winner Eastern Association for the Surgery of Trauma resident competition, 1/17/2010, Phoenix, AZ

Providence Medical System award for best chief resident – 6/2011

Professional Affiliations

Fellow, American College of Surgeons

Extra-curricular

Hiking, backpacking, fishing, skiing, soccer

8

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 17 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018, when he presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Respondent ordered a CT scan "to define anatomy better."

/ / /

/ / /

[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., 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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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

4. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he had acquired short bowel syndrome.

5. Upon healing from those surgeries, Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

6. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laparoscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

7. Upon information and belief, during the surgery on February 22, 2019, Respondent made an attempt to gain laparoscopic access to the peritoneum via the right lower quadrant. When Respondent was unable to gain peritoneal access, it appears from her operative note that she tried to gain access via the left lower quadrant but was also unsuccessful. It appears, upon information and belief, that Respondent then attempted to access the peritoneum via a midline incision and immediately noticed that she had injured Patient A's bowel.

8. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision.

9. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures.

10. Respondent then closed the incision and discharged Patient A without having repaired Patient A's left inguinal hernia.

11. There was no documentation of the injury in the operative note which was unintelligibly written.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

14. 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."

15. 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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

16. 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

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

18. 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.

19. Respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

20. 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 her and give her notice that she 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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@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

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 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AURY NAGY, M.D.
Chairman of the Investigative Committee

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: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1** **FILED UNDER SEAL**

FILED
NOV 17 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. 23-11660-1.

1. Patient A's true and correct identity is as follows:

Name: [redacted]
DOB:

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@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

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 28 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PROOF OF SERVICE

I, Meg Byrd, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on November 20, 2023, I sent the **COMPLAINT** and **PATIENT DESIGNATION**, as well as required fingerprinting card with instructions to:

ANNABEL ELIZABETH BARBER, M.D.
2205 Scarlet Rose Drive
Las Vegas, NV 89134

Via USPS Certified Mail Tracking number 9171969009350241562104 and was delivered on November 22, 2023. *See* **Exhibit 1**.

DATED this 27th day of November, 2023.

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

UNITED STATES POSTAL SERVICE

November 27, 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 0241 5621 04**.

Item Details

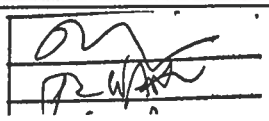
Status:	Delivered, Left with Individual
Status Date / Time:	November 22, 2023, 4:23 pm
Location:	LAS VEGAS, NV 89134
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic

Shipment Details

Weight:	0.3oz

Recipient Signature

Signature of Recipient:



Address of Recipient:



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Sincerely,
United States Postal Service®
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Washington, D.C. 20260-0004

USPS Tracking®

FAQs >

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Tracking Number:

9171969009350241562104

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Latest Update

Your item was delivered to an individual at the address at 4:23 pm on November 22, 2023 in LAS VEGAS, NV 89134.

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Delivered, Left with Individual
LAS VEGAS, NV 89134
November 22, 2023, 4:23 pm

Arrived at USPS Regional Facility
LAS VEGAS NV DISTRIBUTION CENTER
November 21, 2023, 4:42 pm

Arrived at USPS Regional Facility
RENO NV DISTRIBUTION CENTER
November 21, 2023, 12:18 am

Accepted at USPS Origin Facility
RENO, NV 89521
November 20, 2023, 11:03 pm

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FAQs

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.,** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 28 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PROOF OF SERVICE

I, Meg Byrd, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on November 20, 2023, I sent the **COMPLAINT** and **PATIENT DESIGNATION**, as well as required fingerprinting card with instructions to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Egan Daehnke, Esq.
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

Via USPS Certified Mail Tracking number 9171969009350241562111 and was delivered on November 27, 2023. *See* **Exhibit 1**.

DATED this 28th day of November, 2023.

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

UNITED STATES POSTAL SERVICE

November 28, 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 0241 5621 11.**

Item Details

Status:	Delivered, Front Desk/Reception/Mail Room
Status Date / Time:	November 27, 2023, 3:15 pm
Location:	LAS VEGAS, NV 89119
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic

Shipment Details

Weight:	0.3oz

Recipient Signature

Signature of Recipient:

Address of Recipient:

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Sincerely,
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475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

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FAQs >

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Tracking Number:

9171969009350241562111

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 3:15 pm on November 27, 2023 in LAS VEGAS, NV 89119.

Get More Out of USPS Tracking:

USPS Tracking Plus®

Delivered

Delivered, Front Desk/Reception/Mail Room
LAS VEGAS, NV 89119
November 27, 2023, 3:15 pm

Redelivery Scheduled for Next Business Day
LAS VEGAS, NV 89119
November 22, 2023, 2:25 pm

Arrived at USPS Regional Facility
LAS VEGAS NV DISTRIBUTION CENTER
November 21, 2023, 4:42 pm

Arrived at USPS Regional Facility
RENO NV DISTRIBUTION CENTER
November 21, 2023, 12:18 am

Accepted at USPS Origin Facility
RENO, NV 89521
November 20, 2023, 11:03 pm

Feedback

● Hide Tracking History

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Return Receipt Electronic ⌄

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Track Another Package

Enter tracking or barcode numbers

Need More Help?

Contact USPS Tracking support for further assistance.

FAQs

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED

DEC 12 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

RESPONDENT'S ANSWER TO COMPLAINT

Respondent Annabel Elizabeth Barber, M.D., as a licensed Medical Doctor subject to the jurisdiction of the Board, and based upon information and belief, personal knowledge, and review of the available medical records, responds to the factual statements and allegations made in the Complaint as follows:

1. Respondent admits that at all times relative to the Complaint she was a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 8274) and was originally licensed by the Board on July 1, 1997.

2. Respondent admits that Patient A was a 53-year-old male at the time of the events at issue.

3. Respondent admits that Patient A's first clinical visit with Respondent was on December 27, 2018. Respondent admits Patient A presented with a left inguinal hernia. Respondent admits she ordered a CT scan.

4. Respondent admits that Patient A had a history of multiple abdominal surgeries due to a birth defect and prior bowel obstruction. Respondent admits that Patient A previously had a large amount of his small bowel removed.

5. Respondent admits that Patient A developed surgical scar tissue from his prior surgeries. Respondent is without sufficient knowledge or information to form a belief as to the truth of the remaining allegations contained in Paragraph 5, and on that basis denies each and every remaining allegation contained therein.

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

6. Respondent admits that Patient A was admitted for surgery on February 22, 2019. Respondent admits that a laparoscopic procedure was planned. Respondent denies all other allegations contained therein.

7. Respondent admits that she made an attempt to gain laparoscopic access via the right lower quadrant, via the left lower quadrant, and via the midline. Respondent admits that she had suspicion of entering the small bowel. Respondent is without sufficient knowledge or information to form a belief as to the truth of the remaining allegations contained in Paragraph 7, and on that basis denies each and every remaining allegation contained therein.

8. Respondent admits she attempted to gain access through the midline. Respondent is without sufficient knowledge or information to form a belief as to the truth of the remaining allegations contained in Paragraph 8, and on that basis denies each and every remaining allegation contained therein.

9. Respondent admits a small bowel injury was identified during the February 22, 2019 surgery. Respondent admits the small bowel was repaired with endo-GIA stapling device and sutures.

10. Respondent admits the incision was closed and Patient A was discharged without repairing the left inguinal hernia.

11. Respondent denies the allegations in Paragraph 11.

COUNT I

NRS 630.301(4) – Malpractice

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

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

14. Respondent admits 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."

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15. Respondent denies the allegations in Paragraph 15.

16. Respondent denies the allegations in paragraph 16 and denies that she is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

COUNT II

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

17. All of the responses to the allegations contained in the above paragraphs are hereby incorporated by reference as through fully set forth herein.

18. 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" constitute grounds for initiating discipline against a licensee.

19. Respondent denies the allegations in Paragraph 19.

20. Respondent denies the allegations in paragraph 20 and denies that she is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

AFFIRMATIVE DEFENSES

1. Respondent denies she committed malpractice as defined in Nevada Administrative Code Section 630.040.

2. Respondent denies she violated medical records requirements as defined in NRS 360.3062(1)(a).

3. Respondent contends that all medical records relating to the diagnosis, treatment and care of Patient A are timely, legible, accurate and complete in accordance with NRS 360.3062(1)(a).

4. There is documentation of the injury in the operative note.

5. Respondent contends that in all professional services rendered by Respondent to Patient A, Respondent possessed and exercised that degree of skill ordinarily possessed and exercised by reasonably well-qualified physicians practicing in the same field and acting

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under the same or similar conditions. At no time was Respondent guilty of malpractice or improper treatment.

6. The allegations in the Complaint with respect to Respondent, Patient A, and each and every purported cause for discipline fail to allege facts sufficient, or facts at all, to constitute a cause or causes for discipline against the Respondent.

7. At all times mentioned in the Complaint, Patient A was suffering from a medical condition which is one that Respondent did not cause, nor was Respondent responsible for said medical condition.

8. Patient A's medical conditions and/or injuries were the result of forces of nature over which this Respondent had no control.

9. Patient A's injuries were not the result of any acts of omission, commission, or malpractice, but were the results of known risks and complications which were consented to by Patient A, such risks being inherent in the nature of the care rendered and such risks were assumed by Patient A when he consented to the treatment.

10. Patient A's injuries, if any, were caused by the acts or inactions of persons beyond the control or right of control of Respondent and for whom Respondent is not liable or responsible.

11. Respondent has fully performed and discharged all obligations owed to Patient A, including meeting the requisite standard of care to which Patient A was entitled.

12. Respondent denies that Patient A has sustained any injury, damage, or loss by reason of any act or omission on the part of Respondent.

13. If patient A sustained any injuries or damages, such were the result of intervening or superseding events, factors, occurrences or conditions, which were in no way caused by Respondent, and for which Respondent is not subject to discipline.

14. Patient A knew, or in the exercise of ordinary care was charged with knowledge, that he was submitting himself to medical techniques, treatment and/or medication with full knowledge of the risks attendant thereto.

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15. Respondent alleges allege that the injuries and damages, if any, suffered by Patient A can and do occur in the absence of malpractice.

16. Patient A was a candidate for the procedure Respondent performed.

17. Respondent performed Patient A's procedure within the standard of care.

18. By responding to this Complaint, Respondent does not stipulate to the authenticity or admissibility of any medical records as they are hearsay.

19. The Complaint, or portions thereof, should be dismissed on grounds of due process and equal protection, including the right to an unbiased investigation. *See Mishler v. Clift, M.D. et al*, 191 F.3d 998 (9th Cir. 1999).

20. Any scope of practice allegations should be dismissed, as the statutes and regulations are unconstitutionally vague and ambiguous as applied to the subject matter of this case, and do not clearly prohibit the conduct which the Board seeks to discipline.

21. Respondent objects to the Complaint on the ground that it does not state acts or omissions upon which the agency may proceed.

22. NRS 622.400 is unconstitutional on due process and/or equal protection grounds. Alternatively, if such provision is constitutional, the statute should be interpreted as mutual and reciprocal, and Respondent is entitled to and hereby prays for an award against the Complainant of the Respondent's costs and/or fees in his investigation, preparation and defense to the Board's charges herein, to the extent that she prevails. If not reciprocal, then Complainant should receive a cost recovery, if at all, proportionate to the extent it prevails.

23. The Nevada State Board of Medical Examiners exceeded its regulatory function by proceeding to file a Complaint without informing Respondent of the investigation and without giving Respondent an opportunity to respond to the allegations.

24. The Nevada State Board of Medical Examiners exceeded its regulatory function by proceeding to file a Complaint prior to meeting the statutory requirements.

25. This Complaint does not further the goal of public protection or protection of the public health, safety or morals.

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26. The Complaint, or portions thereof, should be dismissed on grounds of equitable estoppel.

27. The Complaint is barred by the doctrine of laches.

28. The Nevada State Board of Medical Examiners violated Respondent's due process rights as Investigative Committee member Chowdhury H. Ahsan, M.D. was a treating provider of Patient A and this conflict was not disclosed or addressed by the Board.

29. The Nevada State Board of Medical Examiners violated Respondent's due process rights as the Investigative Committee obstructed Respondent's right to have an Order entered on her Motion to Dismiss in case 22-11660-1 where the Hearing Officer ordered that the Complaint should be dismissed due to the undisclosed conflict of interest of Investigative Committee member Chowdhury H. Ahsan, M.D.

30. The Nevada State Board of Medical Examiners violated Respondent's due process rights as the Investigative Committee in case 23-11660-1 failed to conduct a complete and proper investigation regarding this matter and instead relied on the flawed investigation conducted by the Investigative Committee in case 22-11660-1.

31. All possible affirmative defenses many not have been alleged herein insofar as sufficient facts were not available after reasonable inquiry upon the filing of this Answer. Respondent therefore reserves the right to amend this Answer to allege additional affirmative defenses if subsequent investigation warrants.

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Based on the above, Respondent Dr. Barber respectfully requests that she be assessed no administrative penalty or any sanctions authorized by NRS 630.352. Dr. Baber submits that no violation of the Medical Practice Act occurred and the facts of this case do not support the allegations in the Complaint.

Dated: December 12, 2023

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

CERTIFICATE OF SERVICE

I hereby certify that on this 12th day of December, 2023, a true and correct copy of RESPONDENT'S ANSWER TO COMPLAINT was served by email to the following parties:

Donald K. White, J.D. Deonne Contine 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov dcontine@medboard.nv.gov *Attorneys for the Investigative Committee*	

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

In the Matter of Charges and Complaint Against ANNABEL ELIZABETH BARBER, M.D., Respondent.	**CASE NO. 23-11660-1** **Early Case Conference: 1:00 P.M.** **December 28, 2023**

FILED
DEC 27 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

NOTICE AND ORDER SCHEDULING EARLY CASE CONFERENCE

TO: DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL, NEVADA STATE BOARD OF MEDICAL EXAMINERS, 9600 GATEWAY DRIVE RENO, NV 89521

SCHON COLBY ROBERTS, M.D., C/O PATRICIA EGAN DAEHNKE, ESQ., COLLINSON, DAEHNKE, INLOW & GRECO 2110 E. FLAMINGO ROAD, SUITE 212, LAS VEGAS, NV 89119

NOTICE IS HEREBY GIVEN that on November 17, 2023, a Complaint was filed in the name of the Investigative Committee of the Nevada State Board of Medical Examiners pursuant to Chapter 630 of the Nevada Revised Statutes, charging Respondent with violation of the Medical Practice Act. A true and correct copy of said Complaint was personally served upon Respondent on November 22, 2023, and is hereby incorporated by this reference.

Based upon the calendar of the undersigned Hearing Office this Notice and Order Scheduling an Early Case Conference is hereby filed.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that in compliance with NRS 630.339(3)[1], **an Early Case Conference will be conducted on December 28, 2023, beginning**

[1] 3. 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:

(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 be required for the matter;

at the hour of 1:00 P.M., in the Conference Room at the Office of the Nevada State Board of Medical Examiners, located at 9600 Gateway Drive, Reno, Nevada 89521, or as soon thereafter as it may be heard.

NOTICE IS FURTHER HEREBY GIVEN that the 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 in order to discuss and designate the dates for the Pre-Hearing Conference and Hearing and other procedural matters established in NRS 630.339. Respondent may elect to participate in the Early Case Conference by telephone if prior arrangements are made with the General Counsel for the Investigative Committee of the Nevada State Board of Medical Examiners in sufficient time prior to the time and date fixed to arrange that alternative means of participation.

NOTICE IS FINALLY HEREBY GIVEN that the possible sanctions authorized by NRS 630.352 and NRS 622.400 to be imposed on the Respondent based on a sustained charge in regard to one or more of the issues raised in said Complaint include one or more of the following sanctions:

A. Placement on probation for a specified period on any of the conditions specified in the order;

B. Administration of a public reprimand;

C. Suspension of his license for a specified period or until further order of the Board;

D. Revocation of his license to practice;

E. A requirement that he participate in a program to correct alcohol or drug dependence or any other impairment;

F. A requirement that there be specified supervision of his practice;

G. A requirement that he perform public service without compensation;

H. A requirement that he take a physical or mental examination or an examination testing his medical competence;

I. A requirement that he fulfill certain training or educational requirements, or both,

---

(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.

as specified by the Board;

J. Imposition of a fine on you not to exceed $5,000 for each violation;

K. A requirement that a practitioner licensed by the State Board of Medical Examiners, pursuant to NRS 622.400 pay all costs incurred by the Board relating to the disciplinary proceedings as more fully set forth in said statute.

DATED this 27 day of December, 2023.



CHARLES B. WOODMAN, Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

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 NOTICE AND ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 GATEWAY DRIVE
RENO, NV 89521

ANNABEL ELIZABETH BARBER, M.D.
C/O PATRICIA EGAN DAEHNKE, ESQ.
COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. FLAMINGO ROAD, SUITE 212
LAS VEGAS, NV 89119

DATED this 27th day of December, 2023

MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners

UNITED STATES POSTAL SERVICE

January 16, 2024

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED
JAN - 5 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

In the Matter of Charges and Complaint Against ANNABEL ELIZABETH BARBER, M.D., Respondent.	**CASE NO.: 23-11660-1**

NOTICE AND ORDER SCHEDULING PRE-HEARING AND HEARING

TO: Donald K. White, Senior Deputy General Counsel, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, NV 89521

Annabel Elizabeth Barber, M.D., c/o Patricia Egan Daehnke, Esq. and Amanda Rosenthal, Esq., Collinson, Daehnke, Inlow & Greco 2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119

On Thursday, December 28, 2023, a telephonic Early Case Conference was conducted in this matter. Donald K. White, Esq. was present on behalf of the Investigative Committee in the conference room of the Nevada State Board of Medical Examiners. Patricia Egan Daehnke, Esq. and Amanda Rosenthal, Esq., appeared telephonically on behalf of Respondent. The undersigned Hearing Officer also participated telephonically. Formal dates were set for the pre-hearing conference, exchange of documents, and the hearing date.

Accordingly, in compliance with NAC 630.465, **a pre-hearing conference will be conducted on Wednesday, May 15, 2024, beginning at the hour of 1:30 P.M.**, Pacific Standard Time, in the conference room at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. The conference, to be attended by the parties in person or by counsel,[1] will be conducted before the undersigned hearing officer to assure that all written information and documentation to be presented by the parties at the formal hearing is fully and completely exchanged.

[1]Respondent or Respondent's counsel may participate in the pre-hearing conference by telephone if prior arrangements are made with counsel for the Investigative Committee.

At the pre-hearing conference each party is to provide the other party with a copy of the list of witnesses they intend to call to testify, including their qualifications, as well as a brief summary of their 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.

The formal hearing in this matter is hereby scheduled for Thursday, June 20, 2024, commencing at 9:00 A.M. and Friday, June 21, 2024, commencing at 9:00 A.M. at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. Respondent must be present at the hearing in person. Following the hearing, the hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. **NAC 630.470.**

Any other hearings previously set in this matter which conflict with the hearing schedule set out herein are vacated.

All further pleadings in this case will be served upon Respondent's counsel in accordance with the Board's standard practices.

It is further ordered that legal counsel for the Investigative Committee and Respondent or Respondent's counsel shall keep this hearing officer advised of each issue which has been resolved by negotiation or stipulation, or any other change in the status of this case.

DATED this 5 day of January, 2024

CHARLES B. WOODMAN, ESQ., Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

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 document addressed as follows:

Donald K. White, Senior Deputy General Counsel, Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, NV 89521

Annabel Elizabeth Barber, M.D., c/o Patricia Egan Daehnke, Esq. or Amanda Rosenthal, Esq., Collinson, Daehnke, Inlow & Greco 2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119

DATED this 5th day of January, 2024.

Legal Assistant
Nevada State Board of Medical Examiners

UNITED STATES POSTAL SERVICE

January 16, 2024

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

FILED
FEB 27 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

In the Matter of Charges and Complaint Against ANNABEL ELIZABETH BARBER, M.D., Respondent.	**CASE NO. 23-11660-1** **Early Case Conference: 3:30 P.M. February 27, 2024**

NOTICE AND ORDER SCHEDULING EARLY CASE CONFERENCE

TO: DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL, NEVADA STATE BOARD OF MEDICAL EXAMINERS, 9600 GATEWAY DRIVE RENO, NV 89521

ANNABEL ELIZABETH BARBER, M.D., C/O PATRICIA EGAN DAEHNKE, ESQ., COLLINSON, DAEHNKE, INLOW & GRECO 2110 E. FLAMINGO ROAD, SUITE 212, LAS VEGAS, NV 89119

NOTICE IS HEREBY GIVEN that on November 17, 2023, a Complaint was filed in the name of the Investigative Committee of the Nevada State Board of Medical Examiners pursuant to Chapter 630 of the Nevada Revised Statutes, charging Respondent with violation of the Medical Practice Act. A true and correct copy of said Complaint was personally served upon Respondent on November 22, 2023, and is hereby incorporated by this reference.

Based upon the calendar of the undersigned Hearing Office this Notice and Order Scheduling an Early Case Conference is hereby filed.

ACCORDINGLY, NOTICE IS HEREBY GIVEN that in compliance with NRS 630.339(3)[1], **an Early Case Conference will be conducted on February 27, 2024, beginning**

[1]3. 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:

(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 be required for the matter;

at 3:30 P.M., in the Conference Room at the Office of the Nevada State Board of Medical Examiners, located at 9600 Gateway Drive, Reno, Nevada 89521, or as soon thereafter as it may be heard.

NOTICE IS FURTHER HEREBY GIVEN that the 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 in order to discuss and designate the dates for the Pre-Hearing Conference and Hearing and other procedural matters established in NRS 630.339. Respondent may elect to participate in the Early Case Conference by telephone if prior arrangements are made with the General Counsel for the Investigative Committee of the Nevada State Board of Medical Examiners in sufficient time prior to the time and date fixed to arrange that alternative means of participation.

NOTICE IS FINALLY HEREBY GIVEN that the possible sanctions authorized by NRS 630.352 and NRS 622.400 to be imposed on the Respondent based on a sustained charge in regard to one or more of the issues raised in said Complaint include one or more of the following sanctions:

A. Placement on probation for a specified period on any of the conditions specified in the order;

B. Administration of a public reprimand;

C. Suspension of his license for a specified period or until further order of the Board;

D. Revocation of his license to practice;

E. A requirement that he participate in a program to correct alcohol or drug dependence or any other impairment;

F. A requirement that there be specified supervision of his practice;

G. A requirement that he perform public service without compensation;

H. A requirement that he take a physical or mental examination or an examination testing his medical competence;

I. A requirement that he fulfill certain training or educational requirements, or both,

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(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.

as specified by the Board;

J. Imposition of a fine on you not to exceed $5,000 for each violation;

K. A requirement that a practitioner licensed by the State Board of Medical Examiners, pursuant to NRS 622.400 pay all costs incurred by the Board relating to the disciplinary proceedings as more fully set forth in said statute.

DATED this 27 day of February, 2024.

CHARLES B. WOODMAN, Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

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 NOTICE AND ORDER SCHEDULING EARLY CASE CONFERENCE addressed as follows:

DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 GATEWAY DRIVE
RENO, NV 89521

ANNABEL ELIZABETH BARBER, M.D.
C/O PATRICIA EGAN DAEHNKE, ESQ.
COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. FLAMINGO ROAD, SUITE 212
LAS VEGAS, NV 89119

DATED this 21st day of February, 2024.

MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED
FEB 29 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

In the Matter of Charges and Complaint Against ANNABEL ELIZABETH BARBER, M.D., Respondent.	**CASE NO.: 23-11660-1**

NOTICE AND ORDER RESCHEDULING PRE-HEARING AND HEARING

TO: DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 GATEWAY DRIVE
RENO, NV 89521

ANNABEL ELIZABETH BARBER, M.D., c/o PATRICIA EGAN DAEHNKE, ESQ., COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. FLAMINGO ROAD, SUITE 212
LAS VEGAS, NV 89119

On Tuesday, February 27, 2024, a telephonic conference was conducted in this matter. Donald White was present on behalf of the Investigative Committee in the conference room of the Nevada State Board of Medical Examiners, and Patricia Daehnke and Amanda Rosenthal appeared telephonically on behalf of Annabel Elizabeth Barber, M. D. The undersigned Hearing Officer appeared telephonically as well. The parties agreed to new dates for the pre-hearing conference, exchange of documents, and the hearing date.

Accordingly, in compliance with NAC 630.465, **a pre-hearing conference will be conducted on Thursday, May 2, 2024 commencing at 2:00 P.M.,** in the conference room at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. The conference to be attended by the parties in person or by counsel,[1] will be conducted before the undersigned hearing officer to assure that all written information and documentation to be presented by the parties at the formal hearing is fully and completely exchanged.

[1]Respondent or Respondent's counsel may participate in the pre-hearing conference by telephone if prior arrangements are made with counsel for Investigative Committee.

At the pre-hearing conference each party is to provide the other party with a copy of the list of witnesses they intend to call to testify, including their qualifications, as well as a brief summary of their 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. **All motions are to be filed no later than Friday, May 24, 2024 by 5:00 P.M. Responses to motions are to be filed by Friday May 31, 2024 by 5:00 P.M.**

The formal hearing in this matter is hereby scheduled for Tuesday, June 4, 2024, commencing at 9:00 A.M. and continuing on Wednesday, June 5, 2024, commencing at 9:00 A.M., at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. Respondent must be present at the hearing in person. Following the hearing, the hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. **NAC 630.470.**

Any other hearings previously set in this matter which conflict with the hearing schedule set out herein are vacated.

It is further ordered that legal counsel for the Investigative Committee and Respondent or Respondent's counsel shall keep this hearing officer advised of each issue which has been resolved by negotiation or stipulation, or any other change in the status of this case.

DATED this 28 day of February, 2024

CHARLES B. WOODMAN, ESQ., Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

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 document addressed as follows:

DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 GATEWAY DRIVE
RENO, NV 89521

ANNABEL ELIZABETH BARBE, M.D.
c/o PATRICIA EGAN DAEHNKE, ESQ.
COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. FLAMINGO ROAD, SUITE 212
LAS VEGAS, NV 89119

DATED this 21st day of February, 2024.

MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED

MAY 0 1 2024

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

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 Notice and Order Rescheduling Pre-hearing and Hearing filed on February 29, 2024.

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. Monica Gustafson, Investigator
Nevada State Board of Medical Examiners

Ms. Gustafson is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Annabel Elizabeth Barber, M.D.

Dr. Barber is expected to testify regarding the facts and circumstances surrounding the formal Complaint in this case.

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c. Nicholas Spoerke, M.D., FACS

Dr. Spoerke is a Board-Certified General and Critical Care Surgeon and is licensed to practice medicine in the State of Nevada. Dr. Spoerke 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 her prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons she 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, Order and Response to Allegation Letter	001-048
2	Dr. Davis's Request Letter and Statement of Treatment	049-079
3	Dr, Javed's 2nd Request & Request Letters and Statements	080-083
4	Las Vegas Surgery Center – Request Letter and Records	084-132
5	CV of Nicholas Spoerke, M.D., FACS	133-0136
6	Diagnostics from University Medical Center	137
7	Diagnostic Films from Spring Valley Hospital	138

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Reno, Nevada 89521
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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 before the Prehearing Conference.

DATED this 1ST day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 1st day of May, 2024, 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 FedEx Priority Overnight, postage pre-paid, to the following parties:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. and Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

CHARLES B. WOODMAN, ESQ.
548 W. Plumb Lane, Suite B
Reno, NV 89501

Rosenthal Tracking No.: 776191169029

Woodman Tracking No.: 776191295761

With courtesy copy by email to:

Patricia Daehnke, Esq., at [Patricia.Daehnke@cdiglaw.com]
Charles B. Woodman Esq. at [hardywoodmanlaw@msn.com]

DATED this 1st day of May, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

May 02, 2024

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The following is the proof-of-delivery for tracking number: 776191169029

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Reference 23-11660-1 Barber



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		Delivery date:	May 2, 2024 10:29

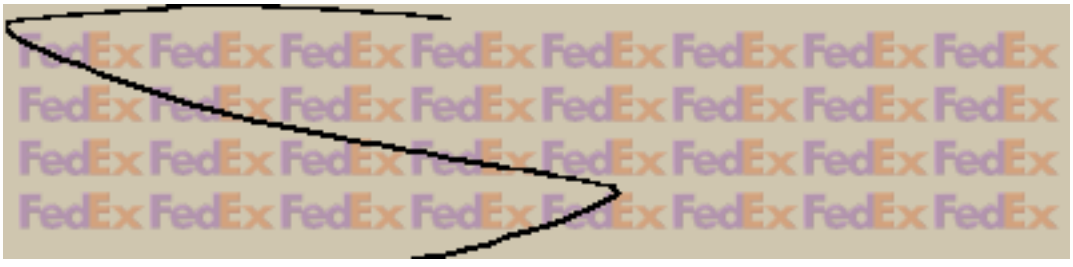
Shipping Information:

Tracking number:	776191295761	**Ship Date:**	May 1, 2024
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Charles Woodman, Esq.,
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Reference 23-11660-1 Barber



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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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FILED

MAY - 2 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

RESPONDENT ANNABEL ELIZABETH BARBER, M.D.'S PREHEARING CONFERENCE STATEMENT

COMES NOW, Respondent Annabel Elizabeth Barber, M.D. by and through his counsel of record, and hereby submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Notice and Order Rescheduling Pre-Hearing and Hearing filed on February 29, 2024.

List of Witnesses

Respondent Dr. Barber lists the following witnesses whom she may call at the hearing on the charges in the Complaint against her filed herein.

A. Annabel Elizabeth Barber, M.D.

Dr. Barber is expected to testify regarding the care and treatment provided to Patient A as well as the facts and circumstances surrounding the allegations in the Complaint. Dr. Barber's qualifications are set forth in her Curriculum Vitae.

B. Arnold Baskies, M.D.

Dr. Baskies is a board-certified general surgeon and is expected to testify regarding the care and treatment provided to Patient A, as well as standard of care and causation and the allegations in the Complaint. Dr. Baskies' qualifications are set forth in his Curriculum Vitae.

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C. Maxwell Vest, M.D.

Dr. Vest was the assistant surgeon during Patient A's February 22, 2019 surgery. Dr. Vest is expected to testify regarding the care and treatment provided to Patient A as well as the facts and circumstances surrounding the allegations in the Complaint.

D. All witnesses identified by the Investigative Committee of the Nevada State Board of Medical Examiners in its prehearing conference statement and any amendments, revisions or supplements thereto.

Dr. Barber reserves the right to amend and supplement this list as necessary as this case progresses.

List of Exhibits

Respondent Dr. Barber lists the following exhibits she may introduce at the hearing on the charges and complaint against her.

1. Nevada State Board of Medical Examiners inquiry letter dated October 28, 2019, bates Barber 000001-000002.

2. Dr. Barber's response to the Nevada State Board of Medical Examiners inquiry letter dated November 15, 2019, bates Barber 000003.

3. Patient A's medical records from UNLV Medicine, previously provided to the Nevada State Board of Medical Examiners with Dr. Barber's response to the inquiry letter, bates Barber 000004-000046.

4. Patient A's January 15, 2019 CT Abdomen Pelvis Without Contrast from Desert Radiology, bates Barber 000047.

5. Patient A's Las Vegas Surgery Center medical records, bates Barber 000048-000096.

6. Complaint filed on November 17, 2023, bates Barber 000097-000101.

7. Dr. Barber's Answer to Complaint filed on December 12, 2023, bates Barber 000102-000109.

8. Annabel Barber, M.D.'s Curriculum Vitae, bates Barber 000110-000129.

9. Arnold Baskies, M.D.'s Curriculum Vitae, bates Barber 000130-000144.

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10. Maxwell Vest, M.D.'s qualification information from the Nevada State Board of Medical Examiners, bates Barber 000145-000148.

11. Complaint filed in case 22-11660-1 on September 20, 2022, bates Barber 000149-000153.

12. Order of dismissal without prejudice, filed on November 16, 2023, bates Barber 000154.

13. Patient A's January 15, 2019 CT Abdomen Pelvis Without Contrast films from Desert Radiology, to be requested through the Board and produced upon receipt.

Respondent Dr. Barber reserves the right to use any exhibits relied upon or identified by the Investigative Committee of the Nevada State Board of Medical Examiners and further reserves the right to amend and supplement this list to include any additional documents as required.

Dated: May 1, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on this 1st day of May, 2024, a true and correct copy of **RESPONDENT ANNABEL ELIZABETH BARBER, M.D.'S PREHEARING CONFERENCE STATEMENT** was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Charles B. Woodman, Esq. Woodman Law Group 548 W. Plumb Lane, Suite B Reno, NV 89509 hardywoodmanlaw@msn.com tiffany@woodmanlawgroup.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

FILED

MAY 24 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

In the Matter of Charges and Complaint Against:	**Case No. 23-11660-1**
ANNABEL ELIZABETH BARBER, M.D.	**ANNABEL ELIZABETH BARBER, M.D.'S MOTION TO EXCLUDE EVIDENCE AT HEARING**
Respondent.	

Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby moves to exclude evidence of the "Diagnostics from University Medical Center" (Exhibit 6), "Diagnostics Films from Spring Valley Hospital" (Exhibit 7), letter from Dr. Davis (Exhibit 2), and letter from Dr. Javed (Exhibit 3) as exhibits or evidence in this matter. This Motion is brought pursuant to NRS 622A.360(2)(f), the attached Memorandum of Points and Authorities, and any argument that a hearing officer or panel will allow upon a hearing in this matter.

Dated: May 24, 2024 **COLLINSON, DAEHNKE, INLOW & GRECO**

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
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2110 E. Flamingo Road, Suite 212
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Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The Investigative Committee of the Nevada State Board of Medical Examiners filed their Complaint in this matter on November 17, 2023. Exhibit A, Complaint. The Complaint relates to Respondent's care and treatment of Patient A. Generally, the Complaint alleges that Respondent failed to use proper discretion when making surgical decisions in relation to Patient A's February 22, 2019 surgery by performing a laparoscopic surgery on a patient with an extensive surgical history and surgical scarring. The Complaint further generally alleges that Respondent failed to correctly document her actions during surgery and Patient A's extensive medical history. The Complaint alleges the following Counts:

- Count I: Malpractice (NRS 630.301(4); and
- Count II: Failure to Maintain Accurate Medical Records (NRS 630.3062(1)(a).

Respondent denies she violated the provisions of the Medical Practice Act (NRS 630 and NAC 630).

The parties conducted a Prehearing Conference on May 2, 2024. At the Prehearing Conference, counsel for Dr. Barber requested leave to file motions in limine. The Hearing Officer indicated he would consider any motions as filed and make determinations as to whether such were appropriate.

In their Prehearing Conference Statement, the Investigative Committee listed "Diagnostics from University Medical Center" and "Diagnostics Films from Spring Valley Hospital" as exhibits in this matter. Exhibit B, Prehearing Statement at Exhibits 6 and 7. The diagnostic imaging from University Medical Center and Spring Valley Hospital is irrelevant and immaterial as to the issues set forth in the Investigative Committee's Complaint. The sole allegations in the Complaint relate to Dr. Barber's care and treatment of Patient A on or before February 22, 2019 when she performed surgery at Las Vegas Surgery Center. The sole focus of the Complaint is Dr. Barber's decision-making in determining to proceed with a laparoscopic procedure in a patient with an extensive surgical history and surgical scarring, which the Investigative Committee alleges is contraindicated. Nothing in the Complaint relates to anything that occurred at University Medical Center or Spring Valley Hospital.

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Whether or not Patient A had continuing care and treatment at University Medical Center or Spring Valley Hospital has no bearing on whether or not Respondent violated the Nevada Medical Practice Act on February 22, 2019, which is the sole focus of the Complaint. The imaging films are irrelevant, immaterial, are a waste of time, and are prejudicial. There is no reason for their introduction at the Hearing in this matter and they should be excluded.

Likewise, the Investigative Committee also designated letters from treating providers Dr. Davis and Dr. Javed as exhibits in this matter. Exhibit B, Prehearing Statement at Exhibits 2 and 3. Both Dr. Davis and Dr. Javed treated Patient A subsequent to the February 22, 2019 surgery. Neither Dr. Davis nor Dr. Javed were involved in Patient A's medical care and treatment on February 22, 2019 or prior to February 22, 2019. It is unclear why the correspondence from these treating providers has been designated, as neither has been designated as a witness in this matter. Their letters are hearsay, and Respondent is unable to cross-examine the physicians who purportedly drafted the hearsay letters. Information regarding Patient A's subsequent care and treatment is simply irrelevant, immaterial, a waste of time, and prejudicial, as the sole focus of the Hearing in this matter is on Dr. Barber's decision-making related to the February 22, 2019 surgery and her documentation of the surgery and her pre-operative care. The correspondence from Dr. Davis and Dr. Javed should be excluded.

II. HISTORY OF RELEVANT CARE AND TREATMENT

The allegations in the Complaint relate solely to Dr. Barber's care and treatment on February 22, 2019 at prior. Patient A first saw Respondent Annabel Barber, M.D. on December 27, 2018 at UNLV. He had been referred to Dr. Barber for a left inguinal hernia repair. Dr. Barber planned to obtain a CT scan. The CT scan was performed on January 15, 2019 at Desert Radiology.

On February 22, 2019, Patient A presented to Las Vegas Surgery Center for a planned laparoscopic left inguinal hernia repair with mesh. This February 22, 2019 surgery is the surgery at issue in this case. Patient A was discharged home after surgery to follow up with Dr. Barber.

On February 25, 2019, Patient A presented to University Medical Center. Patient A

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received care and treatment at University Medical Center until March 10, 2019.

Patient A was thereafter admitted to Spring Valley Hospital several times. Dr. Barber did not treat Patient A at Spring Valley Hospital.

III. EVIDENCE TO BE EXCLUDED

In their Prehearing Conference Statement, the Investigative Committee listed "Diagnostics from University Medical Center" and "Diagnostics Films from Spring Valley Hospital" as exhibits in this matter. Exhibit B, Prehearing Statement at Exhibits 6 and 7. Specifically, the diagnostics from UMC produced by the Investigative Committee as Exhibit 6 are as follows:

- 2/25/2019 - XR Chest 1 View Portable
- 2/26/2019 - XR Chest 1 View Portable
- 2/27/2019 - XR Chest 1 View Portable
- 2/28/2019 - XR Chest 1 View Portable
- 3/1/2019 – IR PICC Placement
- 3/1/2019 - XR Chest 1 View Portable
- 3/2/2019 - XR Chest 1 View Portable
- 3/3/2019 - XR Chest 1 View Portable
- 3/4/2019 - XR Chest 1 View Portable
- 3/5/2019 - XR Chest 1 View Portable
- 3/6/2019 – XR Chest 1 View Portable
- 3/7/2019 – XR Chest 1 View Portable

The diagnostics from Spring Valley Hospital produced by the Investigative Committee as Exhibit 7 are as follows:

- 3/28/2019 – XR Chest 2 Views
- 3/28/2019 - CT Abdomen/Pelvis w/Contrast
- 3/29/2019 – CT Drainage Peritoneal
- 4/1/2019 - CT Abdomen/Pelvis w/Contrast
- 4/1/2019 – XR Sinus Tract Injection
- 4/3/2019 – CT Abdomen/Pelvis w/Contrast
- 4/5/2019 – XR Chest 2 Views

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- 4/16/2019 – XR Chest 1 View Frontal
- 4/17/2019 - CT Abdomen/Pelvis w/Contrast
- 6/7/2019 – US UE Arterial Duplex Right
- 6/9/2019 – XR Chest 1 View Frontal
- 6/24/2019 – CR Abdomen/Pelvis w/Contrast
- 6/26/2019 – XR Sinus Tract Injection
- 7/15/2019 – CT Abdomen/Pelvis w/Contrast
- 7/16/2019 – US UE Venous Duplex Right
- 7/17/2019 – XR Sinus Tract Injection
- 7/17/2019 – XR Abdomen AP

Notably, the Investigative Committee did not designate the corresponding radiology reports for any of these films and it is unclear who will be testifying regarding the interpretation of these films.

The Investigative Committee also designated letters from treating providers Dr. Davis and Dr. Javed as exhibits in this matter. John Davis, M.D. treated Patient A at Spring Valley Hospital beginning on March 28, 2019. *See* Exhibit B at Exhibit 2. Dr. Javed treated Patient A at the Spring Valley Hospital Advanced Wound Care and Hyperbaric Center for wound care from March 28, 2019 – March 10, 2020. *See* Exhibit B at Exhibit 3. Neither of these treating providers were involved with Patient A's care and treatment on February 22, 2019 or prior.

IV. AUTHORITY FOR THIS MOTION

Pursuant to NRS 622A.360(f), a party may file, with leave of the hearing panel officer, "any other motion requesting appropriate action or relief." In this case, Dr. Barber requested leave to file this Motion at the May 2, 2024 Prehearing Conference. To the extent necessary, Dr. Barbar again respectfully requests leave for this motion in limine, as Dr. Barber believes the evidence the Investigative Committee has designated is irrelevant, immaterial, a waste of time, and will be prejudicial. Dr. Barber respectfully requests that the Hearing Officer consider this Motion. Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing. However,

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NRS 622A.360 specifically provides provisions for parties to "request a ruling" from the hearing officer on "any issue of law or procedure in a case," by filing motions as set forth in NRS 622A.360.

V. LEGAL STANDARD

A motion in limine may be used to limit the introduction of evidence at trial. *Luce v. United States,* 469 U.S. 38, 41, 105 S.Ct. 460, n.4 (1984). The primary use of a motion in limine is to determine in advance whether the court will admit or exclude specific items of evidence at the time of trial. *See generally, Bayerische Motoren Werke Aktiengesellschaft v. Roth,* 127 Nev. 122, 252 P.3d 649 (2011). Motions in limine enable a party to preclude the introduction of evidence to avoid undue prejudice. *Edwards v. Centex Real Estate Corp.*, 53 Cal.App.4th 15, 61 Cal.Rptr.2d 518, 524 (1997) ("A motion in limine is made to exclude evidence before the evidence is offered at trial, on grounds that it would be insufficient to object to or move to strike the evidence."); *Kelly v. New W. Fed. Says,* 49 Cal.App.4th 659, 56 Cal.Rptr.2d 803, 808 (1996) (noting that pretrial motions in limine to preclude the introduction of prejudicial evidence "avoid the obviously futile attempt to 'unring the bell' once the evidence is before the jury.").

The Investigative Committee has the burden of proof in this matter. NRS 622A.370(1). The standard of proof for this matter is a preponderance of the evidence. *Id.*; NRS 630.346(2). The hearing officer is not bound by strict rules of procedure or rules of evidence, except that evidence must be taken and considered in the Hearing pursuant to NRS 233B.123. NRS 622A.370(2). Similarly, NRS 630.346 provides that the hearing officer is "not bound by formal rules of evidence, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123, and a witness must not be barred from testifying solely because the witness was or is incompetent."

Pursuant to NRS 233B.123(1), "irrelevant, immaterial or unduly repetitious evidence must be excluded." "Evidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs." NRS 233B.123. Pursuant to NRS 233B.123, "each party may call and examine

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witnesses, introduce exhibits, cross-examine opposing witnesses on any matter relevant to the issues . . . ." (emphasis added).

In *Nassiri v. Chiropractic Physicians' Board of Nevada*, the Nevada Supreme Court explained:

> Although administrative proceedings typically need not strictly follow the rules of evidence, *see* NRS 233B.123(1) (allowing the admittance of evidence during administrative proceedings "except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs"), the fact-finder is charged with making a decision based only on evidence of a type and amount that will ensure a fair and impartial hearing. *See* NRS 233B.125; *State, Dep't of Motor Vehicles & Pub. Safety v. Evans*, 114 Nev. 41, 44–45, 952 P.2d 958, 961 (1998); *Steamboat Canal Co. v. Garson*, 43 Nev. 298, 308–09, 185 P. 801, 804 (1919). The substantial evidence standard of review thus refers to the quality and quantity of the evidence necessary to support factual determinations. It contemplates deference to those determinations on review, asking only whether the facts found by the administrative factfinder are reasonably supported by sufficient, worthy evidence in the record. *See U.S. Steel Mining Co. v. Dir., Office of Workers' Comp. Programs*, 187 F.3d 384, 389 (4th Cir.1999) (explaining that, under analogous federal Administrative Procedure Act provisions, an agency fact-finder has a "duty to qualify evidence as reliable, probative, and substantial before relying upon it to grant or deny a claim," so to avoid a decision based on speculation and conjecture (internal quotations omitted)); 3 Charles H. Koch, Jr., *Administrative Law and Practice* § 9:24[1] (3d ed.2010) (explaining that "substantial evidence" language most often conveys a reasonableness standard of review, leaving the decision-making power with the agency).

Nassiri v. Chiropractic Physicians' Bd. of Nev., 327 P.3d 487, 130 Nev. Adv. Op. 27 (Nev. 2014). Thus, in considering this Motion, the issue is whether the evidence at issue is reliable, worthy, and probative to ensure a fair and impartial hearing.

Although the Nevada rules of evidence may not technically apply in administrative hearing, the hearing officer may follow those rules at their discretion. Pursuant to NRS 48.015, relevant evidence is evidence "having any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence," that is, evidence that is probative of some disputed issue in the case. NRS 48.015. There must be a "clear connection" between the evidence and the proposition for which it is offered. *See Beck v. State*, 105 Nev. 910, 912, 784 P.2d 983, 984 (1989). Evidence relevant only to a fact "not of consequence to the determination of the action"

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should be excluded. *Vipperman v. State*, 96 Nev. 592, 595, 614 P.2d 532, 534 (1980). NRS 48.035 also permits the evidence to be excluded if its "probative value is substantially outweighed by the danger of unfair prejudice, or confusion of the issues." Furthermore, relevant evidence may be excluded if its "probative value is substantially outweighed by considerations of undue delay, waste of time or needless presentation of cumulative evidence." NRS 48.035.

VI. ARGUMENT

Pursuant to NRS 233B.123(1), "irrelevant, immaterial or unduly repetitious evidence must be excluded." Emphasis added. The imaging films from University Medical Center and Spring Valley Hospital, along with the correspondence from Dr. Davis and Dr. Javed, are entirely irrelevant and immaterial to the issues in this case. The imaging and correspondence have no tendency to make the existence of any fact that is of consequence to this action more or less probable than it would be without the evidence. Furthermore, this evidence is unduly repetitious and will result in a waste of time.

In this case, the Investigative Committee bears the burden to prove the Counts in the Complaint, which focus solely on Respondent's decision to proceed with the February 22, 2019 laparoscopic surgery. 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." Pursuant to NRS 630.346, "proof of actual injury need not be established." Thus, in this case, the outcome of the patient's care and treatment is irrelevant, as is the patient's alleged need for further surgery or treatment. The outcome or complications suffered by the patient after February 22, 2019 is not relevant to the issues at Hearing. Instead, the relevant issue is whether Dr. Barber violated the Nevada Medical Practice Act on February 22, 2019 as alleged in the Complaint. What occurred after February 22, 2019 at University Medical Center or Spring Valley Hospital does nothing to prove or disprove whether Respondent used reasonable care, skill, or knowledge ordinarily used under similar circumstances in the care of Patient A on February 22, 2019. The imaging and

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correspondence from the treating providers at these other facilities does nothing to prove or disprove whether Respondent maintained accurate medical records.

The Investigative Committee has reviewed Respondent's care and treatment and has made specific allegations which the Investigative Committee believes violated the Nevada Medical Practice Act. In this case, the Complaint filed by the Investigative Committee solely focuses on Respondent's decision-making on February 22, 2019 and prior. The imaging from University Medical Center and Spring Valley Hospital all occurred after February 22, 2019. Furthermore, the Investigative Committee has not designated the related imaging reports to give the imaging any context, nor have they designated any witness who will testify as to the imaging. Respondent should not have to guess which imaging the Investigative Committee will discuss, nor should the Investigative Committee waste time presenting evidence that is irrelevant and immaterial to the issue in this case – which is simply Respondent's decision-making on February 22, 2019. Regarding the correspondence from the treating providers, they likewise relate to care and treatment that occurred after February 22, 2019, and have absolutely no bearing on Respondent's decision-making on February 22, 2019.

Additionally, the correspondence from the treating providers is irrelevant and immaterial as they consist entirely of inadmissible hearsay pursuant to NRS 51.065. Allegations or statements made by third parties are statements, other than those made by the declarant while testifying at the trial or hearing, offered into evidence to prove the truth of the matter asserted. *See* NRS 51.035. "Evidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs." NRS 233B.123. Hearsay statements such as these are not the type of evidence commonly relied upon by reasonable and prudent persons in the conduct of their affairs.

Furthermore, allowing the Investigative Committee to introduce the statements of Dr. Davis and Dr. Javed puts additional opinions in front of the fact-finder in an improper manner. Pursuant to NRS 233B.123, "each party may call and examine witnesses, introduce exhibits, cross-examine opposing witnesses on any matter relevant to the issues . . . ." The Investigative Committee has not designated Dr. Davis or Dr. Javed as witnesses. Respondent

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has no opportunity to cross-examine them. These physicians have not been retained by the Board, and their opinions and statements therefore have no place in this matter, where the Investigative Committee bears the burden of proof, and where Respondent is entitled to a fair hearing. Furthermore, a review of their statements does not indicate that they have any information, or provided any information, relevant to the issues in this case relating to Respondent's decision-making on February 22, 2019.

Additionally, the statements are unduly repetitious, which warrants their exclusion pursuant to NRS 233B.123(1). The Investigative Committee has designated expert witness Nicholas Spoerke, M.D. to provide expert opinions in this case regarding Respondent's care and treatment. Dr. Spoerke can testify to the issues necessary for the Investigative Committee to meet their burden of proof. There is no viable reason to allow hearsay statements from treating providers which are not relevant to any issues in this case. Use of the statements ensures there will not be a fair and impartial hearing in this matter. As such, they must be excluded.

VII. CONCLUSION

For the reasons set forth herein, Respondent respectfully requests that the Hearing Officer exclude evidence of the "Diagnostics from University Medical Center" (Exhibit 6), "Diagnostics Films from Spring Valley Hospital" (Exhibit 7), letter from Dr. Davis (Exhibit 2), and letter from Dr. Javed (Exhibit 3) as exhibits in this matter.

Dated: May 24, 2024 **COLLINSON, DAEHNKE, INLOW & GRECO**

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
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CERTIFICATE OF SERVICE

I hereby certify that on this 24th day of May, 2024, a true and correct copy of ANNABEL ELIZABETH BARBER, M.D.'S MOTION TO EXCLUDE EVIDENCE AT HEARING was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Charles B. Woodman, Esq. Woodman Law Group 548 W. Plumb Lane, Suite B Reno, NV 89509 hardywoodmanlaw@msn.com tiffany@woodmanlawgroup.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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Exhibit A

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 17 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018, when he presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Respondent ordered a CT scan "to define anatomy better."

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[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., 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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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4. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he had acquired short bowel syndrome.

5. Upon healing from those surgeries, Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

6. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laparoscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

7. Upon information and belief, during the surgery on February 22, 2019, Respondent made an attempt to gain laparoscopic access to the peritoneum via the right lower quadrant. When Respondent was unable to gain peritoneal access, it appears from her operative note that she tried to gain access via the left lower quadrant but was also unsuccessful. It appears, upon information and belief, that Respondent then attempted to access the peritoneum via a midline incision and immediately noticed that she had injured Patient A's bowel.

8. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision.

9. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures.

10. Respondent then closed the incision and discharged Patient A without having repaired Patient A's left inguinal hernia.

11. There was no documentation of the injury in the operative note which was unintelligibly written.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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14. 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."

15. 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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

16. 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

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

18. 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.

19. Respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

20. 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 her and give her notice that she 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;

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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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
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Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@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 17th day of November, 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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Exhibit B

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED

MAY 0 1 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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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 Notice and Order Rescheduling Pre-hearing and Hearing filed on February 29, 2024.

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. Monica Gustafson, Investigator
Nevada State Board of Medical Examiners

Ms. Gustafson is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Annabel Elizabeth Barber, M.D.

Dr. Barber is expected to testify regarding the facts and circumstances surrounding the formal Complaint in this case.

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c. Nicholas Spoerke, M.D., FACS

Dr. Spoerke is a Board-Certified General and Critical Care Surgeon and is licensed to practice medicine in the State of Nevada. Dr. Spoerke 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 her prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons she 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, Order and Response to Allegation Letter	001-048
2	Dr. Davis's Request Letter and Statement of Treatment	049-079
3	Dr, Javed's 2nd Request & Request Letters and Statements	080-083
4	Las Vegas Surgery Center – Request Letter and Records	084-132
5	CV of Nicholas Spoerke, M.D., FACS	133-0136
6	Diagnostics from University Medical Center	137
7	Diagnostic Films from Spring Valley Hospital	138

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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 before the Prehearing Conference.

DATED this 1st day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
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Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 1st day of May, 2024, 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 FedEx Priority Overnight, postage pre-paid, to the following parties:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. and Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

CHARLES B. WOODMAN, ESQ.
548 W. Plumb Lane, Suite B
Reno, NV 89501

Rosenthal Tracking No.: 776191169029

Woodman Tracking No.: 776191295761

With courtesy copy by email to:

Patricia Daehnke, Esq., at [Patricia.Daehnke@cdiglaw.com]
Charles B. Woodman Esq. at [hardywoodmanlaw@msn.com]

DATED this 1st day of May, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

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.

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.,** **Respondent.**	**Case No. 23-11660-1**

FILED
MAY 31 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' OPPOSITION TO RESPONDENT'S MOTION TO EXCLUDE EVIDENCE AT HEARING

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through its undersigned counsel hereby opposes Respondent's Motion to Exclude Evidence at Hearing filed May 24, 2024.

MEMORANDUM OF POINTS AND AUTHORITIES

I. BACKGROUND

On November 17, 2023, the IC filed a formal Complaint against Respondent based on her treatment of Patient A, spanning from in or about December 2018 through in or about February 2019.[1] The following assertions regarding Respondent's treatment of this patient are set forth in greater detail in the Complaint. The IC acknowledges that the parties' asserted facts will be the subject of the proceedings in this matter and will be tested through the adversarial process. Respondent was originally licensed to practice medicine in Nevada on July 1, 1997, and lists her specialties as abdominal surgery, colon/rectal surgery, and general surgery. Respondent's license is listed as active.

Respondent filed a motion to exclude the IC's Exhibits 6, 7, 2, and 3 relating to Respondent's care and treatment of Patient A. This request seemingly is based on contentions that

[1] The identity of Patients A is not disclosed herein to protect their privacy but was disclosed to Respondent in a Patient Designation served upon her along with the formal Complaint filed in this matter on November 17, 2023.

the exhibits are irrelevant, immaterial, are a waste of time, and are prejudicial. The IC opposes this motion as follows.

II. ARGUMENT

A. NRS 630 and NRS 233B Provide the Legal Standard for Determining Whether to Allow Evidence in an Administrative Hearing.

> **NRS 630.346** Board, panel or hearing officer not bound by formal rules of evidence; requirements for proof; burden of proof.
>
> In any disciplinary hearing:
>
> 1. The Board, a panel of the members of the Board and *a hearing officer are not bound by formal rules of evidence, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123,* and a witness must not be barred from testifying solely because the witness was or is incompetent.
> 2. A finding of the Board must be supported by a preponderance of the evidence.
> 3. Proof of actual injury need not be established.
> 4. A certified copy of the record of a court or a licensing agency showing a conviction or plea of nolo contendere or the suspension, revocation, limitation, modification, denial or surrender of a license to practice medicine, perfusion or respiratory care is conclusive evidence of its occurrence.

(Emphasis Added)

> **NRS 233B.123 Evidence.** In contested cases:
>
> 1. *Irrelevant, immaterial or unduly repetitious evidence must be excluded. Evidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs.* Agencies shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers may be made and must be noted in the record. Subject to the requirements of this subsection, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form.
> 2. Documentary evidence may be received in the form of authenticated copies or excerpts. Upon request, parties must be given an opportunity to compare the copy with the original.
> 3. Every witness shall declare, by oath or affirmation, that he or she will testify truthfully.
> 4. Each party may call and examine witnesses, introduce exhibits, cross-examine opposing witnesses on any matter relevant to the issues even though the matter was not covered in the direct examination, impeach any witness, regardless of which party first called the witness to testify, and rebut the evidence against him or her.

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> 5. Notice may be taken of judicially cognizable facts and of generally recognized technical or scientific facts within the specialized knowledge of the agency. Parties must be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material noticed, including any staff memoranda or data, and they must be afforded an opportunity to contest the material so noticed. The experience, technical competence and specialized knowledge of the agency may be utilized in the evaluation of the evidence.

(Emphasis Added)

Based on the foregoing, only evidence that is irrelevant, immaterial, or unduly repetitious must be excluded.

B. Legal Standards Cited by Respondent in His Motion Are Erroneous and Not Analogous to This Case and Are Not Applicable in Considering Respondent's Motion.

Interestingly, in the Motion, Respondent copies and incorporates in its "Legal Standard" section a long string cite quote from *Nassiri v. Chiropractic Physicians' Bd of Nev.,* 130 Nev. 245, 327 P.3d 487 (2014). However, Respondent's reliance on *Nassiri* as a legal standard to exclude the records is misplaced.

Nassiri addressed the standard for judicial review of an agency adjudication and its interplay with the standard of proof by which an agency prosecutes a licensee. It clarifies that the use of the term substantial evidence in NRS 233B.135 is a standard whereby the reviewing court must determine that evidentiary findings meet the requirements of the statutory provision. ("Substantial evidence is a standard of court review that inquires whether the facts found by the administrative factfinder are reasonably supported by sufficient, worthy evidence in the record.") *Nassiri.* at 250, 490.

Accordingly, *Nassiri* does not create a legal standard whereby the hearing officer must prohibit evidence. Instead, while the hearing officer determines whether the Board meets the burden of proof (i.e. preponderance of the evidence), the court in reviewing whether the hearing officer's decision supports the findings that the burden of proof was met, will "give deference to factual determinations on review, asking only whether the facts found by the administrative factfinder are reasonably supported by sufficient, worthy evidence in the record." *Id.* Thus, because a determination whether the evidence is reliable, worthy, and probative is the standard for

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judicial review not the evidentiary standard for admissibility of evidence in an administrative hearing, it cannot be considered[2] in determining this motion.

Similarly, as other support for excluding the listed exhibits, Respondent (also in the Legal Standard section of his Motion) cites two (2) criminal cases: *Beck v. State*, 105 Nev. 910, 784 P.2d 983 (1989) and *Vipperman v. State,* 96 Nev. 592, 614 P.2d 532 (1980). First, the standard in criminal law is not the relevant standard in administrative law and should not be presented as a legal standard in this case and could only be considered persuasive if there was a logical connection between the standard and the facts at issue here.

However, the facts in *Beck* are not analogous to the facts in Respondent's case. Mr. Beck was a teacher who was criminally prosecuted for inappropriate sexual contact with one of his students. Evidence from an alleged prior victim who testified about an alleged encounter with Mr. Beck that occurred sixteen (16) years prior and was never charged was admitted as prior bad act evidence. The Court in *Beck* held 1) the bad act evidence was not relevant because there was no clear connection between an alleged incident that occurred sixteen (16) years prior and for which Mr. Beck was never charged, and the allegations against Beck made regarding the current victim; 2) there was no evidence that Mr. Beck committed the prior act; and 3) the probative value of the prior bad act was not outweighed by its prejudicial effect especially since it was relied upon in the closing argument.

This is not a criminal case demanding applicable criminal law standards. Additionally, those exhibits are not being offered to introduce prior bad acts of Respondent. With respect to the two (2) counts, one (1) patient, and three (3) attempts at surgery for Patient A at issue in the IC's Complaint, the exhibits in question are to give the full story that Respondent's actions required much more medical care subsequent to the initial surgery by Respondent.[3]

In *Vipperman*, evidence of a murder victim's alleged criminal conduct was not relevant to determining the guilt of defendant, who was the victim's business partner, in a dispute with the

[2] See Respondent's Motion, page 7, lines 20-21.

[3] Though not a required standard in administrative hearings, to the extent that NRS 48.015 is considered, the evidence in question will have the tendency to make the fact of Respondent's malpractice in this case more or less probable because it is evidence of the personal care of Patient A and the evidence explains the medical decisions made in this matter which can then also be compared to Respondent's care in this case.

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victim and stood to benefit from his death. Although not articulated in Respondent's Motion, it appears she hopes to use this holding to exclude the exhibits in question as irrelevant because it is supposedly of no consequence to the determination of the action against Respondent. In doing so, Respondent is asking to make a jump from not allowing an alleged murderer to bring up his victim's character to not allowing two (2) treating physicians' response letters to illustrate their care and treatment of Patient A who is the only patient at issue in this case. Quite the jump - and one that is not supported by legal authority nor warranted here.

Respondent then turns very briefly to NRS 48.035 and inexplicably alludes to subsection (2) which allows exclusion of evidence when the probative value is substantially outweighed by considerations of undue delay, waste of time or needless presentation of cumulative evidence. NRS 48.035(3) allows "[e]vidence of another act or crime which is so closely related to an act in controversy or a crime charged that an ordinary witness cannot describe the act in controversy or the crime charged without referring to the other act or crime shall not be excluded, but at the request of an interested party, a cautionary instruction shall be given explaining the reason for its admission." Respondent admits (1) she perforated Patient A's bowel, (2) had to halt Patient A's planned surgery, (3) did not repair Patient A's hernia, and (4) had to switch her plans to repairing Patient A's perforated bowel. Respondent was the cause for Patient A having to seek more medical treatment from other providers, for months.

Respondent also argues that the evidence she would like to exclude is prejudicial. The Nevada Supreme Court has defined "unfair prejudice" under NRS 48.035 as an appeal to "the emotional and sympathetic tendencies of a jury, rather than the jury's intellectual ability to evaluate evidence." *State v. Dist. Ct. (Armstong)*, 127 Nev. 927, 933, 267 P.3d 777, 781 (2011) citing *Krause Inc. v. Little*, 117 Nev. 929, 935, 34 P.3d 566, 570 (2001); *Schlotfeldt v. Charter Hosp. of Las Vegas*, 112 Nev. 42, 46, 910 P.2d 271, 273 (1996).

In *Armstong*, the Court also refers to a note on the Federal law analogous to NRS 48.035 which provides that undue prejudice is an undue tendency to suggest decision on an improper basis though not necessarily, an emotional one. Citing *Tome v. United States*, 513 U.S. 150, 160, 115 S. Ct. 696, 130 L.Ed.2d 574 (1995).

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Accordingly, in analyzing whether to exclude evidence on the basis of undue prejudice, the hearing officer must determine whether her intellectual ability to evaluate evidence will be overcome by his emotional and sympathetic tendencies toward the IC's exhibits 2, 3, 6, and 7. The IC respectfully submits that the hearing officer can give all evidence the proper probative weight that it is due, and his recommendations to the Board will not be decided on an improper basis.

Furthermore, this is not the standard for admissibility of evidence in administrative hearings such as this one. NRS 233B.123(1) in part states that [i]rrelevant, immaterial or unduly repetitious evidence must be excluded. Evidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs. Agencies shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers may be made and must be noted in the record. Subject to the requirements of this subsection, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form. The evidence in question (IC Exhibits 2, 3, 6, and 7) are neither irrelevant, immaterial nor unduly repetitious, as all of the evidence pertains directly to Patient A's subsequent procedures, required by Respondent's mistreatment of Patient A.

C. Exceptions To the General Rule of Hearsay Make the Letters from the Doctors Who Subsequently Treated Patient A Admissible.

Monica Gustafson, Senior Investigator for the Board, and the investigator assigned to this matter sent letters in the regular course and scope of her employment with the Board to Dr. John Davis on October 28, 2019, and to Dr. Lubna Javed on August 24, 2020. She received responses from both doctors. Again, this occurred in the normal course of Ms. Gustafson's duties as an investigator for the Board. NRS 51.075(1) states that [a] statement is not excluded by the hearsay rule if its nature and the special circumstances under which it was made offer assurances of accuracy not likely to be enhanced by calling the declarant as a witness, even though the declarant is available. See NRS 51.115 which states that [s]tatements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain or sensations, or the inception or general character of the cause or external source thereof are not

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inadmissible under the hearsay rule insofar as they were reasonably pertinent to diagnosis or treatment. The letters and attached medical records identified by the IC fall under both exceptions, so all the exhibits described by Respondent in the motion should be admitted.

The IC respectfully submits that the hearing officer may give IC's Exhibits 2, 3, 6, and 7 the proper probative weight that it is due for each, and his recommendations provided to the Board will not be provided on an improper basis.

III. CONCLUSION

In contested cases, only irrelevant, immaterial or unduly repetitious evidence must be excluded. Unless otherwise precluded, evidence of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs may be admitted.[4] *See* NRS 233B.123(1). As discussed extensively above, Respondent has claimed based on inapplicable legal standards that IC Exhibits 2, 3, 6, and 7 should be excluded as irrelevant or unduly prejudicial, which is incorrect. Additionally, Respondent posits that IC Exhibits 2, 3, 6, and 7 is unduly repetitious because the IC has included exhibits that pertain to Patient A's post-surgical treatment. The Rule only excludes unduly repetitive evidence and unduly is defined as more than is necessary, acceptable, or reasonable.[5]

Respondent misinterprets and misapplies the evidentiary standards in administrative law in her request to exclude IC Exhibits 2, 3, 6, and 7 in this matter. However, those exhibits comply

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[4] Medical evidence, including documents and letters related to the care and treatment of patients, like that intended to be offered by the IC in this case, is the type of evidence commonly and reasonably relied upon in cases alleging violations of the Nevada Medical Practices Act.

[5] https://dictionary.cambridge.org/dictionary/english/unduly

with NRS 233B.135 and the hearsay exceptions discussed above. Accordingly, Respondent's Motion must be denied in its entirety.

DATED this 31st day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 31st day of May, 2024, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' OPPOSITION TO RESPONDENT'S MOTION TO EXCLUDE EVIDENCE AT HEARING** via US Certified Mail to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. & Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

Tracking No.: 9171 9690 0935 0241 6279 95

And by electronic mail to:

CHARLES B. WOODMAN, ESQ.
hardywoodmanlaw@msn.com
Hearing Officer

DATED this 31st day of May, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

UNITED STATES POSTAL SERVICE

June 17, 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 6279 95**.

Item Details

Status:	We regret to inform you that we were unable to locate any delivery information in our records for your item.
Status Date / Time:	N/A
Location:	N/A
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic

Shipment Details

Weight:	0.3oz

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

Attorney or Party without Attorney: Patricia Egan Daehnke Collinson, Daehnke, Inlow & Greco – Attorneys at Law 2110 East Flamingo Road, Suite 212 Las Vegas, NV 89119 *Telephone No:* 7029792132 *Attorney For:*	*For Court Use Only* FILED JUN 03 2024 NEVADA STATE BOARD OF MEDICAL EXAMINERS By:
Ref. No. or File No.: PROAS-0380	
Insert name of Court, and Judicial District and Branch Court: The Board of Medical Examiners of the State of Nevada	
Plaintiff: In the Matter of the Charges and Complaint Against: Annabel Elizabeth Barber, MD *Defendant:*	

DECLARATION OF SERVICE	*Hearing Date:* 5/24/24	*Time:*	*Dept/Div:*	*Case Number:* 23-11660-1

1. *At the time of service I was at least 18 years of age and not a party to this action.*

2. I served copies of the Subpoena Duces Tecum to Custodian of Records for Desert Radiology

3. *a. Party served:* Custodian of Records for Desert Radiology
   b. Person served: Davia B. - Medical Records Assistant, authorized to accept
   Desc: Hispanic , Female , Age: 40s , Hair: Brown , Eyes: Brown

4. *Address where the party was served:* 3920 South Eastern Avenue 100, Las Vegas, NV 89119

5. *I served the party:*
   a. by **personal service.** I personally delivered the documents listed in item 2 to the party or person authorized to receive process for the party (1) on: Wed, May 08 2024 (2) at: 02:51 PM

Fee for Service:
Pursuant to NRS 53.045
I Declare under penalty of perjury under the laws of the State of NEVADA that the foregoing is true and correct.

6. ***Person Who Served Papers:***
   a. Domenique Palmer (R-2022-20586)
   b. **FIRST LEGAL**
   NEVADA PI/PS LICENSE 1452
   2920 N. GREEN VALLEY PARKWAY, SUITE 514
   HENDERSON, NV 89014
   c. (702) 671-4002

05/13/2024
(Date)

(Signature)

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1** **ANNABEL ELIZABETH BARBER, M.D.'S REPLY IN SUPPORT OF MOTION TO EXCLUDE EVIDENCE AT HEARING**

FILED
JUN - 3 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
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I. INTRODUCTION

Respondent Dr. Barber filed her Motion to exclude diagnostic films from Spring Valley Hospital (Exhibits 6 and 7), and designated letters from treating providers Dr. Davis and Dr. Javed (Exhibits 2 and 3) as exhibits in this matter. Respondent argued that since the allegations in the Complaint relate solely to Respondent's decision-making on February 22, 2019 and prior, the films related to subsequent treatment, along with correspondence from treating providers who did not treat Patient A on February 22, 2019 or prior, are irrelevant, immaterial, and unduly repetitious pursuant to NRS 233B.123 and **must** be excluded.

The Investigative Committee's Opposition to Respondent's Motion offers no argument as to why Exhibits 2, 3, 6, and 7 are relevant or material, or how they are not unduly repetitious. Instead, the Investigative Committee focused exclusively on arguing that case law cited by Respondent for general principles of law regarding evidentiary issues was "inexplicable" and "quite the jump." The Investigative Committee's lack of argument regarding the substance of the Motion, with focus entirely on trying to distance itself from general principles of law, is telling and indicates that Respondent's Motion should be granted.

II. ARGUMENT

The focus of the Complaint in this matter is solely on Respondent's decision-making as it relates to the February 22, 2019 surgery. NRS 630.346 makes it clear that "proof of actual injury need not be established." Therefore, Patient A's ultimate alleged injury, or

subsequent care and treatment, is not relevant in this matter. Instead, the focus of the Complaint is solely on whether Respondent committed malpractice on February 22, 2019 and prior, which NAC 630.040 defines as the "failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances." Furthermore, at issue is whether Respondent's medical records on February 22, 2019 and prior were "timely, legible, accurate and complete" as set forth in NRS 630.3062(1)(a).

The Investigative Committee has the burden of proof in this matter. NRS 622A.370(1). The standard of proof for this matter is a preponderance of the evidence. *Id.*; NRS 630.346(2). The hearing officer is not bound by strict rules of procedure or rules of evidence, except that evidence must be taken and considered in the Hearing pursuant to NRS 233B.123. NRS 622A.370(2); NRS 630.346. Despite the Investigative Committee's arguments that they are not bound by the rules of evidence, NRS 622A.370 specifically references the "rules of evidence." Therefore, there is certainly no prohibition on the hearing officer following generally accepted rules of evidence that apply in civil cases. The Investigative Committee is subject to the laws and procedural rules designed to guarantee Respondent due process. NRS 622A.370's statement that the Hearing Officer does not need to "strictly adhere" to the rules of evidence does not mean that statutes, case law, and other precedent discussing the rules of evidence and the application of these rules in inapplicable in this case. Simply stated, the general rules of evidence as set forth in Title 4 of the NRS can be applied in this case and can and should be used by the Hearing Officer to guide his decisions in this case.

Nonetheless, even looking at the much smaller universe of rules regarding evidence in this administrative matter, pursuant to NRS 233B.123(1), "irrelevant, immaterial or unduly repetitious evidence **must be excluded**." (Emphasis added). "Evidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs." NRS 233B.123. Pursuant to NRS 233B.123, "each party may call and examine witnesses, introduce exhibits, cross-examine opposing witnesses on any matter relevant to the issues . . . ." (emphasis added).

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In this case, Exhibits 2, 3, 6 and 7 are irrelevant, immaterial, and unduly repetitious, and **must** be excluded. The Investigative Committee does not explain why these Exhibits should be admitted in this case. At one point, the Investigative Committee states that the Exhibits "give the full story that Respondent's actions required much more medical care subsequent to the initial surgery by Respondent," and that "Respondent was the cause for Patient A having to seek more medical treatment from other providers, for months." Opposition at 4, 5. The Investigative Committee further states that the "evidence pertains directly to Patient A's subsequent procedures, required by Respondent's mistreatment of Patient A." Opposition at 6. However, as set forth in NRS 630.346, "proof of actual injury need not be established." Therefore, the sole issue in this case is the standard of care, and not causation. What ultimately happened to Patient A is not the focus of the Complaint, nor can it be the focus of any discipline imposed. Instead, the focus is on whether Respondent used the reasonable care, skill, or knowledge ordinarily used under similar circumstances in planning and executing Patient A's February 22, 2019 surgery.

Next, the Investigative Committee argues that the evidence in question "will have the tendency to make the fact of Respondent's malpractice in this case more or less probable because it is evidence of the personal care of Patient A and the evidence explains the medical decisions made in this matter which can then also be compared to Respondent's care in this case." Opposition, at footnote 3. It is unclear how imaging taken after February 22, 2019, or correspondence from Dr. Davis or Dr. Javed has any tendency to explain the medical decisions made in this matter. The sole issue is whether Respondent used the reasonable care, skill, or knowledge ordinarily used under similar circumstances in planning and executing Patient A's February 22, 2019 surgery. How Dr. Javed provided wound care, or how Dr. Davis provided subsequent care, has no bearing on whether Respondent's decisions on February 22, 2019 met the standard of care. Neither Dr. Davis nor Dr. Javed were involved in Patient A's care and treatment on February 22, 2019. Furthermore, it is unclear how imaging, including numerous chest x-rays taken after February 22, 2019, has any tendency to indicate whether Respondent's care and treatment on February 22, 2019 and prior met the standard of

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care. Evidence of the standard of care in this case must be presented by expert testimony. The Investigative Committee has designated Nicholas Spoerke, M.D. to provide expert testimony in this matter. Respondent is unable to cross-examine Dr. Davis or Dr. Javed, and it would be inappropriate to allow their unsworn correspondence to be used as evidence to somehow establish a standard of care, or to be used to judge Dr. Barber's care and treatment in this case. The evidence is simply not relevant, and must be excluded.

The Investigative Committee argues that the correspondence from Dr. Davis and Dr. Javed were obtained by Monica Gustafson during her investigation of this matter. Notably, the Investigative Committee has not provided Respondent with the entirety of the Investigative Committee file, including Dr. Spoerke's expert reports or opinions, yet they seek to use hearsay statements from Dr. Davis and Dr. Javed at hearing.[1] This is inappropriate. The Investigative Committee argues that the correspondence from Dr. Javed and Dr. Davis are "statements made for purposes of medical diagnosis or treatment" as set forth in NRS 51.115. This is an incorrect interpretation. NRS 51.115 applies to statements made at the time of the care and treatment for purposes of medical diagnosis or treatment. It does not refer to statements made by a treating physician months after the fact. Their letters are hearsay, and Respondent is unable to cross-examine the physicians who purportedly drafted the hearsay

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[1] Respondent has requested that the Investigative Committee produced their investigative file, including Dr. Spoerke's expert report and opinions. Pursuant to NRS 622A.330(1), "at any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case . . ." Furthermore, pursuant to NRS 630.336(5), "the formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records." Respondent Dr. Barber has the right to receive all of the evidence that will be presented against her, to allow her to meaningfully prepare for the Hearing in this matter. The Investigative Committee has an independent duty to provide this information. By designating Monica Gustafson, the Investigator, as a witness in this matter, and by designating correspondence from Dr. Davis and Dr. Javed as exhibits in this matter (which were part of the investigative file), the Investigative Committee has waived any right to withhold the remainder of the investigative file. Now that a Complaint has been filed, the investigative file has lost the protection of confidentiality and must be produced. Failure to do so is a violation of Respondent's due process rights. The Investigative Committee has indicated they will not provide the investigative file, despite Respondent's request.

letters. Information regarding Patient A's subsequent care and treatment is simply irrelevant, immaterial, and a waste of time, and prejudicial, as the sole focus of the Hearing in this matter is on Dr. Barber's decision-making related to the February 22, 2019 surgery and her documentation of the surgery and her pre-operative care. The correspondence from Dr. Davis and Dr. Javed should be excluded.

III. CONCLUSION

For the reasons set forth herein, Respondent respectfully requests that the Hearing Officer exclude evidence of the "Diagnostics from University Medical Center" (Exhibit 6), "Diagnostics Films from Spring Valley Hospital" (Exhibit 7), letter from Dr. Davis (Exhibit 2), and letter from Dr. Javed (Exhibit 3) as exhibits in this matter.

Dated: June 3, 2024 **COLLINSON, DAEHNKE, INLOW & GRECO**

By */s/ Patricia Egan Daehnke*

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CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of June, 2024, a true and correct copy of ANNABEL ELIZABETH BARBER, M.D.'S REPLY IN SUPPORT OF MOTION TO EXCLUDE EVIDENCE AT HEARING was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Charles B. Woodman, Esq. Woodman Law Group 548 W. Plumb Lane, Suite B Reno, NV 89509 hardywoodmanlaw@msn.com tiffany@woodmanlawgroup.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

FILED

JUN - 3 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1** **ANNABEL ELIZABETH BARBER, M.D.'S REQUEST FOR PRODUCTION OF PUBLIC RECORDS AND/OR PRODUCTION OF THE INVESTIGATIVE FILE**

Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby submits this Request for copies of all documents and evidence relied upon by the Investigative Committee of the Nevada State Board of Medical Examiners in filing the November 16, 2023 Complaint in this matter, including expert reports and opinions of Nicholas Spoerke, M.D., pursuant to NRS 239.010(1), NRS 622A.330, and NRS 630.336(5). To the extent this Request is deemed a Motion, it is filed pursuant to NRS 622A.360(2)(f) and leave is requested of the Hearing Officer to file this Motion. This Request is also based on the attached Memorandum of Points and Authorities and any argument that the Hearing Officer or panel will allow upon a hearing in this matter.

Dated: June 3, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The instant Complaint against Respondent Annabel Barber, M.D. was filed on November 16, 2023 by the Investigative Committee of the Nevada State Board of Medical Examiners. However, the Nevada State Board of Medical Examiner's investigation of this matter began a long time prior, on October 28, 2019. Once a formal Complaint was filed in this matter, the Investigative file became subject to production to Respondent pursuant to principles of statutory construction and basic guarantees of fairness and due process. Respondent Dr. Barber is entitled to review all of the evidence and information the Investigative Committee has considered in this matter, in order to properly defend against those issues which form the basis of the Formal Complaint in this matter. Furthermore, it is anticipated that the Investigative Committee will list their Investigator as a witness in this matter, and will have the Investigator testify as to portions of the Investigative file in this matter. Therefore, by designating the Investigator as a witness to testify regarding the Investigative file, Respondent is entitled to review of the Investigative file. Furthermore, the Investigative Committee will call expert witness Nicholas Spoerke, M.D. to testify in this matter. Similarly, Respondent is entitled to review of his expert report and opinions, and that matters considered by him. Production of the Investigative file in this matter is necessary in order to allow Respondent to fairly prepare for the June 4-5, 2024 Hearing in this matter and to anticipate the testimony that may be offered by the Investigator and Dr. Spoerke. Respondent Dr. Barber respectfully requests an Order requiring the Investigative Committee to produce their complete Investigative file in this matter, including the report of Dr. Spoerke and/or his opinions.

II. PROCEDURAL HISTORY

The factual basis of the formal Complaint in this matter relates to Respondent Dr. Barber's preoperative decision making and her performance of an attempted laparoscopic left inguinal hernia repair on February 22, 2019. On October 28, 2019, the Nevada State Board of Medical Examiners sent correspondence to Dr. Barber initiating their investigation in this

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matter. Exhibit A. On November 17, 2023, the Investigative Committee filed their Complaint in this matter.[1] Exhibit B. In their Prehearing Conference Statement, the Investigative Committee listed Investigator Monica Gustafson as a witness to testifying regarding the "documentary evidence obtained during the investigation of this case" and to testify "regarding the investigation of this matter." Exhibit C. The Investigative Committee also listed expert Nicholas Spoerke, M.D. to testify regarding his "medical review of this matter and the applicable standard of care." *Id.*

On June 2, 2024, Respondent's counsel emailed Don White, counsel for the Investigative Committee to request the investigative file in this matter. Exhibit D. On June 3, 2024, Don White advised counsel that "we have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file." *Id.* Given the June 4-5, 2024 Hearing in this matter, Respondent wishes to bring this matter to the Hearing Officer's attention and request a ruling on this issue of law and these evidentiary issues prior to the commencement of the Hearing on this matter. Should the Hearing Officer want further/more extensive briefing, Respondent will provide such.

III. AUTHORITY FOR THIS REQUEST / MOTION

Pursuant to NRS 622A.320, "**[a]t any time** after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses." Pursuant to NRS 622A.320, on June 2, 2024, Respondent made a written request to counsel for the Investigative Committee for a copy of the investigative file in this matter. Counsel for the

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[1] This is the second Complaint the Investigative Committee has filed against Respondent regarding her care and treatment of Patient A. The first Complaint, case 22-11660-1, was dismissed by Hearing Officer Nancy Moss Ghusn when she granted Respondent's Motion to Dismiss after it was discovered that Investigative Committee Choudhury Ahsan, M.D. had treated Patient A, and also served on the Investigative Committee that recommended filing a Complaint. However, the Investigative Committee requested the ability to comment on the proposed Order, but never provided comment, and then dismissed the Complaint on November 16, 2023 without an Order being entered on Respondent's Motion to Dismiss. This Complaint was filed on November 17, 2023.

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Investigative Committee indicated the investigative file would not be produced.

To the extent the Hearing Officer believes this request should be filed a as a Motion, pursuant to NRS 622A.360(f), a party may file, with leave of the hearing panel officer, "any other motion requesting appropriate action or relief." Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing. However, NRS 622A.360 specifically provides provisions for parties to "request a ruling" from the hearing officer on "any issue of law or procedure in a case," by filing motions as set forth in NRS 622A.360. To the extent the Hearing Officer determines that Respondent's request is more properly styled as a Motion, Respondent respectfully requests leave to file this Motion as Respondent believes this is a matter of great importance and substantially impacts her due process rights and ability to prepare to defend against the evidence and testimony that may be presented at the Hearing in this matter on June 4-5, 2024.

IV. ARGUMENT

The Nevada State Board of Medical Examiners has filed a disciplinary Complaint against Respondent Dr. Barber in this matter, seeking to impose discipline on Dr. Barber's license to practice medicine in Nevada. The United States Constitution guarantees that "[n]o person shall be...deprived of life, liberty, or process without due process of law." U.S. Const. amend. V. This protection is incorporated at the state level through the Fourteenth Amendment (U.S. Const. amend. XIV) and the Constitution of the State of Nevada (Nev. Const. art. I, § 8).

A physician's license to practice medicine is a property right, and this right to earn a living is a liberty interest, and neither a property right nor liberty interest may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d 506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366 (9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy."

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Stretten, 537 F.2d at 366. Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971); *see also Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 573, 92 S. Ct. 2701, 2707, 33 L. Ed. 2d 548 (1972) (internal quotation omitted).

"[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." *Dutchess Bus. Servs. v. Nev. State Bd. Of Pharm.*, 124 Nev. 701, 711 (2008) (citing *Givins Constr. v. State Contractors' Bd.*, 107 Nev. 281, 283, 809 P.2d 1268, 1270 (1991); *McClelland v. Andrus*, 606 F.2d 1278, 1285 (D.C. Cir. 1979), *Silverman v. Commodity Futures Trading Com'n*, 549 F.2d 28, 33 (7th Cir. 1977)). Administrative parties must give notice to the defending party of "the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it. *Dutchess Bus. Servs. V. Nev. State Bd. Of Pharm.*, 124 Nev. 701, 711 (2008) (citing *Bowman Tanspo. v. Ark.-Best Freight System*, 419 U.S. 281, 288 n. 4 (1974); *Nevada St. Apprenticeship v. Joint Appreh.*, 94 Nev. 763, 765, 587 P.2d 1315, 1317 (1978).

The Nevada Supreme Court has held the Investigative Committee process constitutes the investigatory stage of the administrative process through the issuance of the formal Complaint. *Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 713, 429 P.3d 650, 654 (2018). In *Sarfo*, Kofi Sarfo, M.D. received an inquiry letter from the Nevada State Board of Medical Examiners regarding a complaint that had been filed against him. 134 Nev. 709, 429 P.3d 650 (2018). The letter did not include the name of the complainant or specify the claims, and instead requested medical records for several of his patients to allow the Board to investigate the complaint. *Id.* Dr. Sarfo refused to comply and filed a writ petition seeking injunctive

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relief in the district court, arguing that the Board violated his due process rights by keeping the identity of the complainant and the allegations in the complaint confidential. *Id.*

In *Sarfo*, the Nevada Supreme Court explained:

> There are two types of complaints that come before the Board: a complaint initially generated by a member of the public and a formal complaint generated by the IC following the completion of its investigation. *See* NRS 630.311. Upon receipt of the initial complaint filed by a member of the public against a physician, the Board must designate an IC to "review each complaint and conduct an investigation to determine if there is a reasonable basis for the complaint." NRS 630.311(1). The IC has no disciplinary powers and can only file a formal complaint with the Board if it concludes that a complaint from a member of the public has a reasonable basis. NRS 630.311(2). **Once a formal complaint has been filed, the adjudicative process begins, and the physician is provided with notice and an opportunity to be heard at a formal hearing. *See* NRS 630.339.** Here, Dr. Sarfo is alleging a due process violation stemming from an initial complaint, not a formal complaint.

Id. (Emphasis added). The Court went on to analyze the facts and law, noting case law suggesting that due process does not attach in proceedings merely involving fact-finding or investigatory exercises, recognizing a distinction between fact-finding and adjudicatory roles. *Id.* In *Sarfo*, the Court cited to *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007), stating that this case stood for the proposition that "subpoenas issued pursuant to the department of Public Health's investigation do not implicate due process unless and until the department files a formal complaint." *Id.* (Emphasis added).

Sarfo is distinguishable from the case at hand. In *Sarfo,* the Nevada Supreme Court addressed the issue while the matter was still in the investigatory phase. The Nevada Supreme Court did not address the distinctly different situation where an investigation has proceeded to a formal Complaint. Although the Nevada Supreme Court noted that the Investigative Committee members ultimately do not adjudicate the matter, thereby supporting their conclusion that due process rights did not attach in Dr. Sarfo's case, the Nevada Supreme Court did not consider the separate situation where a formal Complaint has been filed and the Respondent seeks discovery or information to protect her due process rights in relation to the formal hearing. Respondent believes that a close analysis of the second

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situation would result in a different result in cases where a formal Complaint has been filed.

In this case, a formal Complaint has been filed. The Investigative Committee of the Nevada State Board of Medical Examiners is pursuing formal disciplinary action against Respondent, which implicates her due process rights. Even if the Investigative Committee does not ultimately decide whether discipline will be ordered, due process rights have attached to the Investigative Committee's investigatory process in this case because the Board has filed a formal Complaint. See *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007) (investigation does not implicate due process unless and until the department files a formal complaint). Therefore, Respondent is entitled to discovery of the investigative file to allow her to meaningfully prepare for the Hearing and to protect her due process rights.

NRS 622A.330 provides, in relevant part:

> 1. At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses.
> 2. The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case. The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee.

Furthermore, NRS 630.336(4)-(5) provides:

> 4. . . . a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential.
>
> 5. The formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records.

Finally, NAC 630.465(3) provides that "[a]ll 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."

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The Investigative file in this matter is a government record. Pursuant to NRS 239.0107(1)a), a government entity must provide access of copies of records. Any denial of the request based on confidentiality must be in writing and must include a citation to the specific statute of legal authority that makes the requested records confidential. NRS 239.0107(1)(d).

Although statutes should be given their plain meaning, a hallmark of statutory interpretation is that statutory interpretation should avoid absurd or unreasonable results. *See Sheriff v. Smith*, 91 Nev. 723, 733, 542 P.2d 440, 443 (1975); *Berkson v. LePome*, 126 Nev. 492, 497, 245 P.3d 560, 563 (2010); *State v. Tatalovich*, 309 P.3d 43, 44 (2013). Pursuant to NRS 630.336(5), the formal Complaint or other document filed by the NBME to initiate disciplinary action and all documents and information considered by the Board when determining to impose discipline are public records." A formal Complaint has been filed in this matter. Now that a Complaint has been filed, the Investigative file is open to Respondent, and should be produced. Furthermore, the Investigative file and the opinions of Dr. Spoerke are evidence that the Investigative Committee intends to admit at the Hearing in this matter. Therefore, the plain language of NAC 630.465(3) requires that the Investigative Committee provide the evidence which will be admitted – including the Investigative file and the opinions of Dr. Spoerke. Arguing that Respondent is not entitled to the Investigative file or the opinions of Dr. Spoerke when her license in livelihood is on the line results in an absurd and unreasonable result.

Pursuant to NRS 622A.330(1), the Investigative Committee has an independent duty to provide Respondent with a copy of the Investigative file, including Dr. Spoerke's reports and opinions, in order to allow her to meaningfully prepare for the Hearing. Pursuant to NRS 622A.330, Respondent Dr. Barber has a right to the production of documents or other evidence intended to be presented by the prosecutor in support of the IC's case. Although NRS 630.336(4) provides that documents compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential, NRS 630.336(5) provides that all documents considered by the Board when determining whether to impose discipline

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are public records. Therefore, although the Investigative file may remain confidential if a formal Complaint is never filed, by implication, once the decision to move forward with formal discipline is made and a formal Complaint is filed, the Investigative file loses the protection of confidentiality. Furthermore, pursuant to NAC 630.456(3), the Investigative Committee must provide the evidence that will be admitted at the Hearing.

In this case, the Investigative Committee has disclosed investigator Monica Gustafson to verify evidence obtained during the investigation of the case and to testify regarding the investigation of this matter, including correspondence received from Dr. Davis and Dr. Javed during the course of the investigation. Given that the Investigator will be testifying regarding the investigation and will be verifying evidence obtained during the investigation, Respondent Dr. Barber is entitled to production of the Investigative file before the Hearing, to allow her to prepare for this testimony. Furthermore, by disclosing a part of the Investigative file (the letters of Dr. Javed and Dr. Davis), the Board has waived any right to claim the investigative file is confidential. The Investigative Committee cannot pick and choose which portions of the investigative file Respondent is entitled to. Furthermore, the Investigative Committee has disclosed expert witness Nicholas Spoerke, M.D. However, the Investigative Committee has not provided his expert report or any information regarding the substance of his opinions, which would allow Respondent to meaningfully prepare to cross-examine Dr. Spoerke. Failure to provide Respondent with the investigative file and expert reports/opinions is a violation of Respondent's due process rights, and ensures that Respondent will not receive a fair hearing in this matter. Dr. Spoerke will undoubtedly rely on materials from the investigative file to support his opinions as set forth in NRS 622A.330. Therefore, the investigative file is discoverable and must be produced.

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V. CONCLUSION

Based on the foregoing, Respondent Dr. Barber requests that the Investigative Committee provide a copy of the Investigative file, including Dr. Spoerke's expert report and opinions, prior to the commencement of the June 4-5, 2024 Hearing in this matter.

Dated: June 3, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
Nevada Bar No. 10748
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of June, 2024, a true and correct copy of ANNABEL ELIZABETH BARBER, M.D.'S REQUEST FOR PRODUCTION OF PUBLIC RECORDS AND/OR PRODUCTION OF THE INVESTIGATIVE FILE was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Charles B. Woodman, Esq. Woodman Law Group 548 W. Plumb Lane, Suite B Reno, NV 89509 hardywoodmanlaw@msn.com tiffany@woodmanlawgroup.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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Exhibit A

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

October 28, 2019

Annabel Barber, M.D.
1701 W. Charleston Blvd., Suite 490
Las Vegas, NV 89102

RE: BME CASE #: 19-19059
PATIENT: [redacted]

Dear Dr. Barber:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges you provided substandard medical care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on or around February 22, 2019, for a hernia repair surgery.
2. The patient had undergone six previous surgeries, including the removal of two thirds of his small intestine, prior to presenting to you for surgery.
3. You disregarded the patient's requests that you enter through the groin for his hernia surgery and not touch his adhesions.
4. You entered through the patient's abdomen. By entering through the abdomen you perforated the remaining one third of the patient's small intestine, causing the small intestine's contents to spill into the patient's stomach cavity.
5. The contents of the intestines resulted in the patient suffering with near death sepsis, two blood transfusions, five additional surgical procedures, three fistulas, open wounds, total parenteral nutrition, migraine headaches and excruciating pain.

It is further alleged:

1. The patient is irreparably disabled and unable to work.
2. Due to the perforation you inflicted, you had to remove more of the patient's small intestines.
3. The patient only gave consent for you to enter through the groin during his hernia repair surgery, not through the abdomen. You did not adhere to proper consent from the patient nor did you consider the patient's pertinent medical history of six previous surgeries and adhesions.
4. Furthermore, you never repaired the hernia.
5. The patient has felt undue pain and his quality of life has suffered.

Received 11/18/2019

6. Therefore your care and treatment of the patient may have fallen below the standard of care.

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 the allegations noted above, as well as complete health care records for the aforesaid patient. Please provide 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.

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: **NAC 630.040; NAC 630.620 (2); NRS 630.301 (4),(8); NRS 630.306 (1)(f), (1)(g), (1)(p).**

Respectfully,

Monica C. Gustafson, CMBI
Senior Investigator

Exhibit B

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: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 17 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018, when he presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Respondent ordered a CT scan "to define anatomy better."

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[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., 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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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4. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he had acquired short bowel syndrome.

5. Upon healing from those surgeries, Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

6. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laparoscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

7. Upon information and belief, during the surgery on February 22, 2019, Respondent made an attempt to gain laparoscopic access to the peritoneum via the right lower quadrant. When Respondent was unable to gain peritoneal access, it appears from her operative note that she tried to gain access via the left lower quadrant but was also unsuccessful. It appears, upon information and belief, that Respondent then attempted to access the peritoneum via a midline incision and immediately noticed that she had injured Patient A's bowel.

8. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision.

9. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures.

10. Respondent then closed the incision and discharged Patient A without having repaired Patient A's left inguinal hernia.

11. There was no documentation of the injury in the operative note which was unintelligibly written.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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(775) 688-2559

14. 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."

15. 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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

16. 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

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

18. 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.

19. Respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

20. 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 her and give her notice that she 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;

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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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@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

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 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Exhibit C

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED

MAY 0 1 2024

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

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 Notice and Order Rescheduling Pre-hearing and Hearing filed on February 29, 2024.

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. Monica Gustafson, Investigator
Nevada State Board of Medical Examiners

Ms. Gustafson is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Annabel Elizabeth Barber, M.D.

Dr. Barber 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. Nicholas Spoerke, M.D., FACS

Dr. Spoerke is a Board-Certified General and Critical Care Surgeon and is licensed to practice medicine in the State of Nevada. Dr. Spoerke 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 her prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons she 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, Order and Response to Allegation Letter	001-048
2	Dr. Davis's Request Letter and Statement of Treatment	049-079
3	Dr, Javed's 2nd Request & Request Letters and Statements	080-083
4	Las Vegas Surgery Center – Request Letter and Records	084-132
5	CV of Nicholas Spoerke, M.D., FACS	133-0136
6	Diagnostics from University Medical Center	137
7	Diagnostic Films from Spring Valley Hospital	138

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 before the Prehearing Conference.

DATED this 1st day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Email: dwhite@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

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 1st day of May, 2024, 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 FedEx Priority Overnight, postage pre-paid, to the following parties:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. and Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

CHARLES B. WOODMAN, ESQ.
548 W. Plumb Lane, Suite B
Reno, NV 89501

Rosenthal Tracking No.: 776191169029

Woodman Tracking No.: 776191295761

With courtesy copy by email to:

Patricia Daehnke, Esq., at [Patricia.Daehnke@cdiglaw.com]
Charles B. Woodman Esq. at [hardywoodmanlaw@msn.com]

DATED this 1st day of May, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

Exhibit D

Amanda Rosenthal

From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 10:05 AM
To: Patricia Daehnke
Cc: Amanda Rosenthal; Lacey Ambro; Meg Byrd
Subject: RE: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good morning Tricia,

We have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Sunday, June 2, 2024 4:45 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hi Don,

You could send over a paper copy to me at my hotel or we can send a secure link in the morning so the file can be downloaded whichever you prefer.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On Jun 2, 2024, at 4:36 PM, Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

Good afternoon Don,

I am getting ready for the hearing and don't see that you have produced either investigative file in this matter. I checked and the board did not provide the investigative file from the case that was dismissed nor the current case. Please provide a copy of the investigative file.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On May 31, 2024, at 10:47 AM, Donald K. White <dwhite@medboard.nv.gov> wrote:

Good morning Mr. Woodman,

Thank you for checking on this. I'm forwarding the email below again. I withdrew my motion since I was able to correspond with Dr. Spoerke, and he confirmed that he is available for the hearing.

Sincerely,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

Notice of Confidentiality: The information transmitted is intended only for the person or entity to whom it is addressed and may contain confidential and/or privileged material. Review, retransmission, or dissemination of this information by anyone other than the intended recipient is not authorized. If not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Donald K. White
Sent: Tuesday, May 28, 2024 1:38 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: FW: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good afternoon everyone,

Please allow me to withdraw the Motion to Continue (which was emailed and not filed on Friday, May 24, 2024).

I just spoke with Dr. Spoerke and he is available on June 4, 2024.

Thank you,

Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
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From: Donald K. White
Sent: Friday, May 24, 2024 6:31 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Hello Mr. Woodman and Ms. Daehnke,

Attached is a Motion to Continue the hearing currently set for June 4-5, 2024. As you will read, I have had much difficulty contacting the IC's expert, Dr. Nicholas Spoerke, and therefor I'm unable to confirm his availability for the hearing.

I would have informed you of this earlier, but I was holding out hope that I would have spoken with him by now. This is also the same reason I did not reach out to you, Ms. Daehnke, for a possible stipulation to continue.

Board staff who have the ability to file documents have gone home for the weekend, so this will be filed on Tuesday, May 28, 2024.

Hope everyone has a safe and relaxing Memorial Day weekend.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D., Respondent.**	**Case No. 23-11660-1**

FILED

JUN 04 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. PURSUANT TO NRS 622A.360(2)(b)

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through counsel, Deonne E. Contine, General Counsel for the Board, and attorney for the IC, respectfully moves for recusal of hearing officer Charles Woodman, Esq. ("Woodman") from the instant action based on the following:

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Motion to Recuse Woodman from hearing this case is filed because of a difference between Woodman and the IC and Board regarding an interpretation of NRS 630.336 and NRS 622A.330 which has led to court intervention and Woodman's reaffirming his intention to apply his interpretation prior to the court considering the Petitions for Writ of Mandamus filed by the Board on April 17 and May 31, 2024, in which Woodman is the Respondent.

While it is understood that Woodman disagrees because he feels it is not fair to limit discovery in administrative proceedings, the Board's position is that its interpretation is consistent with Nevada statutory and case law. In fact, previously, a different hearing officer has issued an order consistent with the Board's understanding.[1] Additionally, as this disagreement relates to confidential, non-discoverable information that cannot be made confidential again once it is out in

[1] See attached Order Denying Motion to Compel, filed July 15, 2022.

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the public, the Board must seek court determination prior to the disclosure of the documents. This is not an issue that the Board seeks to unfairly pursue because it wants to penalize or hide information from licensees. The Board must follow its statutory provisions and cannot arbitrarily decide as it see fits when to apply and when not to apply its governing provisions.

II. PROCEDURAL FACTS

On April 17, 2024, the Board, filed its Petition for Writ of Mandamus against Hearing Officer Charles Woodman ("Woodman"), ("Board's Petition, case number CV24-00838") seeking a writ ordering Woodman to rescind a Summary Prehearing Order filed April 11, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file in the Matter of Charges and Complaint Against: SAMUEL RODOLFO CHACON, M.D. The Chacon matter which was set to go to hearing before Woodman on May 13, 2024, was stayed pending resolution of the Board's Petition, case number CV24-00838.

On May 31, 2024, the Board, filed its Petition for Writ of Mandamus against Woodman, ("Board's Petition, case number CV24-01206") seeking a writ ordering Woodman to rescind an Order on Prehearing Motions filed May 29, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file related to the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C.

The Board's Petition, case number CV24-01206, was filed after Woodman ordered the case against McCleve to proceed to a hearing over the objections of the IC's counsel on May 30, 2024, the first day of the hearing on the formal complaint against McCleve. The IC suggested that the formal complaint against McCleve should be stayed pending resolution of the legal issues in Board's Petition, case number CV24-00838. Alternatively, IC counsel suggested that Woodman stay his Order on Prehearing Motions, take evidence as provided by the parties pursuant to NAC 630.465 in the McCleve case, and make his recommendations to the Board after hearing the case against McCleve on the merits and reserve determination on the legal issue to the appropriate forum, the court.

During oral argument at the McCleve's hearing regarding production of the investigative file, it was discussed that the IC would need to seek further Court intervention at which time

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Woodman inquired whether the Board would appeal the matter if it was not successful in district court. Counsel for the IC refused to share attorney client discussions or litigation strategies with Woodman who is the respondent in the writ proceedings.

Woodman denied any continuance request by the IC notwithstanding that the IC maintained that the underlying legal issue must be decided by the court before the IC would produce the legal file as he had determined. Finally, Woodman further escalated issues at the McCleve hearing when he directed a Board witness to answer questions regarding IC proceedings, dismissing the objection of counsel, that IC proceedings are confidential based on NRS 630.311(3), not the confidentiality provisions on which he had previously decided.

Woodman, at the end of the morning session of the McCleve hearing on May 30, 2024, entertained an oral motion by McCleve to dismiss the formal complaint against him. Thereafter, Woodman stated that he would grant the motion to dismiss, wrap the case and send his recommendation to the Board that the case does not go any further. Woodman terminated the proceeding without hearing the case on the merits but not before a soliloquy admonishing the IC's counsel and the Board for not providing discovery to McCleve even though that issue is a subject of the writ petitions which are based on alleged erroneous decisions.

In his soliloquy Woodman referenced the Board's General Counsel directly regarding the intent to file the writ – calling the Board's action unconscionable and stating that in the real world of civil and criminal law - they would laugh at the Board. He further advised counsel to go to court to ask that the writ be combined with the writ that is already pending. He also admonished the Board accusing it of not being fair because the Board will not stipulate around our statutory duties and noted his belief that the Board must be doing something wrong because he has heard Board cases for years and this issue has never come up.

III. LEGAL ARGUMENT

NRS 622A.360(2)(b) provides for a motion requesting, for good cause, the recusal of the hearing officer from participation in a case. While a recusal motion may be made to a hearing officer, panel or the regulatory body, by its plain language, the provision requires the person hearing the matter to determine whether they should recuse themselves. *See also Crandell v.*

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Pennsbury Tp. Bd. of Supervisors, 985 A.2d 288, 296 (2009) ("Recusal motions are directed in the first instance to the official whose recusal is sought, for that official's self-assessment"). Black's Law Dictionary defines good cause as a legally sufficient ground or reason for granting the request. While this is not a judicial proceeding, NRS 1.230(1) provides guidance here in that a judge shall not act in a proceeding when he entertains actual bias or prejudice for or against one of the parties to the action.

The party seeking recusal must show that a judge is biased but if a judge's impartiality might reasonably be questioned, then the judge should recuse himself. *See* NCJC Rule 2.11(A). *See also Roe v. Roe*, 535 P.3d 274, 291, 139 Nev. Adv. Op. 21 (holding that ultimately the judge should be disqualified if "a reasonable person, knowing all the facts, would harbor reasonable doubts about the [judge's] impartiality"). *Id., citing Ybarra v. State*, 127 Nev. 47, 51, 247 P.3d 269, 272 (2011).

In this case, Woodman has demonstrated that he is biased against the Board in the handling of the disciplinary proceeding of McCleve because he continues to apply his interpretation of the law and uses his power as the hearing officer to seek to have Board cases dismissed without being heard on the merits of the complaint. The Board as of today has filed two petitions for writ of mandamus against Mr. Woodman challenging his interpretation of the Board's statutes and he is currently the Respondent in those proceedings pending in the Second Judicial Court.

The second writ petition was filed on May 31, 2024, which was precipitated by his desire to dismiss the case against McCleve prior to hearing the case on the merits because the Board did not comply with his decision that is currently being challenged and pending in court. Without the actual authority to grant dismissal[2], he indicated on the record of the McCleve hearing that he would wrap this hearing and send his recommendations to the Board that this case does not go any further. He

[2] Notably, Woodman has no authority as a hearing officer to dismiss a case on the grounds requested here (i.e. failure to provide confidential non discoverable information). A request for a motion to dismiss is permitted by NRS 622A, if the complaint filed to initiate disciplinary proceedings fails to state facts which, if true, would form a sufficient basis for discipline. Any findings and recommendations of the hearing officer are only final if approved by the regulatory body which may approve, modify, reject, remand, order trial de novo, or take any other action it deems appropriate. For this reason, IC counsel requested that the hearing on the merits go forward, and Woodman could provide his opinion on the legal issue of confidential discovery in his recommendations after hearing all the evidence.

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used time on the record to excoriate the Board for its unfairness while never citing any legal provisions in support of his harsh critique.

The disagreement Woodman has with the Board and its counsel regarding the interpretation of the legal provisions has escalated to the point where Woodman cannot hide his biased. Notwithstanding that Woodman's interpretation of the Board's statutory provision has been pending in the Second Judicial District Court since April 17, 2024, he issued the same decision in yet a second matter on May 29, 2024, then determined that a matter should be dismissed prior to hearing any evidence. He rejected a request to continue the McCleve hearing pending the determination on the pending writ proceedings in the Chacon matter which further demonstrates that his decision making is unreasoned and unbiased as waiting for court input is appropriate in the case where a writ has been filed challenging his statutory interpretation.

Finally, Woodman has already demonstrated his intent to apply his same reasoning to the instant matter, continues to accuse the Board of wrongdoing – i.e. hiding information from licenses - as opposed to seeking determination on an issue of statutory construction - and therefore he should recuse himself.

Woodman inappropriately sought attorney client information from IC counsel regarding the IC's intentions in the Chacon litigation in which he is the Respondent, and the Board is the Petitioner, while at the same time holding the power as a hearing officer in the McCleve case. Woodman also inquired whether the Board would name McCleve as a party in subsequent writ proceedings and then counseled McCleve's attorney to seek intervention in the writ proceeding.

Woodman did not take the time on the record during the McCleve hearing to delineate the legal principles on which his decisions were based. Instead, he laid out his grievances toward the Board (specifically that it is outrageous, unconscionable, and unfair). Any reasonable person witnessing his verbal abuse and personal attacks of the Board at the McCleve hearing would harbor reasonable doubts about his impartiality[3].

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[3] The Board will supplement this request to complete the record pending receipt of the final transcript of the May 30, 2024, hearing in the matter of the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C.

IV. CONCLUSION

Woodman's feelings and opinions are conclusory - he just does not feel that the Board is fair. His tone, forum, and timing of comments at the McCleve hearing raise questions of his impartiality in considering the disciplinary hearings of the IC. Accordingly, the IC requests that Woodman recuse himself from the instant matter.

DATED this 3rd day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Deonne E. Contine

Deonne E. Contine
General Counsel
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Tel: (775) 688-2559
Email: dcontine@medboard.nv.gov
Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 4th day of June, 2024, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. PURSUANT TO NRS 622A.360(2)(b)** via hand delivery to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. & Amanda Rosenthal, Esq.

CHARLES WOODMAN, ESQ.

Further, the document mentioned above was also emailed on June 3, 2024 by Deonne Contine, General Counsel to:

CHARLES WOODMAN, ESQ.
PATRICIA DAEHNKE, ESQ.
AMANDA ROSENTHAL, ESQ.

DATED this 4th day of June, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

FILED

JUL 15 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against

ERIC JOSEPH PIPPI, PA-C,

Respondent.

Case No. 22-48045-1

Hearing Date: July 26 - 27, 2022 @ 8:30 a.m.

ORDER DENYING MOTION TO COMPEL

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

On June 7, 2022, Respondent filed a Motion to Compel (the "Motion") by which he seeks documents that were the subject of a prior "Deposition Subpoena and Subpoena Duces Tecum" (the "Subpoena"). The Subpoena was quashed on the basis set forth in the Order Quashing "Deposition Subpoena and Subpoena Duces Tecum" provided herewith as **Exhibit 1** and incorporated herein by reference (the "Subpoena Order"). By and through the Motion, Respondent argues that, based upon "[b]asic notions of due process and fair play," he is entitled to the production of documents pertaining to the Nevada State Board of Medical Examiners' (the "Board") "decision to discipline Respondent." Motion, p. 1, lines 9-11. Respondent premises this statement upon an allegation of selective enforcement, indicating that Respondent is entitled to

know "whether the Board engaged in arbitrary and selective prosecution." Motion, p. 2, lines 23-25.

The Investigative Committee of the Nevada State Board of Medical Examiners (the "IC") has opposed the Motion, arguing that the Moton is duplicative of the Subpoena, which was already quashed, and that the discovery Respondent is seeking is not permitted in the context of the administrative hearing and its statutory and administrative structure, which themselves ensure due process.

In reply, Respondent argues that case law relied upon by the IC, namely Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), is inapplicable to pending proceedings (versus an investigation into possible proceedings), and that deprivation of the discovery requested will be prejudicial to Respondent and, therefore, contrary to his due process rights.

The majority of the legal analysis relevant to the Motion was previously addressed in the Subpoena Order, which has been incorporated herein by reference. Based upon the analysis therein, which covers the statutory and administrative basis for denying the Motion, it remains that production of the requested documentation cannot be compelled.[1] To the extent additional arguments are made in the Motion with respect to NRS 630.336(5), case law, due process, and selective enforcement, they are addressed as follows.

NRS 630.336(4) provides, in relevant part, "a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint[,] and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential." The following section of that statute, NRS 630.336(5), provides that "[t]he formal complaint or other document filed by the Board to initiate

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[1] A portion of this argument as made by Respondent in the Motion and addressed in the Subpoena Order relies upon NAC 630.470(4), which Respondent advocates "provides that pre-hearing depositions of witnesses and parties may not be taken and no formal discovery conducted, *unless the Hearing Officer allows it.*" Motion, p. 3, lines 26-28 (original emphasis). However, NAC 630.470(4) actually provides, "[p]rehearing depositions of witnesses and parties may not be taken and no formal discovery of evidence, except as otherwise provided in NAC 630.465, will be allowed." NAC 630.465 provides only for the exchange of a list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness, as well as for the production of all evidence, except rebuttal evidence. As such, a hearing officer does not have discretion to allow pre-hearing depositions and formal discovery as Respondent advocates.

disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records."[2] In support of his argument, Respondent relies upon the latter language in subsection 5 that references as public "documents and information considered by the Board when determining whether to impose discipline are public records."

When considering the two provisions, subsection 4 and subsection 5, they establish that investigative documents are not public save and except for if they are relied upon by the Board when determining whether to impose discipline.[3] To that end, what is submitted to the Board in its determination to impose discipline are the documents that consist of the record before the hearing officer and the hearing officer's synopsis of the testimony taken, which includes a recommendation on the veracity of witnesses. NAC 630.470. As such, any documents outside of the evidentiary hearing record and the submission of from the hearing officer, which is likewise based upon the evidentiary hearing record, remain confidential pursuant to subsection 4 and are not discoverable. Thus, reliance upon NRS 630.336(5) is unavailing to compel the production of such documentation.

In consideration of Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), Respondent is correct that Sarfo addressed the confidentiality of an investigative file with respect to the investigative phase and prior to the filing of a formal complaint. Sarfo nonetheless made it clear that the confidentiality provisions apply to a responding licensee and such confidentiality provisions, by their terms, continue past the investigatory phase. Therefore, the

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[2] A complaint as contemplated by NRS 630.307 and as referenced in subsection 4 is the grievance submitted to the Board that is reviewed and investigated as a preface to what may result in a formal complaint lodged pursuant to NRS 630.399. A complaint lodged pursuant to NRS 630.339 is specifically referenced in the statutory scheme as a "formal complaint" as reflected in subsection 5.

[3] If "disciplinary action" and the "imposition of discipline" were similarly defined; for example, if the "imposition of discipline" could encompass instigating disciplinary action, the limitations of NRS 630.336(4) would be rendered meaningless, which would be contrary to rules of statutory interpretation. Further, "imposition of discipline" is referenced in NRS 630.352, which indicates that, at the conclusion of a hearing on the formal complaint, the Board shall vote to "impose discipline" or, alternatively, dismiss the charges if the Board determines that no violation has occurred. Thus, the terms are exclusive and while the disciplinary hearing is a disciplinary action, the imposition of discipline is the step considered after the conclusion of the hearing if the charges stemming from the formal complaint are substantiated.

question that remains is whether a responding licensee remains subject to such confidentiality after a formal complaint is filed based upon considerations of due process.

"Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008). To effectuate this, "[a]dministrative bodies must follow their established procedural guidelines and give notice to the defending party of 'the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it." Id.

To facilitate notice of formal allegations brought against a respondent in a matter deemed sufficient to allow a responding party to defend, NRS 630.339 establishes that the formal complaint must: 1) include a written statement setting forth the charges alleged and setting forth in concise and plain language each act or omission of the respondent upon which the charges are based; 2) be prepared with sufficient clarity to ensure that the respondent is able to prepare a defense; and 3) specify any applicable law or regulation that the respondent is alleged to have violated. In this respect, the Nevada Supreme Court has recognized that so long as these standards are met, the minimum standard of due process with regard to notice are met. Dutchess Bus. Servs., Inc., 124 Nev. at 711, 191 P.3d at 1166 (2008) (the filing and service of accusations against a licensee that sets forth in writing the charges alleged and the acts or omission with which the respondent is charged such that the respondent may prepare a defense comports with due process).

In the formal complaint against Respondent, the IC alleges specific charges, those being Disciplinary Action by Another State Medical Board and Failure to Report Disciplinary Action. The basis of each charge is stated with sufficient clarity in that the circumstances underlying each of the charges is articulated, and each charge identifies the applicable law or regulation alleged to have been violate; in fact, the alleged violations have been thoroughly briefed by the parties by and through Respondent's Motion to Dismiss filed concurrently with the Motion. As such, pursuant to recognized standards of due process applicable to the instant proceeding,

Respondent's due process rights have been met and Respondent may not rely upon the same to overcome the applicable confidentiality provisions.

With respect to Respondent's allegation of selective enforcement, a *prima facia* showing must be made to support such a claim as was indicated in the Subpoena Order in the context of Respondent's discovery request. *See, e.g.,* People v. Tuck, 139 Cal. Rptr. 3d 407, 418 n. 4 (2012) (recognizing that an alleging party must make the necessary *prima facie* showing to justify discovery).

To expand upon this point, to support a claim of selective enforcement, a respondent bears the heavy burden of establishing, at least *prima facie*: 1) that, while others similarly situated have not generally been proceeded against because of conduct of the type forming the basis of the charge against respondent, respondent has been singled out for prosecution; and 2) that the government's discriminatory selection of respondent for prosecution has been invidious or in bad faith, i.e., based upon such impermissible considerations as race, religion, or the desire to prevent respondent's exercise of constitutional rights. *See* State v. Flynt, 407 N.E.2d 15, 17 (OH 1980), writ dismissed, 451 U.S. 619 (1981) (as cited in a medical board case: Brownlee v. State Med. Bd., 2013 WL 6021182, 2013-Ohio-4989).

Nevada articulates this standard in McDonald v. State, 477 P.3d 373 (Nev. App. 2020), which provides:

> To prevail on a selective prosecution claim the claimant must demonstrate that the prosecutorial policy had a discriminatory effect and it was motivated by a discriminatory purpose. United States v. Armstrong, 517 U.S. 456, 465 (1996). "A selective-enforcement claim requires essentially the same showing." United States v. Griffith, 928 F.3d 855, 866 (10th Cir. 2019). To establish a discriminatory effect[,] ... the claimant must show that similarly situated individuals ... were not prosecuted." United States v. Armstrong, 517 U.S. 456, 465 (1996). To show discriminatory purpose, a claimant must establish "that the decision-maker ... selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." Wayte, 470 U.S. at 610 (internal quotation marks omitted). "This standard is a 'demanding one.' " Griffith, 928 F.3d at 866. . . . Unless suspect classes are involved in the selective enforcement, the Equal Protection Clause is violated only if there is no rational basis to justify the selective enforcement. *See* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487-488 (1955).

In sum, "[s]elective enforcement is an equal protection term that applies when a law is selectively enforced based on an unjustifiably discriminatory classification such as race, religion, or some other arbitrary characteristic," nothing of which Respondent has alleged. Low Cost Pharmacy, Inc. v. Arizona State Bd. of Pharmacy, No. 1 CA-CV 07-0547, 2008 WL 2154793, at *9 (Ariz. Ct. App. May 20, 2008) (*citing* State v. Patton, 665 P.2d 587, 590 n. 6 (Ariz. App.1983) and Oyler v. Boyles, 368 U.S. 448, 456 (1962). It also remains that selective enforcement does not encompass mere selectivity of enforcement given that such selectivity has to be unconstitutionally discriminatory to be deemed to be a Constitutional violation. *See* State v. Howard, 337 S.E.2d 598, 601 (N.C. App. 1985) (*citing* People v. Utica Daw's Drug Co., 16 A.D.2d 12, 225 N.Y.S.2d 128, 4 A.L.R.3d 393 (1962)); *see also* People v. Toomey, 157 Cal. App. 3d 1, 12–13, 203 Cal. Rptr. 642 (Ct. App. 1984) ("'an equal protection violation does not arise whenever officials 'prosecute one and not [another] for the same act;' instead, the equal protection guarantee simply prohibits prosecuting officials from purposefully and intentionally singling out individuals for disparate treatment on an invidiously discriminatory basis.' 'Prosecutorial discretion permits the choice among possible defendants which to prosecute, whether to prosecute, and in what order to prosecute.'") (citations omitted).

Even further, as recognized in Williams v. State, 393 So. 2d 492, 494 (Ala. Crim. App. 1981), "the mere showing of selective enforcement of a statute, without more, is not constitutionally impermissible." Id. (*citing* Oyler v. Boles, 368 U.S. 448 (1962) for the proposition that the conscious exercise of some selectivity in enforcement is not in itself a constitutional violation; and, even though statistics might imply a policy of selective enforcement, it remains that the selection must be deliberately based upon an unjustifiable standard such as race, religion, or other arbitrary classification). The fact that some people escape prosecution under a statute is not a denial of equal protection unless selective enforcement of the statute is intentional or purposeful given that the determination to prosecute is within a prosecuting authority's discretion. *See* May v. People, 636 P.2d 672, 681–82 (Colo. 1981) (*citing* Yick Wo v. Hopkins, 118 U.S. 356 (1886); People v. District Court, 632 P.2d 1022 (Colo. 1981)).

Here, Respondent has made a blanket assertion that any and all information related to the Board's prosecution of such claims as those brought against Respondent should have to be produced "to ensure that the Board is not abusing its discretion by unfairly and selectively disciplining healthcare providers." Motion, p. 8, lines 4-9. Such an assertion does not address the relevant standards of selective enforcement, nor a mandated showing of unlawful discrimination, and is, therefore, insufficient to mandate the relief requested. As such, Respondent's Motion to Compel is DENIED.

DATED this 15th day of July 2022.

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 DENYING MOTION TO COMPEL addressed as follows:

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

DATED this 15th day of July, 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D., Respondent.**	**Case No. 23-11660-1**

FILED
JUN - 4 2024
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

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF EXAMINERS' OPPOSITION TO REQUEST FOR PRODUCTION OF PUBLIC RECORDS AND/OR PRODUCTION OF THE INVESTIGATIVE FILE

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through counsel, Donald K. White, Senior Deputy General Counsel for the Board, and attorney for the IC, respectfully moves for recusal of hearing officer Charles Woodman, Esq. from the current action based on the following:

MEMORANDUM OF POINTS AND AUTHORITIES

I. BACKGROUND

For its part, the purpose of the Board is clear: the Legislature has delegated to the Board the responsibility in this State, "to ensure, as far as possible, that only competent persons practice medicine . . ." It must use its regulatory power to ensure the interests of the public – whose interests must not be outweighed by the interests of medical professionals. These regulatory powers are broad and liberally construed in favor of public protection and to benefit the public. *See generally* NRS 630.003.

There is also a growing tendency among counsel who represent licensees in disciplinary proceedings to request extra administrative processes and accommodations that are not provided by law. Administrative proceedings are governed (and limited as compared to matters in civil courts) by NRS 233B, NRS 622A and NRS and NAC 630. Indeed, administrative law contemplates a process free from the burdens and delay of civil practice (e.g. limited discovery and motion

practice). Consequently, requests outside those provided by administrative law unnecessarily create delay, waste resources, and corrupt the administrative process.

Accordingly, to preserve the administrative process as required by law, the IC opposes Respondent's Request for Production of Public Records and/or Production of the Investigative File as follows:

A. The IC's investigative file is confidential and not discoverable unless the IC intends to use material from the file in the prosecution of its case;

B. Investigative file material becomes public only when it is produced pursuant to a request under NRS 622A.330(1) or provided pursuant to NAC 630.465 because at that time the IC is required to demonstrate its intent to use the material in the prosecution of the disciplinary case and, as such, the materials will be reviewed by the Board to determine whether a violation has occurred and whether to impose discipline; and

C. Due process is satisfied in this case because Respondent has been fully apprised of the charges against her and the factual bases underlying them, and the IC of the Board has followed all established procedural guidelines. Additionally, a due process claim is speculative and not ripe for consideration.

II. FACTUAL HISTORY

On November 17, 2023, the IC filed a formal complaint against Respondent. On February 27, 2024, an Early Case Conference (ECC) was held telephonically with all parties and Hearing Officer, Charles Woodman, present. On May 2, 2014, a Prehearing Conference was held telephonically with all parties present, including Mr. Woodman. Both parties disclosed the exhibits they intended to use at the hearing and also presented their Prehearing Conference Statements in a timely manner. For months, the hearing has been set for June 4-5, 2024. After receiving the IC's exhibits, Dr. Barber did not request more documents. In fact, just the opposite occurred, Dr. Barber filed a motion to exclude some of the IC's exhibits, on the last day for filing motions, May 24, 2024.

On Sunday, June 2, 2024, just two days before the hearing in this matter, counsel for Dr. Barber sent counsel for the IC an email requesting the IC's investigative file. *See* **Exhibit 1**. Respondent's counsel then sent another email stating where and/or how we may be able to send the

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IC's investigative file. *Id.* Counsel for the IC responded to Respondent's counsel on Monday morning by stating that, "[w]e have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file." *Id.* Dr. Barber then filed a Request for Production of Public Records and/or Production of the Investigative File in an email at 2:26 pm, the day before the hearing. In an email to Mr. Woodman with counsel for Dr. Barber copied in, at 2:57 pm, counsel for the IC requested a stay to the proceedings in light of the fact that there are two (2) Writs of Mandamus pending in the Second Judicial District Court involving this identical issue (whether the IC can be compelled to disclose its investigative file). *See* **Exhibit 2**. Despite subsequent emails, including one at 4:14 pm sent by counsel for the IC asking that Respondent's last-minute motion be held in abeyance, that as of the writing of this opposition, has gone unanswered. *See* **Exhibit 3**.

III. ARGUMENT

A. The IC's Investigative File is Confidential.

NRS 630.336(4) applies to the complaint, and the file created as a record thereof (collectively "the investigative file"). It states:

> "Except as otherwise provided in subsection 5 and NRS 239.0115, a complaint filed with the Board pursuant to NRS 630.307[1], all documents and other information filed with the complaint and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential."

By its plain language, NRS 239.0115 creates an exception to the strict confidentiality in NRS 630.336(4) when it allows a person to ask the District Court for permission to obtain the otherwise confidential investigative file after thirty (30) years have passed since the investigation or after the subject of the investigation dies. The Nevada State Archivist noting the confidentiality of an investigative file, testified as follows:

> We are looking at a record being closed forever and no one seeing it or it being opened too soon. We do not want individual rights of privacy compromised or third-party concerns, particularly correction or state mental institute records. This could mean psychiatrists, doctors, snitches or people, other than the media, seeing the record and bringing personal vendettas against people if

[1] NRS 630.307 provides for the filing of a complaint by a person against a Board licensee.

> they get the information too soon. . . . With this statute, we tried to include a period that addresses both rights and access to public information for researchers and others without compromising rights of individuals in any acceptable level of privacy. If records were available at ten years, it could raise issues of individuals being compromised with information in these records.

Minutes of the Senate Committee on Government Affairs, (February 26, 2007, Page 27).

This statutory change indicates that the entire investigative file is no longer confidential only after a request for court authorization at a time when the information contained in the file will not negatively impact privacy.

The Nevada Supreme Court also noted its concern about patient privacy when it deferred to the Board's reasonable interpretation of the plain language of NRS 630.336(4), and the fact that disclosing the investigative file may make patients hesitant to report malpractice without the protection of confidentiality. *Sarfo,* 134 Nev. at 714, 429 P.3d at 654. In fact, Dr. Sarfo had sought the IC's investigative file so he could attempt to determine who had filed the complaint against him. *Id.* at 710, 429 P.3d at 651. Additionally, NRS 630.311(3) reinforces the privacy concerns of the IC's investigations because IC proceedings, "are confidential and are not subject to the requirements of NRS 241.020."[2]

B. <u>IC Investigative File Materials Reviewed by the Board in Prosecution of the Formal Complaint Are Not Confidential.</u>

NRS 630.336(5) addresses the information from the investigative file that is introduced as evidence in the contested case. In short, this provision provides another limited exception to the confidentiality of the investigative file. When investigative materials are introduced as evidence in a formal complaint proceeding, they become part of the public record (and are no longer confidential) because they will be considered by the Board when determining whether a statutory violation has occurred, and discipline should be imposed pursuant to NRS 630.352. Indeed, the records of the case are reviewed and discussed in a public meeting under Nevada's Open Meeting Law. *See* NRS 622.320(2) (Board decisions related to disciplinary action are subject to the provision of NRS 241.020). *See also,* NRS 630.336(2) (formal hearings on any charges heard by the Board, records of formal hearings, and orders or decisions of the case are public).

[2] Without NRS 630.311(3), IC proceedings would be subject to the open meeting law because the definition of public body includes committees appointed by a Board. *See* NRS 241.015(4).

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During the 2011 Legislative session, the Board sought to amend NRS 630.336(5) to clarify the confidentiality distinction between a complaint filed by a person pursuant to NRS 630.307 and a complaint filed pursuant to NRS 630.339. Board Executive Director Cooper noted in his testimony that, "the investigative complaint is a confidential report that starts an investigation. This information needs to remain confidential to prevent unscrupulous and nefarious competitors from loading up complaints on their competitors." *Minutes of the Senate Committee on Commerce, Labor and Energy*, (February 23, 2011, Page 29).

Accordingly, the Board sought to add the word, "formal," in NRS 630.336(5) to clarify that the formal complaint and other documents related thereto are public while the investigative file which includes the complaint filed pursuant to NRS 630.307 remains confidential unless the Board intends to introduce certain documents in the investigative file into evidence during prosecution of the formal complaint. The clarification is consistent with NRS 630.339 which allows for filing of a formal complaint to prosecute a violation of NRS Chapter 630. Indeed, NRS 630.336(5) reads today as follows:

> The formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records.

The documents and information considered by the Board when determining whether to impose discipline are limited to the record of the formal complaint proceedings and are reviewed in a public meeting noticed pursuant to Nevada's open meeting law. *See* NRS 622.320(2). The documents and information considered by the Board when determining whether to impose discipline includes those documents from the investigative file introduced at the hearing on a formal complaint and does not include any IC investigative file information not used in prosecuting the violations of NRS Chapter 630.

Based on the confidentiality distinction between the complaint filed by a person to initiate an investigation and the formal complaint filed to initiate disciplinary action, a licensee is entitled only to the documents from the investigative file that the prosecutor intends to use at the hearing, after a formal complaint is filed and the licensee makes a request for such documents under

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NRS 622A.330(1) and as otherwise required by NAC 630.465 because they are discoverable by law and not confidential.

The IC does not intend to present reports of Dr. Nicholas Spoerke as evidence in support of its case against the Respondent. As no reports will be introduced as evidence at the hearing, they will not be reviewed by the Board when determining whether to impose discipline and therefore are not public pursuant to NRS 630.336(5).[3] They remain confidential investigative material pursuant to NRS 630.336(4). Accordingly, the IC will only rely on the testimony of Dr. Spoerke (as a properly designated witness) and after disclosure as required by NRS 622A.330 and NAC 630.465 which is supported by law.

C. The IC Intends to Present the Testimony of Nicholas Spoerke, M.D. Because He Has Been Properly Identified Pursuant to the Requirements of NRS 622A.330 and NAC 630.465.

NRS Chapter 622A governs the administrative procedure before certain regulatory bodies, including this Board. *See* NRS 622A.120. One of the purposes of NRS Chapter 622A is to provide rules that will be consistently applied by each of the regulatory agencies to which it applies. *See* NRS 622A.130(1) (the general purpose is to make uniform among the regulatory bodies the procedures used to prosecute contested cases and take administrative action against a person who violates any law or regulation governing occupational licensing). The intent of the chapter is to supplement a specific Board's statute but, "If there is a conflict between such other provisions and the provisions of this chapter, the provisions of this chapter control." *See* NRS 622A.130(2).

The provisions of NRS Chapter 622A apply not only to the Board but any regulatory body that regulates an occupation or profession pursuant to Title 54 of the NRS. Accordingly, the provisions of NRS 622A cannot be ignored and the confidentiality provisions in NRS 630.336 regarding the investigative file and the formal complaint file must be read in conjunction with the

[3] In addition to ignoring the privacy concerns identified by the Legislature and the Nevada Supreme Court, as discussed in on pages 3-4 herein, interpreting NRS 630.336(5) to eliminate the confidentiality of the entire investigative file when documents from the file are designated for use in the prosecution of a case, such a reading does not consider that the IC proceedings are confidential. *See* NRS 630.311(3). In fact, the IC proceedings include both written and oral attorney client and work product, deliberative process, and peer review privileged communication, among others, which are part of the investigative file pursuant to NRS 622A.330 (The investigative file for the case includes all communications, records, affidavits, or reports acquired or created as part of the investigation of the case).

discovery requirements in NRS Chapter 622A. NRS 622A.330 governs the discovery requirements in administrative procedures before regulatory bodies. It provides:

> **NRS 622A.330 Discovery; limitations on interrogatories and depositions.**
>
> 1. At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses.
>
> 2. The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case. The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee.
>
> 3. A party may not serve any interrogatories on another party or take any depositions relating to the case, unless permitted by the regulations of the regulatory body.

Reading NRS 622A.330(1) and (2) together as a whole elucidates that a licensee, after being served with a formal complaint, may file a written discovery request only for the evidence intended to be presented by the prosecutor at hearing and for a list of proposed witnesses. Otherwise, the materials in the investigative file for the case are not discoverable. A fundamental axiom of statutory interpretation is that related statutes must be read together. *See Barney v. Mt. Rose Heating & Air Conditioning,* 124 Nev. 821, 826-27, 192 P.3d 730, 734 (2008) ("Statutes are to be read in the context of the act and the subject matter as a whole ....").

Indeed, reading NRS 622A.330(2) to allow discovery beyond that permitted by NRS 622A.330(1) would render 622A.330(1) meaningless. There would be no reason to limit the request in NRS 622A.330(1) to only "evidence intended to be used by the prosecutor in support of the case," then turn around and allow discovery of the entire investigative file when a board complies with that request. *See Public Employees' Benefits Program v. Las Vegas Metropolitan Police Department*, 124 Nev. 138, 147, 179 P.3d 542, 548 (Nev. 2008) (Statutes are construed so that no part is render meaningless); *See also, State v. Webster,* 102 Nev. 450, 453, 726 P.2d 831, 833 (1986) (Statutory construction should always avoid absurd result).

Turning to NAC 630.465, at least thirty (30) days prior to a hearing, a prehearing conference is conducted where each party provides the other party with a copy of a list of

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proposed witnesses and their qualifications and summary of their testimony. In addition to the requirements of NRS 622A.330, each party provides any evidence that the party proposes to introduce at a hearing. 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. *See* NAC 630.465 as amended by LCB File No. R171-20, June 2, 2023, and LCB File No. R069-23, April 19, 2024.

In this case, there was no written discovery request under NRS 622A.330(1) by the Respondent for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses. However, by May 2, 2024, the date of the prehearing conference, the IC had identified Nicholas Spoerke, M.D. as a witness who is intended to testify in this matter. The IC identified Dr. Spoerke as having conducted a medical review of this case and designated him to testify regarding his review and the applicable standard of care. A CV was also provided for Dr. Spoerke as Exhibit 5 to the prehearing conference statement. The IC does not intend to use a report from its investigative file as documentary evidence in this case. Accordingly, the IC has provided all the documents required by NAC 630.465(3). Dr. Spoerke was properly designated, and a summary of his testimony was provided. Accordingly, he may testify at the hearing on the IC's formal complaint in this matter.

D. <u>Due Process Does Not Require Disclosure of Reports the IC Does Not Intend to Use In Prosecution of Its Case Against Respondent.</u>

Respondent contends that the IC's denial to produce any reports of its properly designated witness violates her due process rights and therefore, she will not receive a fair hearing. This argument is misplaced.

First, the IC agrees that Respondent is entitled to due process in this proceeding. *See Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy*, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008) ("Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply."). The Nevada Supreme Court has explained that in an administrative proceeding, "it is the opportunity to

prepare a defense that defines due process." *Id.* at 712, 191 P.3d at 1167 (citing *Nevada State Apprenticeship Council v. Joint Apprenticeship & Training Comm.*, 94 Nev. 763, 765, 587 P.2d 1315, 1317 (1978)). Thus, a process that ensures that a respondent is apprised of the charges against him or her and the factual bases underlying them, and where the administrative body follows its established procedural guidelines, provides the required due process. *See id.* at 711-12, 191 P.3d at 1166-67.

In this case, the Board has complied with all established procedural guidelines. Respondent is aware of the charges against her as they are factually alleged in the Complaint served on November 17, 2023, which complies with NRS 630.339. Additionally, both a motion to dismiss and a motion for a more definitive statement were available to Respondent.[4] But, Respondent filed an Answer on December 12, 2023, which included general and narrative denials to most counts in the Complaint.

Additionally, the Early Case Conference was noticed and timely held, the Prehearing Conference was conducted during which the IC identified and provided documents it intends to use at the hearing and included a witness list summarizing the nature of the testimony and qualification, and all motion practice (whether as a right or as requested by the parties) was completed.

A Board is governed by governing chapters and administrative process rules. In the case of the IC, the established procedural guidelines are found in Chapters 630 and 622A of the NRS and NAC and as provided extensively herein, the IC has fully complied.

Furthermore, Respondent has adequate due process protections to defend the IC's charges for violations of NRS Chapter 630. In *Resnick v. Nevada Gaming Commission,* 104 Nev. 60, 752 P.2d 229 (1988), a casino employee filed a petition with the Eighth Judicial District Court requesting that the Court review the gaming commission's order denying him discovery, specifically an investigative report in a licensing matter. The trial Court held that it lacked jurisdiction to provide the relief requested and the casino employee appealed.

[4] *See* NRS 622A.360(2) A party may file prehearing motions including:
(d) A motion requesting a more definite statement regarding the allegations in the charging document on the ground that there is not enough information in the charging document to formulate a defense.
(e) A motion requesting dismissal of the charging document for failure to state facts which, if true, would form a sufficient basis for discipline.

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The Court determined that Mr. Resnick incorrectly assumed that because he has the right to cross-examine a witness, he had a right-of-access to all materials which he believed would assist him in this cross-examination. The Court additionally stated that although the Appellant does not have the right to discover the Board's report, he does have other rights - the right to call witnesses, offer evidence, cross-examine and impeach witnesses, and provide exhibits. Mr. Resnick did not show the Court that these protections inadequately protect his rights. The Court more importantly, opined that "[i]f the legislature intended an applicant to have access to the Board's report or to otherwise be entitled to conduct discovery, it could have so specified. Therefore, Resnick's argument, that NRS 463.313 should be interpreted to allow pre-hearing discovery, was without merit." *Id* at 65, 752 P.2d at 232.

Similar to the statute in *Resnick,* where the Court noted it did not allow pre-hearing discovery based on the statute, in this case, Respondent is limited in her administrative proceeding to discover only the evidence intended to be presented by the prosecutor at her disciplinary hearing. Also like in *Resnick*, the IC has fully complied with its discovery requirements in NRS 622A.330 and NAC 630.465. Respondent also has the right to call, examine, cross examine, and impeach witnesses. Additionally, she can introduce her own exhibits, challenge the IC's exhibits and witnesses, and offer rebuttal evidence. *See* NRS 622A.380. Lastly, as in *Resnick*, Respondent does not need access to any investigative reports to exercise these rights. *Id*

Finally, a speculative deprivation of due process claim is not ripe for consideration in a prehearing motion. *Id* at 66, 752 P.2d at 233, (citing *Doe v. Bryan*, 102 Nev. 523, 525, 728 P.2d 443, 444 (1986) (Nevada has a long history of requiring an actual justifiable controversy as a predicate to judicial relief. Moreover, litigated matters must present an existing controversy, not merely the prospect of a future problem.) With respect to Mr. Resnick's constitutional argument, the Court noted, it was "based on a purely conjectural premise – that in the future he will be denied a license and therefore deprived of property or liberty." *Id* at 65, 752 P.2d at 232. Like Mr. Resnick, any deprivation of due process is conjecture and Respondent can argue that she was deprived of property or liberty without due process when such an argument is ripe – if her license

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is ultimately revoked. At that point, Respondent may have a factual foundation for an assertion that she was deprived of something. *Id* at 66, 752 P.2d at 233.

IV. CONCLUSION

Respondent misinterprets and misapplies the administrative process in her argument that she may not receive a fair hearing and that she is entitled to the IC's investigative file. Testimony intended to be provided by Dr. Spoerke complies with the governing statutes and provisions of the administrative process and this Board. Due process has been met throughout the pendency of this matter and will continue to be met. Accordingly, and based on the foregoing, Respondent's Request for Production of Public Records and/or Production of the Investigative File must be denied in its entirety.

DATED this 4th day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 4th day of June, 2024, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF EXAMINERS' OPPOSITION TO REQUEST FOR PRODUCTION OF PUBLIC RECORDS AND/OR PRODUCTION OF THE INVESTIGATIVE FILE** via hand delivery to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. & Amanda Rosenthal, Esq.
Attorney for Respondent

CHARLES WOODMAN, ESQ.
Hearing Officer

DATED this 4th day of June, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

EXHIBIT 1

EXHIBIT 1

Meg Byrd

From: Donald K. White
Sent: Tuesday, June 4, 2024 8:41 AM
To: Meg Byrd
Subject: FW: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Donald K. White, J.D.
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From: Donald K. White
Sent: Monday, June 3, 2024 10:05 AM
To: 'Patricia Daehnke' <Patricia.Daehnke@cdiglaw.com>
Cc: Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: RE: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good morning Tricia,

We have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file.

Thank you,
Don

Donald K. White, J.D.
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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Sunday, June 2, 2024 4:45 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hi Don,

You could send over a paper copy to me at my hotel or we can send a secure link in the morning so the file can be downloaded whichever you prefer.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On Jun 2, 2024, at 4:36 PM, Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

Good afternoon Don,

I am getting ready for the hearing and don't see that you have produced either investigative file in this matter. I checked and the board did not provide the investigative file from the case that was dismissed nor the current case. Please provide a copy of the investigative file.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On May 31, 2024, at 10:47 AM, Donald K. White <dwhite@medboard.nv.gov> wrote:

Good morning Mr. Woodman,

Thank you for checking on this. I'm forwarding the email below again. I withdrew my motion since I was able to correspond with Dr. Spoerke, and he confirmed that he is available for the hearing.

Sincerely,
Don

Donald K. White, J.D.
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From: Donald K. White
Sent: Tuesday, May 28, 2024 1:38 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: FW: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good afternoon everyone,

Please allow me to withdraw the Motion to Continue (which was emailed and not filed on Friday, May 24, 2024).

I just spoke with Dr. Spoerke and he is available on June 4, 2024.

Thank you,
Don

Donald K. White, J.D.
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From: Donald K. White
Sent: Friday, May 24, 2024 6:31 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Hello Mr. Woodman and Ms. Daehnke,

Attached is a Motion to Continue the hearing currently set for June 4-5, 2024. As you will read, I have had much difficulty contacting the IC's expert, Dr. Nicholas Spoerke, and therefor I'm unable to confirm his availability for the hearing.

I would have informed you of this earlier, but I was holding out hope that I would have spoken with him by now. This is also the same reason I did not reach out to you, Ms. Daehnke, for a possible stipulation to continue.

Board staff who have the ability to file documents have gone home for the weekend, so this will be filed on Tuesday, May 28, 2024.

Hope everyone has a safe and relaxing Memorial Day weekend.

Thank you,
Don

Donald K. White, J.D.
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EXHIBIT 2

EXHIBIT 2

Meg Byrd

From: Donald K. White
Sent: Tuesday, June 4, 2024 8:42 AM
To: Meg Byrd
Subject: FW: Barber M.D. - Request to Stay Proceedings

Donald K. White, J.D.
Senior Deputy General Counsel
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775.324.9355
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From: Donald K. White
Sent: Monday, June 3, 2024 3:55 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: RE: Barber M.D. - Request to Stay Proceedings

Mr. Woodman,

That is correct that the IC does not believe that its investigative file is public record and will refuse to disclose the part of the file protected by NRS 630.336. The only part that becomes public record is what is marked and admitted at the hearing.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Charles Woodman <hardywoodmanlaw@msn.com>
Sent: Monday, June 3, 2024 3:47 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Re: Barber M.D. - Request to Stay Proceedings

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So we have another impasse. Mr. White is proposing a stay for the following reason (I believe - Mr. White correct me /clarify if necessary):

There are two writs currently pending in the Washoe District Court on this issue: the IC does not believe its investigative file is public record. I disagree. We know from past experience (including in a case I just heard last week) that the IC will defy my order to produce what I tell them to produce. Until the writs are adjudicated, we are burning time and fees going to hearing that don't make sense as the IC is going to continue to refuse to produce its file unless the court tells them they have to.

How does Respondent's counsel respond to a proposed stay?

Charles B. Woodman
The Law Offices of Charles B. Woodman
548 W. Plumb Lane, Suite B
Reno, NV 89509

775-786-9800

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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 2:56 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Barber M.D. - Request to Stay Proceedings

Hello Mr. Woodman,

In light of the fact that the Board currently has two Writs in District Court involving the same issue (disclosing the investigative file), I propose that this hearing should be stayed until a judge sorts out the issues in those matters, since they are identical to the very new issue in this matter.

Then there is a probability that Dr. Barber's case can be heard on its merits.

Respectfully, I am not presuming how you might rule, Mr. Woodman, but I know from those other matters that this has become a complicated issue and I want to avoid expending more costs and resources if it's not necessary at this time.

Please stay the proceedings until the subject matter of the Writs is resolved and we have a clear path forward. Once the subject of the Writs has been resolved, we can then set a status conference to move Dr. Barber's case forward. If you are inclined to grant the stay, please issue an order confirming the same.

Thank you,
Don

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EXHIBIT 3

EXHIBIT 3

Meg Byrd

From: Donald K. White
Sent: Tuesday, June 4, 2024 8:43 AM
To: Meg Byrd
Subject: FW: Barber M.D. - Request to Stay Proceedings

Donald K. White, J.D.
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From: Donald K. White
Sent: Monday, June 3, 2024 4:14 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: RE: Barber M.D. - Request to Stay Proceedings

That sounds fine, Mr. Woodman. However, Dr. Barber's Request for Production of Public Records and/or Production of the Investigative File should be held in abeyance until after this matter is heard on its merits. At a time when counsel for the IC has time to respond, or at least until June 10, 2024. Pursuant to your Amended Scheduling Order, "[a]ll motions are to be filed no later than Friday, May 24, 2024 by 5:00 P.M. Dr. Barber filed her request today – 10 days past the deadline to file motions.

Thank you,
Don

Donald K. White, J.D.
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From: Charles Woodman <hardywoodmanlaw@msn.com>
Sent: Monday, June 3, 2024 4:03 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Donald K. White <dwhite@medboard.nv.gov>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Re: Barber M.D. - Request to Stay Proceedings

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That works. We'll go on the record at 9:00 tomorrow.

Charles B. Woodman
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Sent: Monday, June 3, 2024 3:58 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Donald K. White <dwhite@medboard.nv.gov>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: RE: Barber M.D. - Request to Stay Proceedings

Good Afternoon Hearing Officer Woodman,

On behalf of Respondent Dr. Barber, we object to any continuation or stay of the Hearing. Dr. Barber has spent significant money out of pocket to prepare for this Hearing, has traveled to Reno, and her expert is traveling from New Jersey for the Hearing. We will be prepared to proceed as necessary with the Hearing tomorrow and believe any discussions regarding this issue should be made on the record tomorrow so we can preserve the record for future appeal as necessary.



Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
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Thank you,
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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.,** **Respondent.**	**Case No. 23-11660-1**

FILED

JUN 06 2024

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

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. (2ND REQUEST) PURSUANT TO NRS 622A.360(2)(b)

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through counsel, Deonne E. Contine, General Counsel for the Board, and attorney for the IC, respectfully moves for recusal of hearing officer Charles Woodman, Esq. ("Woodman") from the IC's case against Annabel Barber, M.D. based on the following:

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Second Motion to Recuse Woodman from hearing this case is filed because of a difference between Woodman and the IC regarding interpretation of NRS 630.336 and NRS 622A.330. The IC's position with respect to confidentiality and discoverability of the investigative file is a legitimate and longstanding interpretation of the relevant statutes. The interpretation is supported by case law and due process considerations and is consistent with a prior decision by a different hearing officer. The IC does not make these statutes and does not have the authority to defy them. The differing statutory interpretations between the IC and Woodman has led to court intervention by way of Petitions for Writ of Mandamus filed by the Board on April 17, 2024, and May 31, 2024, in which Woodman is the Respondent.

Additionally, as this disagreement relates to confidential, non-discoverable information that cannot be made confidential again once it is out to the public, the Board must seek court

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intervention prior to the disclosure of the documents. This is not an issue that the Board seeks to unfairly pursue because it wants to penalize or hide information from respondents. The Board must follow its statutory provisions and cannot arbitrarily decide as it sees fit when to apply and when not to apply its governing provisions.

II. FACTUAL BACKGROUND

On April 17, 2024, the Board, filed its Petition for Writ of Mandamus against Hearing Officer Charles Woodman ("Woodman"), ("Board's Petition, case number CV24-00838") seeking a writ ordering Woodman to rescind a Summary Prehearing Order filed April 11, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file in the Matter of Charges and Complaint Against: SAMUEL RODOLFO CHACON, M.D. The IC indicated that because of the confidentiality of the investigative file, it could not produce the file until a determination by the Court on the writ petition. Woodman issued an Order Staying All Proceedings in the CHACON matter which was set to go to hearing before Woodman on May 13, 2024, pending resolution of the Board's Petition, case number CV24-00838.

On May 31, 2024, the Board, filed its Petition for Writ of Mandamus against Woodman, ("Board's Petition, case number CV24-01206") seeking a writ ordering Woodman to rescind an Order on Prehearing Motions filed May 29, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file related to the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C ("McCLEVE").

The Board's Petition, case number CV24-01206, was filed after Woodman ordered the case against McCLEVE to proceed to a hearing over the objections of the IC's counsel on May 30, 2024, the first day of the hearing on the formal complaint against McCLEVE. The IC suggested that the formal complaint against McCLEVE should be stayed pending resolution of the legal issues in the Board's Petition, case number CV24-00838. Alternatively, IC counsel suggested that Woodman stay his Order on Prehearing Motions, take evidence as provided by the parties pursuant to NAC 630.465, and make his recommendations to the Board after hearing the case against McCLEVE on the merits, and reserve determination on the legal issue to the appropriate forum, the Board or the Court.

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During oral argument at McCLEVE's hearing on his motion for the IC to produce its investigative file, it was discussed that the IC would need to seek further Court intervention at which time Woodman inquired whether the Board would appeal the matter if it was not successful in district court. Counsel for the IC refused to share attorney client discussions or litigation strategies with Woodman who is the respondent in the writ proceedings.

Woodman denied the IC's request for continuance of the McCLEVE case notwithstanding that the IC maintained that the underlying legal issue must be decided by the court before the IC would produce the legal file as he had ordered. Finally, Woodman further escalated issues at the McCLEVE hearing when he directed a Board witness to answer questions regarding IC proceedings, over the objection of IC Counsel noting that IC proceedings are confidential based on a different confidentiality provision than the provision on which he had previously ruled.

Woodman, at the end of the morning session of the McCLEVE hearing on May 30, 2024, entertained an oral motion by McCLEVE to dismiss the formal complaint against him. Thereafter, Woodman stated that he would grant the motion to dismiss, wrap the case and send his recommendation to the Board that the case does not go any further. Woodman terminated the proceeding without hearing the case on the merits but not before a soliloquy admonishing the IC's counsel and the Board for not providing discovery to McCLEVE which is the subject of the writ petition. IC Counsel indicated its intent to preserve the legal issue by filing a second writ petition, which it did.

In his May 30, 2024, soliloquy on the record of the McCLEVE hearing, Woodman referenced the Board's General Counsel directly regarding the intent to file the writ – calling the Board's action unconscionable and stating that in the real world of civil and criminal law - they would laugh at the Board. He further advised counsel to go to court to ask that the writ be combined with the writ that is already pending. He also admonished the Board accusing it of not being fair because the Board will not stipulate around its statutory duties and noted his belief that the Board must be doing something wrong because he has heard Board cases for years and this issue has never come up.

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On June 4, 2024, the IC filed its first Motion to Recuse Hearing Officer Charles Woodman, Esq. from hearing the Matter of Charges and Complaint Against: ANNABEL ELIZABETH BARBER, M.D. because his comments at the McCLEVE hearing would lead a reasonable person to question whether Woodman could be impartial in hearing Board cases while the Board was disputing, in Court, his interpretation of the Board's discovery and confidentiality provisions.

At the beginning of the hearing in the instant matter, on June 4, 2024, Woodman considered the Motion to Recuse himself and denied it as untimely because it was not filed at least 10 days prior to the hearing date as required by NRS 622A.360 notwithstanding that the facts giving rise to the request for recusal occurred on May 30, 2024, and that that Woodman could have allowed a motion within such other times as he deemed appropriate. Nevertheless, Woodman used additional time on the record in the BARBER case to explain that he thought he could be impartial because he had a long career where he was able to get along with people with whom he had disagreements.

Woodman also rejected a motion by BARBER seeking the IC's entire investigative file as untimely; however, Woodman allowed her to attempt to seek witness testimony regarding the contents of the confidential investigative file and confidential IC proceedings. The first witness, a seasoned investigator, did not answer the questions because IC counsel objected, and because she knew based on her over 17 years of experience as a Board investigator, that IC proceedings and the investigative file are confidential. BARBER also attempted to obtain confidential investigative file and IC proceeding information from the IC's peer reviewer who testified on behalf of the IC.

Woodman's actions and commentary during the BARBER hearing regarding the IC, Board and its counsel further demonstrate that he is biased toward the IC. Woodman continued to make verbal jabs to the IC calling it repugnant and, on several occasions, accused the IC of hiding the ball, being unfair to licensees, and said that the IC's failure to produce documents promoted distrust in the system, even though his position is counter to the longstanding interpretation of the IC and is the subject of multiple legal proceedings.

///

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Woodman terminated the BARBER proceedings midafternoon on June 4, 2024, prior to the end of the hearing and did not indicate when the hearing would resume leaving the IC in limbo as to fulfilling its statutory duties.

III. LEGAL ARGUMENT

NRS 622A.360(2)(b) provides for a motion requesting, for good cause, the recusal of the hearing officer from participation in a case. While a recusal motion may be made to a hearing officer, panel or the regulatory body, by its plain language, the provision requires the person hearing the matter to determine whether they should recuse themselves. *See also Crandell v. Pennsbury Tp. Bd. of Supervisors*, 985 A.2d 288, 296 (2009) ("Recusal motions are directed in the first instance to the official whose recusal is sought, for that official's self-assessment"). Black's Law Dictionary defines good cause as a legally sufficient ground or reason for granting the request. While this is not a judicial proceeding, NRS 1.230(1) provides guidance here in that a judge shall not act in a proceeding when he entertains actual bias or prejudice for or against one of the parties to the action.

The party seeking recusal must show that a judge is biased but if a judge's impartiality might reasonably be questioned, then the judge should recuse himself. *See* NCJC Rule 2.11(A). *See also Roe v. Roe*, 535 P.3d 274, 291, 139 Nev. Adv. Op. 21 (holding that ultimately the judge should be disqualified if "a reasonable person, knowing all the facts, would harbor reasonable doubts about the [judge's] impartiality"). *Id., citing Ybarra v. State*, 127 Nev. 47, 51, 247 P.3d 269, 272 (2011).

In this case, Woodman has demonstrated that he cannot be impartial in the handling of the disciplinary proceeding of McCLEVE because, in violation of the duty of the Board to determine the continued competency of its licensees[1], Woodman continues to apply his interpretation of the law and uses his power as the hearing officer to seek to have Board cases dismissed without being heard on the merits of the complaint.

The second writ petition was filed on May 31, 2024, which was precipitated by his desire to dismiss the case against McCLEVE prior to hearing the case on the merits because the Board

[1] *See* NRS 630.003(1)(b).

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did not immediately turn over its entire investigative file. Without the actual authority to grant dismissal[2], he indicated on the record of the McCLEVE hearing that he would wrap this hearing and send his recommendations to the Board that this case does not go any further. He used time on the record to excoriate the Board for its unfairness while never citing any legal provisions in support of his harsh critique.

The disagreement Woodman has with the Board and its counsel regarding the interpretation of the legal provisions has escalated to the point where Woodman cannot hide his biased even as he tries to convince the parties that he gets along with everyone. He rejected a request to continue the McCLEVE hearing pending the determination on the pending writ proceedings in the CHACON matter which further demonstrates that his decision making is unreasoned and unbiased as waiting for court input is appropriate when litigation has been initiated challenging his statutory interpretation especially as confidential materials cannot be made confidential again after it is released to the public. Additionally, Woodman had previously ordered the proceedings stayed in CHACON.

Woodman inappropriately sought attorney client information from IC counsel regarding the IC's intentions in the CHACON writ litigation in which he is the Respondent, while at the same time holding the power as the hearing officer to affect the outcome of the McCLEVE case. Woodman also inquired on the record whether the Board would name McCLEVE as a party in subsequent writ proceedings and then counseled McCLEVE's attorney to seek intervention in the writ proceeding.

Woodman rejected a motion by BARBER seeking the IC's entire investigative file as untimely; however, Woodman allowed BARBER to attempt to seek witness testimony regarding the contents of the confidential investigative file and confidential IC proceedings. The witness, a

---

[2] This is important because Woodman could easily preserve the confidentiality issue for appeal pending a decision of the case on the merits. Notably, Woodman has no authority as a hearing officer to dismiss a case on the grounds requested here (i.e. failure to provide confidential non discoverable information). A request for a motion to dismiss is permitted by NRS 622A, if the complaint filed to initiate disciplinary proceedings fails to state facts which, if true, would form a sufficient basis for discipline. Any findings and recommendations of the hearing officer are only final if approved by the regulatory body which may approve, modify, reject, remand, order trial de novo, or take any other action it deems appropriate. For this reason, IC counsel requested that the hearing on the merits go forward, and Woodman could provide his opinion on the legal issue of confidential discovery in his recommendations after hearing all the evidence.

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seasoned investigator, did not answer the questions because IC counsel objected, and because she knew based on her over 17 years of experience as a Board investigator, that IC proceedings and the investigative file are confidential.

However, Woodman's actions and commentary during the BARBER hearing regarding the IC, Board and its counsel further demonstrated that he cannot be impartial toward the IC. On the record in the BARBER hearing, Woodman continued to make verbal jabs to the IC calling it repugnant and, on several occasions, accused the IC of hiding the ball, being unfair to licensees, and said that the IC's failure to produce documents promoted distrust in the system, even though his position is counter to the longstanding interpretation of the IC and is the subject of multiple legal proceedings.

Finally, questions and objections regarding confidential materials dominated the BARBER hearing and as Woodman's animus toward the IC is clear, BARBER continued her questioning unfettered. A frustrated Woodman, midway through the BARBER hearing, suspended the hearing, indicated that he did not want to hear from counsel, and noted that he wished to talk to the Board Chairman, Dr. Spirtos[3], about fairness. He directed counsel not to contact him regarding the rescheduling of the hearing.

Woodman has continually demonstrated his intent to eviscerate the IC on the record in hearings and continues to accuse the IC of wrongdoing because it is seeking to enforce confidentiality and discovery provisions pending a court decision on an important issue of statutory construction instead of immediately agreeing with his unlawful orders. Woodman, at any point he could, took time on the record during the McCLEVE and BARBER hearings to lay out his grievances toward the Board specifically using the exact words repugnant, outrageous, unconscionable, and unfair, (among others) in two disciplinary proceedings. Respondent's counsel has used Woodman's anger toward the IC to disrupt the proceedings, which he has permitted and supported. Any reasonable person witnessing or with knowledge of his verbal abuse and personal

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[3] Dr. Spirtos is the Chair of the IC that authorized filing of the formal complaint against CHACON, McCLEVE, and BARBER. Counsel for the IC is the prosecutor each of those cases. Dr. Spirtos is also the Chair of the Board, and the Board is the Petitioner in the pending writ proceedings. Accordingly, Woodman should not speak to Dr. Spirtos without the presence of counsel.

attacks of the Board at the McCLEVE and BARBER hearings for maintaining its legal position would harbor reasonable doubts about his impartiality.[4]

IV. CONCLUSION

Woodman's feelings and opinions are conclusory - he just does not feel that the Board is fair. His tone, forum, and timing of comments at the McCLEVE and BARBER hearings raise questions of his impartiality in considering the disciplinary hearings of the IC. Accordingly, the IC requests that Woodman recuse himself from the instant matter.

DATED this 6th day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Deonne E. Contine

DEONNE E. CONTINE
General Counsel
9600 Gateway Drive
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Attorney for the Investigative Committee

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[4] The Board will supplement this recusal request to complete the record pending receipt of the final transcript of the May 30, 2024, hearing in the matter of the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C and the June 4, 2024, hearing in the matter of the IC's formal complaint against ANNABEL ELIZABETH BARBER, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 6th day of June, 2024, I served a file-stamped copy of the foregoing THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. (2ND REQUEST) PURSUANT TO NRS 622A.360(2)(b) via U.S. Certified Mail to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. & Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

Tracking No. 9171 9690 0935 0252 5680 96

CHARLES WOODMAN, ESQ.
Law Office of Charles Woodman, Esq.
548 Plumb Lane, Suite B
Reno, NV 89501-2001

Tracking No. 9171 9690 0935 0252 5681 02

And by electronic mail to:

CHARLES B. WOODMAN, ESQ.
hardywoodmanlaw@msn.com
Hearing Officer

PATRICIA EGAN DAEHNKE, ESQ.
Patricia.daehnke@cdiglaw.com
AMANDA ROSENTHAL, ESQ.
Amanda.Rosenthal@cdiglaw.com
Attorneys for Respondent

DATED this 6th day of June, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

UNITED STATES POSTAL SERVICE

June 10, 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 0252 5680 96**.

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

FILED

JUL 15 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against

ERIC JOSEPH PIPPI, PA-C,

Respondent.

Case No. 22-48045-1

Hearing Date: July 26 - 27, 2022 @ 8:30 a.m.

ORDER DENYING MOTION TO COMPEL

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

On June 7, 2022, Respondent filed a Motion to Compel (the "Motion") by which he seeks documents that were the subject of a prior "Deposition Subpoena and Subpoena Duces Tecum" (the "Subpoena"). The Subpoena was quashed on the basis set forth in the Order Quashing "Deposition Subpoena and Subpoena Duces Tecum" provided herewith as **Exhibit 1** and incorporated herein by reference (the "Subpoena Order"). By and through the Motion, Respondent argues that, based upon "[b]asic notions of due process and fair play," he is entitled to the production of documents pertaining to the Nevada State Board of Medical Examiners' (the "Board") "decision to discipline Respondent." Motion, p. 1, lines 9-11. Respondent premises this statement upon an allegation of selective enforcement, indicating that Respondent is entitled to

know "whether the Board engaged in arbitrary and selective prosecution." Motion, p. 2, lines 23-25.

The Investigative Committee of the Nevada State Board of Medical Examiners (the "IC") has opposed the Motion, arguing that the Moton is duplicative of the Subpoena, which was already quashed, and that the discovery Respondent is seeking is not permitted in the context of the administrative hearing and its statutory and administrative structure, which themselves ensure due process.

In reply, Respondent argues that case law relied upon by the IC, namely Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), is inapplicable to pending proceedings (versus an investigation into possible proceedings), and that deprivation of the discovery requested will be prejudicial to Respondent and, therefore, contrary to his due process rights.

The majority of the legal analysis relevant to the Motion was previously addressed in the Subpoena Order, which has been incorporated herein by reference. Based upon the analysis therein, which covers the statutory and administrative basis for denying the Motion, it remains that production of the requested documentation cannot be compelled.[1] To the extent additional arguments are made in the Motion with respect to NRS 630.336(5), case law, due process, and selective enforcement, they are addressed as follows.

NRS 630.336(4) provides, in relevant part, "a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint[,] and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential." The following section of that statute, NRS 630.336(5), provides that "[t]he formal complaint or other document filed by the Board to initiate

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[1] A portion of this argument as made by Respondent in the Motion and addressed in the Subpoena Order relies upon NAC 630.470(4), which Respondent advocates "provides that pre-hearing depositions of witnesses and parties may not be taken and no formal discovery conducted, *unless the Hearing Officer allows it.*" Motion, p. 3, lines 26-28 (original emphasis). However, NAC 630.470(4) actually provides, "[p]rehearing depositions of witnesses and parties may not be taken and no formal discovery of evidence, except as otherwise provided in NAC 630.465, will be allowed." NAC 630.465 provides only for the exchange of a list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness, as well as for the production of all evidence, except rebuttal evidence. As such, a hearing officer does not have discretion to allow pre-hearing depositions and formal discovery as Respondent advocates.

disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records."[2] In support of his argument, Respondent relies upon the latter language in subsection 5 that references as public "documents and information considered by the Board when determining whether to impose discipline are public records."

When considering the two provisions, subsection 4 and subsection 5, they establish that investigative documents are not public save and except for if they are relied upon by the Board when determining whether to impose discipline.[3] To that end, what is submitted to the Board in its determination to impose discipline are the documents that consist of the record before the hearing officer and the hearing officer's synopsis of the testimony taken, which includes a recommendation on the veracity of witnesses. NAC 630.470. As such, any documents outside of the evidentiary hearing record and the submission of from the hearing officer, which is likewise based upon the evidentiary hearing record, remain confidential pursuant to subsection 4 and are not discoverable. Thus, reliance upon NRS 630.336(5) is unavailing to compel the produetion of such documentation.

In consideration of Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), Respondent is correct that Sarfo addressed the confidentiality of an investigative file with respect to the investigative phase and prior to the filing of a formal complaint. Sarfo nonetheless made it clear that the confidentiality provisions apply to a responding licensee and such confidentiality provisions, by their terms, continue past the investigatory phase. Therefore, the

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[2] A complaint as contemplated by NRS 630.307 and as referenced in subsection 4 is the grievance submitted to the Board that is reviewed and investigated as a preface to what may result in a formal complaint lodged pursuant to NRS 630.399. A complaint lodged pursuant to NRS 630.339 is specifically referenced in the statutory scheme as a "formal complaint" as reflected in subsection 5.

[3] If "disciplinary action" and the "imposition of discipline" were similarly defined; for example, if the "imposition of discipline" could encompass instigating disciplinary action, the limitations of NRS 630.336(4) would be rendered meaningless, which would be contrary to rules of statutory interpretation. Further, "imposition of discipline" is referenced in NRS 630.352, which indicates that, at the conclusion of a hearing on the formal complaint, the Board shall vote to "impose discipline" or, alternatively, dismiss the charges if the Board determines that no violation has occurred. Thus, the terms are exclusive and while the disciplinary hearing is a disciplinary action, the imposition of discipline is the step considered after the conclusion of the hearing if the charges stemming from the formal complaint are substantiated.

question that remains is whether a responding licensee remains subject to such confidentiality after a formal complaint is filed based upon considerations of due process.

"Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008). To effectuate this, "[a]dministrative bodies must follow their established procedural guidelines and give notice to the defending party of 'the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it." Id.

To facilitate notice of formal allegations brought against a respondent in a matter deemed sufficient to allow a responding party to defend, NRS 630.339 establishes that the formal complaint must: 1) include a written statement setting forth the charges alleged and setting forth in concise and plain language each act or omission of the respondent upon which the charges are based; 2) be prepared with sufficient clarity to ensure that the respondent is able to prepare a defense; and 3) specify any applicable law or regulation that the respondent is alleged to have violated. In this respect, the Nevada Supreme Court has recognized that so long as these standards are met, the minimum standard of due process with regard to notice are met. Dutchess Bus. Servs., Inc., 124 Nev. at 711, 191 P.3d at 1166 (2008) (the filing and service of accusations against a licensee that sets forth in writing the charges alleged and the acts or omission with which the respondent is charged such that the respondent may prepare a defense comports with due process).

In the formal complaint against Respondent, the IC alleges specific charges, those being Disciplinary Action by Another State Medical Board and Failure to Report Disciplinary Action. The basis of each charge is stated with sufficient clarity in that the circumstances underlying each of the charges is articulated, and each charge identifies the applicable law or regulation alleged to have been violate; in fact, the alleged violations have been thoroughly briefed by the parties by ... and through Respondent's Motion to Dismiss filed concurrently with the Motion. As such, pursuant to recognized standards of due process applicable to the instant proceeding,

Respondent's due process rights have been met and Respondent may not rely upon the same to overcome the applicable confidentiality provisions.

With respect to Respondent's allegation of selective enforcement, a *prima facia* showing must be made to support such a claim as was indicated in the Subpoena Order in the context of Respondent's discovery request. *See, e.g.,* People v. Tuck, 139 Cal. Rptr. 3d 407, 418 n. 4 (2012) (recognizing that an alleging party must make the necessary *prima facie* showing to justify discovery).

To expand upon this point, to support a claim of selective enforcement, a respondent bears the heavy burden of establishing, at least *prima facie*: 1) that, while others similarly situated have not generally been proceeded against because of conduct of the type forming the basis of the charge against respondent, respondent has been singled out for prosecution; and 2) that the government's discriminatory selection of respondent for prosecution has been invidious or in bad faith, i.e., based upon such impermissible considerations as race, religion, or the desire to prevent respondent's exercise of constitutional rights. *See* State v. Flynt, 407 N.E.2d 15, 17 (OH 1980), writ dismissed, 451 U.S. 619 (1981) (as cited in a medical board case: Brownlee v. State Med. Bd., 2013 WL 6021182, 2013-Ohio-4989).

Nevada articulates this standard in McDonald v. State, 477 P.3d 373 (Nev. App. 2020), which provides:

> To prevail on a selective prosecution claim the claimant must demonstrate that the prosecutorial policy had a discriminatory effect and it was motivated by a discriminatory purpose. United States v. Armstrong, 517 U.S. 456, 465 (1996). "A selective-enforcement claim requires essentially the same showing." United States v. Griffith, 928 F.3d 855, 866 (10th Cir. 2019). To establish a discriminatory effect[,] ... the claimant must show that similarly situated individuals ... were not prosecuted." United States v. Armstrong, 517 U.S. 456, 465 (1996). To show discriminatory purpose, a claimant must establish "that the decision-maker ... selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." Wayte, 470 U.S. at 610 (internal quotation marks omitted). "This standard is a 'demanding one.' " Griffith, 928 F.3d at 866. . . . Unless suspect classes are involved in the selective enforcement, the Equal Protection Clause is violated only if there is no rational basis to justify the selective enforcement. *See* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487-488 (1955).

In sum, "[s]elective enforcement is an equal protection term that applies when a law is selectively enforced based on an unjustifiably discriminatory classification such as race, religion, or some other arbitrary characteristic," nothing of which Respondent has alleged. Low Cost Pharmacy, Inc. v. Arizona State Bd. of Pharmacy, No. 1 CA-CV 07-0547, 2008 WL 2154793, at *9 (Ariz. Ct. App. May 20, 2008) (*citing* State v. Patton, 665 P.2d 587, 590 n. 6 (Ariz. App.1983) and Oyler v. Boyles, 368 U.S. 448, 456 (1962). It also remains that selective enforcement does not encompass mere selectivity of enforcement given that such selectivity has to be unconstitutionally discriminatory to be deemed to be a Constitutional violation. *See* State v. Howard, 337 S.E.2d 598, 601 (N.C. App. 1985) (*citing* People v. Utica Daw's Drug Co., 16 A.D.2d 12, 225 N.Y.S.2d 128, 4 A.L.R.3d 393 (1962)); *see also* People v. Toomey, 157 Cal. App. 3d 1, 12–13, 203 Cal. Rptr. 642 (Ct. App. 1984) ("'an equal protection violation does not arise whenever officials 'prosecute one and not [another] for the same act;' instead, the equal protection guarantee simply prohibits prosecuting officials from purposefully and intentionally singling out individuals for disparate treatment on an invidiously discriminatory basis.' 'Prosecutorial discretion permits the choice among possible defendants which to prosecute, whether to prosecute, and in what order to prosecute.'") (citations omitted).

Even further, as recognized in Williams v. State, 393 So. 2d 492, 494 (Ala. Crim. App. 1981), "the mere showing of selective enforcement of a statute, without more, is not constitutionally impermissible." Id. (*citing* Oyler v. Boles, 368 U.S. 448 (1962) for the proposition that the conscious exercise of some selectivity in enforcement is not in itself a constitutional violation; and, even though statistics might imply a policy of selective enforcement, it remains that the selection must be deliberately based upon an unjustifiable standard such as race, religion, or other arbitrary classification). The fact that some people escape prosecution under a statute is not a denial of equal protection unless selective enforcement of the statute is intentional or purposeful given that the determination to prosecute is within a prosecuting authority's discretion. *See* May v. People, 636 P.2d 672, 681–82 (Colo. 1981) (*citing* Yick Wo v. Hopkins, 118 U.S. 356 (1886); People v. District Court, 632 P.2d 1022 (Colo. 1981)).

Here, Respondent has made a blanket assertion that any and all information related to the Board's prosecution of such claims as those brought against Respondent should have to be produced "to ensure that the Board is not abusing its discretion by unfairly and selectively disciplining healthcare providers." Motion, p. 8, lines 4-9. Such an assertion does not address the relevant standards of selective enforcement, nor a mandated showing of unlawful discrimination, and is, therefore, insufficient to mandate the relief requested. As such, Respondent's Motion to Compel is DENIED.

DATED this 15th day of July 2022.

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 DENYING MOTION TO COMPEL addressed as follows:

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

DATED this 15th day of July, 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

FILED

JUN 14 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1** **RESPONDENT ANNABEL ELIZABETH BARBER, M.D.'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE OF THE STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. (2ND REQUEST) PURSUANT TO NRS 622a.360(2)(b)**

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL (702) 979-2132 | FAX (702) 979-2133

Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby files her Opposition to the Investigative Committee of the State Board of Medical Examiners' Motion to Recuse Hearing Officer Charles Woodman, Esq. (2nd Request) Pursuant to NRS 622A.360(2)(b) filed on June 6, 2024. Respondent requests that the Motion be denied.

Dated: June 13, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
Nevada Bar No. 10748
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The Investigative Committee of the Nevada State Board of Medical Examiners ("IC") has filed this second Motion for Recusal of Hearing Officer Woodman because Hearing Officer Woodman does not agree with the IC's interpretation of the law, and therefore, according to the IC, this means he is biased. After Hearing Officer Woodman ruled in a manner the IC disagreed with in two other cases (Chacon and McCleve), the IC refused to comply with the Hearing Officer's orders, and now the IC states that Hearing Officer Woodman is biased because he has told the IC that it is inappropriate for them to refuse to comply with his orders. Hearing Officer Woodman is upholding his statutory duty as a hearing officer, and is performing his duty to ensure due process for the Respondent Dr. Barber in this Hearing. The IC should not be allowed to manipulate this process so they control every facet of what occurs, as they are attempting to do. The IC's Motion should be denied.

II. PROCEDURAL HISTORY

The Investigative Committee of the Nevada State Board of Medical Examiners filed their first Complaint against Respondent Annabel Barber, M.D. on September 20, 2022 regarding Respondent's care and treatment of Patient A. Exhibit A, Complaint 22-11660-1. Prior to the Hearing in that matter, Respondent discovered that IC member Choudhury Ahsan, M.D. had treated patient A, and Respondent moved to dismiss the Complaint due to the undisclosed conflict of interest. Hearing Officer Nancy Moss Ghusn, who was appointed by the Nevada State Board of Medical Examiners, allowed oral argument and full briefing on the Motion to Dismiss. *See* Exhibit B. Thereafter, Dr. Barber filed her formal Motion to Dismiss. Exhibit C, Motion to Dismiss (without attached exhibits). The IC filed their Opposition and argued that Hearing Officer Ghusn had no authority to dismiss the Complaint. Exhibit D, Opposition. Respondent Dr. Barber filed her Reply. Exhibit E, Reply (without attached exhibits). Hearing Officer Ghusn ultimately issued her order by email, granting Respondent's Motion to Dismiss. Exhibit B. Hearing Officer Ghusn instructed counsel for Respondent to prepare the formal order. *Id.* Counsel for the IC requested to see the proposed

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order and make comments on the order before Hearing Officer Ghusn signed the order. Counsel for Respondent prepared the order, and provided it to the Hearing Officer and counsel for the IC. Exhibit B. After weeks of the IC's counsel promising to provide his comments, Hearing Officer Ghusn advised on November 16, 2023 that she would no longer consider the IC's edits if she did not hear from IC's counsel by 5:00 p.m. Exhibit F. On November 16, 2023 at 4:28 p.m., the IC served a "Order for Dismissal Without Prejudice" of case 22-11660-1. Exhibit G.

On November 17, 2023, the IC filed their Complaint in this matter regarding the care and treatment of Patient A. Exhibit H. The allegations in this Complaint, and in the prior Complaint, are nearly identical. However, in this case, the Nevada State Board of Medical Examiners appointed Charles Woodman, Esq. as the hearing officer, rather than sending the case to Hearing Officer Ghusn once again.

On November 27, 2023, counsel for Dr. Barber requested that Hearing Officer Ghusn enter an order on her Motion to Dismiss. Exhibit I. Hearing Officer Ghusn stated she was considering the matter. *Id*. On December 1, 2023, Deonne Contine advised that the "IC has voluntarily dismissed the case and the docket is closed," and "nothing further can be filed in the matter." *Id*.

According to the IC's Second Motion to Recuse, on April 11, 2024, Hearing Officer Woodman issued a Summary Prehearing Order in the IC's case against Samuel Rodolfo Chacon, M.D., resulting in the Board's filing a Petition for Writ of Mandamus on April 17, 2024 (case CV24-00838). The IC alleges this order forms part of the basis for recusal in this case.

In this case, the parties conducted a Prehearing Conference on May 2, 2024. At the Prehearing Conference, counsel for the IC made no objection to Hearing Officer Woodman continuing as the hearing officer in this matter. Exhibit J, Amended Scheduling Order. Furthermore, pursuant to the Amended Scheduling Order, all motions in this matter were to be filed by Friday, May 24, 2024 at 5:00 p.m. *Id*.

On May 24, 2024 at 6:31 p.m., after the motion deadline had expired, counsel for the

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IC filed a Motion to Continue the June 4-5, 2024 Hearing in this matter, arguing that the IC's expert witness was unavailable. Exhibit K. On May 28, 2024, counsel for the IC withdrew the Motion to Continue, stating that he had confirmed the expert's availability. *Id.*

According to the IC's Second Motion to Recuse, on May 29, 2024, Hearing Officer Woodman issued an Order on Prehearing Motions in the IC's case against David Kayle McCleve, PA-C, resulting in the Board filing a Petition for Writ of Mandamus on May 31, 2024 (case CV24-01206).

On June 2, 2024, Respondent's counsel emailed Don White, counsel for the IC to request the investigative file in this matter. Exhibit L. On June 3, 2024, Don White advised counsel that "we have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file." *Id.* On June 3, 2024, Respondent filed her "Request for Production of Public Records and/or Production of the Investigative File." Exhibit M.

On June 3, 2024, counsel for the IC Don White emailed Hearing Officer Woodman to request that he immediately stay this matter. Exhibit N. Thereafter, counsel for the IC and Hearing Officer Woodman exchanged emails regarding the issue of a stay and Dr. Barber's request for the investigative file. Exhibits O. Counsel for Respondent asked that the parties argue the issues at the Hearing in this matter on June 4-5, 2024, and Hearing Officer Woodman agreed. Exhibit O.

On June 3, 2024 at 7:52 p.m., Deonne E. Contine, General Counsel for the Nevada State Board of Medical Examiners sent an email containing "The Investigative Committee of the Nevada State Board of Medical Examiners' Motion to Recuse Hearing Officer Charles Woodman, Esq. Pursuant to NRS 622A.360(2)(b)." Exhibit P. This Motion was not filed until June 4, 2024. Exhibit Q.

On June 4, 2024, the formal Hearing in this matter commenced. Hearing Officer Woodman allowed some argument regarding the IC's Motion to Recuse. Hearing Officer Woodman denied the Motion.

Thereafter, the Hearing proceeded. Counsel for Respondent asked the IC's witness,

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Investigator Monica Gustafson, questions regarding the investigative file in this matter. Ms. Gustafson confirmed there was an expert medical report in the file. Counsel for the IC objected to the questions, and instructed Ms. Gustafson to not answer the questions despite Hearing Officer Woodman overruling some of the IC's objections to the questions.

Thereafter, counsel for the IC called the IC's expert witness Nicholas Spoerke, M.D. as a witness. Counsel for Respondent asked Dr. Spoerke questions regarding the material he had reviewed and/or prepared, including whether he had prepared an expert report. He stated he had done so. In fact, he testified he had prepared a report and discussed it with Mr. White prior to the scheduled Hearing in case 22-11660-1. He testified the report contained his opinions and a bibliography of 10 articles he relied on to formulate his opinion. He could not recall the articles without the report. Throughout Dr. Spoerke's testimony, counsel for the IC often objected, and instructed Dr. Spoerke not to answer most of the questions, even when counsel's objections were overruled by the Hearing Officer.

On the afternoon of June 4, 2024, Hearing Officer Woodman suspended the formal Hearing. He stated he would contact the parties to advise the next steps.

On June 5, 2024, counsel for the IC, counsel for Respondent, Respondent, and Respondent's expert presented for continuation of the Hearing in this matter. Hearing Officer Woodman was not present, and the Hearing did not proceed.

On June 6, 2024, the IC filed this "Motion to Recuse Hearing Officer Charles Woodman, Esq. (2nd Request) Pursuant to NRS 622A.360(2)(b)." The IC's Second Motion to Recuse is nearly identical to their first Motion.

III. ARGUMENT

A. The IC's Motion is Untimely and the IC Has Waived Their Right to Object

The IC filed their first Motion to Recuse Hearing Officer Woodman in this matter on June 4, 2024, the day the Hearing in this matter was scheduled to begin. At the Hearing, Hearing Officer Woodman denied the IC's first Motion to Recuse, in part, as untimely. Likewise, the IC's instant Motion to Recuse (2nd request) is also untimely.

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Pursuant to NRS 622A.360(3), a prehearing motion must be filed with the hearing officer at least 10 days before the date of the hearing. Pursuant to the Amended Scheduling Order in this matter, prehearing motions were due no later than 5:00 p.m. on May 24, 2024. The IC's second Motion for Recusal is untimely pursuant to NRS 622A.360(3) and the provisions of the Amended Scheduling Order, and should denied as untimely, just as the first Motion was.

Furthermore, when counsel knows of facts that would support a motion for recusal based on judicial bias, counsel "may not lie in wait and raise those allegations . . . only after learning the court's ruling on the merits." *Ainsworth v. Combined Ins. Co. of Am.*, 105 Nev. 237, 260, 772 P.2d 1003, 1019 (1989).[1] A party's failure to timely seek recusal of a judicial officer results in a waiver of the issue. *Brown v. Fed. Sav. & Loan Ins. Corp.*, 105 Nev. 409, 412, 777 P.2d 361, 363 (1989); *see also T.L. Townsend Builders v. Nev State Contrs. Bd.*, No. 80518, 81185 (April 16, 2021) (unpublished) (noting that a party in an administrative matter can waive its right to challenge the adjudicator by participating in multiple hearings without objecting or otherwise seeking his recusal).

The IC provided their first Motion for Recusal by email on June 3, 2024 at 7:52 p.m. However, the Motion was not ultimately filed until the next day, on June 4, 2024. According to the IC's Motion (including the first Motion for Recusal served on June 3, 2024 and filed on June 4, 2024), the basis of Hearing Officer Woodman's bias is his decision in the Chacon and David Kayle McCleve, PA-C matters. However, according to the IC's Motion, Hearing Officer Woodman issued his Summary Prehearing Order in the Chacon matter on April 17, 2024 (47 days prior to the IC serving their first Motion to Recuse), and his Order on Prehearing Motions in the McCleve matter on May 31, 2024 (3 days prior to the IC serving their First Motion to Recuse). Furthermore, counsel for the IC attended the Prehearing Conference in this matter on May 2, 2024, **after** the Chacon matter was decided, and failed to

[1] In their Motion, the IC cites to the NRS regarding judges and the NCJC, including case law interpreting rules and statutes regarding the disqualification of judges. The IC notes that while this is not a judicial proceeding, these rules provide guidance in this case.

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raise any objection to Hearing Officer Woodman's participation in this matter. In this case, the IC did not file their Motion to Recuse until **after** Respondent Dr. Barber had filed her June 3, 2024 "Request for Production of Public Records and/or Production of the Investigative File," and after Hearing Officer Woodman had expressed in email that his interpretation of the law may favor Respondent's position. In this case, the IC knew of the facts to allegedly support their motion for recusal on April 17, 2024, yet they lay in wait, attended the Prehearing Conference without making any objection, allowed the prehearing motion deadline to pass without filing a motion for recusal, and raised those allegations in this case only **after** learning Hearing Officer Woodman's inclination for ruling in this case. This is entirely inappropriate pursuant to *Ainsworth* and *Brown*. The IC has waived the issue by failing to timely seek recusal and the IC's Motion should be denied.

B. The IC's Motion Should be Denied as There is no Provision Allowing for Rehearing of a Matter Already Decided

In every filing, the IC construes what may or may not be done in any matter so as to strictly comply with the provisions of NRS 622A relating to administrative procedure. However, in this case, the IC seeks reconsideration, or rehearing, of a motion Hearing Officer Woodman has already denied. There is simply no provision in NRS 622A that allows for rehearing of a motion that has been denied. Furthermore, even if this was considered a "post-hearing" motion, NRS 622A.390 does not allow for a post-hearing motion for recusal of a hearing officer. Instead, after the close of a hearing a party may only file motions to: 1) request a rehearing, 2) to request reconsideration of the findings and recommendations of the hearing officer; or 3) a motion requesting that the final decision be vacated or modified. NRS 622A.390(1). There is no provision allowing a post-hearing motion to reconsider a motion for recusal of the hearing officer. As such, the IC's Motion should be denied.

C. Hearing Officer Woodman has a Duty to Sit and the IC has not Established Sufficient Factual Grounds to Warrant Disqualification

The IC argues that Hearing Officer Woodman is biased, and that he must recuse himself, because he disagrees with the IC's interpretation of Nevada statutes and codes

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regarding production of the investigative file, and he "uses his power as the hearing officer to seek to have Board cases dismissed without being heard on the merits of the complaint." Motion, at 5, lines 24-25. The IC's argument for recusal violates longstanding tenets of Nevada law, that "a judge shall hear and decide matters assigned to the judge," and that "rulings and actions of a judge during the course of official judicial proceedings do not establish legally cognizable grounds for disqualification." *Matter of Dunleavy*, 104 Nev. 784, 789, 769 P.3d 1271, 1275 (1988); NCJC 2.7.

1. A Ruling Granting the IC's Motion Would Violate Principles of Due Process

Failure to deny the IC's Motion would make a mockery of the due process protections afforded to Respondent in this administrative matter. "[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." *Dutchess Bus. Servs. v. Nev. State Bd. Of Pharm.*, 124 Nev. 701, 711 (2008). Due process mandates a neutral and unbiased decision-maker. A neutral and unbiased decision-maker is one of the core requirements of fair adjudicatory decision-making. *See e.g., Arnett v. Kennedy*, 416 U.S. 134, 171 (1974). Judges are presumed to be unbiased. *Millen v. Eighth Judicial Dist. Court*, 122 Nev. 1245, 1254, 148 P.3d 694, 701 (2006).

In this case, the IC argues that because Hearing Officer Woodman does not rule in a manner that they agree with, he must be biased and removed so they can install a hearing officer who will, by implication, rule in the manner they approve of. This absurd argument flies in the face of the notion of a "fair trial in a fair tribunal" before a "neutral and unbiased decision-maker." As noted in the Board's own application for renewal of Hearing Officer Woodman's contract, "**Hearing officers need to be independent from the Board staff in order to ensure due process for the respondents in the hearing**." See Exhibit R (emphasis

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added). Yet, the IC's Motion makes it clear that the IC is not interested in ensuring adequate due process. Instead, the IC is apparently only interested in installing hearing officers who will rule as they want, and they will defy the orders of the hearing officer if they disagree with his interpretation. This mockery of principles of due process should be stopped, and the IC's Motion should be denied.

2. The IC Has Not Met Their Burden to Establish Sufficient Grounds for Disqualification

The burden is on the party asserting the challenge for bias to establish sufficient factual grounds to warrant disqualification. *Ybarra v. State*, 127 Nv. 47, 51, 247 P.3d 269, 272 (2011). When a judge determines he may not voluntarily disqualify himself, his decision should be given substantial weight, and should not be overturned in the absence of a clear abuse of discretion. *Rivero v. Rivero*, 125 Nev. 410, 439, 216 P.3d 213, 233 (2009); *United States v. Halderman*, 559 F.2d 31, 139 (D.C. Cir. 1976), cert. denied, 431 U.S. 933 (1977). Summary dismissal of the challenge is appropriate, and no hearing is required, where the challenge fails to allege legally cognizable grounds supporting a reasonable inference of bias or prejudice." *Matter of Dunleavy*, 104 Nev. 784, 789, 769 P.3d 1271, 1275 (1988). In this case, Hearing Officer Woodman has already denied the IC's first Motion for Recusal. His summary dismissal of the challenge was appropriate, and his decision denying recusal should be given substantial weight.

3. Hearing Officer Woodman has a Duty to Sit in this Matter

NCJC 2.4 provides that "[a] judge shall not be swayed by public clamor or fear of criticism." NCJC 2.7 provides that "[a] judge shall hear and decide matters assigned to the judge, except when disqualification is required by Rule 2.11 or other law." A judge has a "duty to preside . . . in the absence of some statute, rule of court, ethical standard, or other compelling reason to the contrary." *Ham v. District Court*, 93. Nev. 409, 566 P.2d 420 (1977); *see also Millen v. Eighth Judicial Dist. Court*, 122 Nev. 1245 , 1253, 148 P.3d 694, 700 (2006).

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NCJC 2.11(A)(1) provides that "a judge shall disqualify himself or herself in any proceeding in which the judge's impartiality might reasonably be questioned, including but not limited to the following circumstances: (1) The judge has a personal bias or prejudice concerning a party or a party's lawyer, or personal knowledge of facts that are in dispute in the proceeding. . . ." NCJC 2.11(A) requires disqualification for implied bias at any time the judge's "impartiality might be reasonably questioned." *See Rippo v. Baker*, 580 U.S. 285, 287, 137 S. Ct. 905 (2017) ("recusal is required when, objectively speaking, the probability of actual bias on the part of the judge or decisionmaker is too high to be constitutionality tolerable.") To evaluate impartiality, the court determines "whether a reasonable person, knowing all the facts, would harbor reasonable doubts." *People for the Ethical Treatment of Animals v. Bobby Berosini, Ltd.*, 111 Nev. 431, 438, 894 P.2d 337, 341 (1995), overruled on other grounds by *Towbin Dodge, LLC v. Eighth Judicial Dist. Court*, 121 Nev. 251, 112 P.3d 1063 (2005).

Importantly, "rulings and actions of a judge during the course of official judicial proceedings do not establish legally cognizable grounds for disqualification." *Matter of Dunleavy*, 104 Nev. 784, 789, 769 P.3d 1271, 1275 (1988); *see also Liteky v. U.S.*, 510 U.S. 540, 555-56 (1994), 114 S. Ct. 1147 (noting that it would be rare for a judge's rulings or impressions formed while deciding a case to be grounds for disqualification.) Bias must result from something other than what the judge learned from their participation in the case. *Rivero v. Rivero*, 125 Nev. 410, 439, 216 P.3d 213, 233 (2009). "The personal bias necessary to disqualify must 'stem from an extrajudicial source and result in an opinion on the merits on some basis other than what the judge learned from his participation in the case.'" *Matter of Dunleavy*, 104 Nev. at 790. "To permit an allegation of bias, partially founded upon a justice's performance of his constitutionally mandated responsibilities, to disqualify that justice from discharging those duties would nullify the court's authority and permit manipulation of justice, as well as the court." *Id*. When tension arises between either actual or implied bias and the duty to sit, the court must first apply the plain meaning of NCJC 2.4,

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NCJC 2.7, and NCJC 2.11(A)(1), and, if necessary, weigh the respective considerations based upon the individual facts presented.

The request for recusal in this case creates an absurd rule of disqualification that a dissatisfied party, who disagrees with the judge's decision, may create a "do over" by filing a motion for recusal alleging bias, when the party has failed to comply with the judge's ruling and has essentially stated to the judge "you can't make me." Hearing Officer Woodman must deny recusal to prevent this type of manipulation.

Hearing Officer Woodman has expressed no opinion regarding the merits of the underlying issue and allegations in the Complaint. There is absolutely no evidence that he cannot hear the evidence in this matter and make a decision on the merits of the evidence presented. Instead, he has made rulings on an issue of law, the IC disagrees with his ruling, and the IC now seeks his recusal so they can appoint a Hearing Officer who they know will rule consistent with their view of the law. This is entirely inappropriate.

While actual bias creating a reasonable doubt as to the impartiality of the tribunal may, of itself, constitute grounds for recusal, the recusing court must also consider the counter-doctrine of its "duty to sit" in the event a party to the action involved has created the bias by its own action. In this case, recusal is not necessary, as any bias has been created solely by the IC when it refused to comply with Hearing Officer Woodman's orders, and when the IC argued that the hearing officer has no actual authority to dismiss, and by their actions demonstrated that the IC will do whatever it wants. Hearing Officer Woodman has appropriately made rulings on issues of law, as he is entitled to do, and the request for recusal is nothing more than blatant "judge shopping" for a hearing officer who will do whatever the IC desires.

In this case, there is no evidence of personal bias which would warrant recusal. Instead, the IC, through their own actions, has caused any alleged bias by inexplicably refusing to comply with the orders of a hearing officer, who was appointed by the Nevada State Board of Medical Examiners, because "Hearing officers need to be independent from the Board staff in order to ensure due process for the respondents in the hearing." However,

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when Hearing Officer Woodman has taken a view of the law that the IC disagrees with, and when they have refused to comply with the order of Hearing Officer Woodman, they argue his bias and request his refusal. The IC's request for recusal for personal bias is woefully insufficient. The alleged bias was caused by the IC, and recusal in this case would lead to manipulation of the administrative hearing process by the IC. As such, the IC's Motion should be denied.

4. An Allegation of Bias Against an Attorney, or Expression of a Belief that Misconduct has Occurred, is Insufficient Grounds for Disqualification

The IC argues that Hearing Officer Woodman has personal grievances toward the Board and their counsel because he used the words "repugnant, outrageous, unconscionable, and unfair, (among others), in two disciplinary proceedings." Motion at 7, lines 22-23. The IC states that Hearing Officer Woodman engaged in "verbal abuse and personal attacks of the Board." Motion at 7, line 25 and 8, line 1. However, the allegations made by the IC do not constitute grounds for disqualification. In fact, Hearing Officer Woodman's statements to the IC's counsel regarding his conclusions regarding the IC's misconduct for failing to comply with his orders are entirely appropriate.

"An allegation of bias in favor or against an attorney for a litigant generally states an insufficient ground for disqualification because 'it is not indicative of extrajudicial bias against a 'party.'" *Matter of Dunleavy*, 104 Nev. at 790; *see also Davis v. Board of School Com'rs of Mobile County*, 517 F.2d 1044, 1050 (5th Cir. 1975) (a bias allegations could be based upon bias against a party's attorney it "would bid fair to decimate the bench" as lawyers who had controversy with a judge "would have a license under which the judge would serve at their will."). In *Matter of Dunleavy,* the Nevada Supreme Court noted that "in a small state such as Nevada, with a concomitantly limited bar membership, it is inevitable that frequent interactions will occur between the members of the bar and the judiciary. Thus, allegations of bias based upon a judge's associations with counsel for a litigant pose a particularly onerous potential for impeding the dispensation of justice." *Matter of Dunleavy*, 104 Nev. at 790-791.

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In *Millen v. Dist. Ct.*, 148 P.3d 694, 699-700 (2006), the Nevada Supreme Court observed as follows:

> Subjective reasons for disqualification based on a judge's personal bias or prejudice or knowledge of disputed facts presents another dimension to our consideration of recusal lists' propriety. A judge is presumed to be unbiased, and generally, "the attitude of a judge toward the attorney for a party is largely irrelevant." We have concluded that disqualification for personal bias requires "an extreme showing of bias [that] would permit manipulation of the court and significantly impede the judicial process and the administration of justice." Generally, disqualification for personal bias or prejudice or knowledge of disputed facts will depend on the circumstances of each case. . . .
>
> On the other hand, attorney disqualification may be an appropriate remedy when a lawyer is retained for the purpose of forcing a judge's disqualification, thus obstructing the management of the court's calendar. "[A] party or his attorney should not be permitted to cause the disqualification of a judge by virtue of his or her own intentional actions."

(Footnotes omitted, emphasis added.)

In this case, the IC has created the circumstances which they now allege warrant the recusal of Hearing Officer Woodman. Hearing Officer Woodman ruled on legal issues in the matters involving Chacon, McCleve, and Respondent, and issued orders requiring the production of the investigative file in the Chacon and McCleve matters, and orders regarding the dismissal of the matter McCleve matter. In those cases, counsel for the IC refused to comply with Hearing Officer Woodman's orders, and now state that he is "biased" because he expressed that their failure to comply with this orders is inappropriate. In this case, Hearing Officer Woodman ruled on objections to questions at the Hearing regarding the contents of the investigative file, yet counsel for the IC refused to allow the witnesses to answer the questions, even when the Hearing Officer overruled the objections and ordered the witnesses to answer. Counsel for the IC, by their own intentional actions, have created the circumstance which they allege is a basis for disqualification. Disqualification is not appropriate.

Furthermore, Hearing Officer Woodman's statements that the IC's counsel's actions are repugnant, outrageous, unconscionable, and unfair are entirely appropriate. In fact, any judge should be taking action when encountering inappropriate conduct. NRS 1.210 provides that every court shall have power: 1) to preserve and enforce order in its immediate presence,

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2) to enforce order in the proceedings before it, and 3) to compel obedience to its lawful judgments, orders and process. Even assuming that Hearing Officer Woodman's interpretation of Nevada law at issue in this case (and in Chacon and McCleve) is incorrect, Hearing Officer Woodman still has the absolute duty to enforce his orders and compel obedience to his orders. Even assuming Hearing Officer Woodman's decision is overturned, this still does not constitute bias. A judge's errors during trial are not evidence of personal bias warranting disqualification. *Matter of Dunleavy*, 104 Nev. 784, 789, 769 P.3d 1271, 1275 (1988). Therefore, Hearing Officer Woodman has a duty to enforce his orders, even if they are ultimately found to be incorrect.

Furthermore, "[a] judge who believes misconduct has occurred has a responsibility to act. If a counsel oversteps his bounds, delay in issuing warnings or taking action may lead to matters getting further out of hand . . . ." *In re Cooper*, 821 F.2d 833, 843 (1st Cir. 1987). A judge's referral of an attorney to the state disciplinary board does not constitute disqualifying bias against the attorney. *See State v. Mata*, 71 Haw. 319, 789 P.2d 1122 (Haw. 1990). In fact, NCJC 2.15 states "a judge having knowledge that a lawyer has committed a violation of the Nevada Rules of Professional Conduct that raises a substantial question regarding the lawyer's honesty, trustworthiness, or fitness as a lawyer in other respects shall inform the appropriate authority," and a "judge who receives information indicating a substantial likelihood that a lawyer has committed a violation of the Nevada Rules of Professional Conduct shall take appropriate action." In this case, Hearing Officer Woodman has a duty to call out behavior, such as the failure to comply with orders of the presiding judge or hearing officer. Hearing Officer Woodman's response is and has been appropriate for a party who refuses to comply with his orders. There is no evidence of extrajudicial bias to support disqualification in this matter.

D. The IC's Motion is Simply an Attempt at "Judge-Shopping"

As set forth above, this is the second Complaint filed against Respondent relating to her care and treatment of Patient A. In the first Complaint, Hearing Officer Nancy Moss Ghusn dismissed the Complaint because IC member Choudhury Ahsan, M.D. treated Patient

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A. However, instead of allowing an order to be entered on Hearing Officer Ghusn's decision, the IC dismissed the Complaint without prejudice before an order could be entered. Then, when this case was filed, the Board picked a new hearing officer. This was the first instance of "judge-shopping" in this case.

Now, the IC's new hearing officer, Charles Woodman, has also made a decision the IC disagrees with. It was not until Hearing Officer Woodman made an expression of his potential inclination to rule on an issue in a manner the IC disapproved of, that the IC filed their Motion to Recuse. Now that the IC believes Hearing Officer Woodman's decisions will be unfavorable, they are simply seeking recusal to allow them to select a new hearing officer for this matter, who they hope will rule as they want. This is inappropriate and cannot be allowed. The IC should not be allowed to manipulate every facet of the hearing process in this way. An unbiased and neutral hearing officer is necessary and vital, and recusal should be denied.

IV. CONCLUSION

For the reasons set forth herein, Respondent respectfully requests the IC's Motion to Recuse Hearing Officer Woodman be denied. Recusal is inappropriate and unnecessary in this matter.

Dated: June 13, 2024 **COLLINSON, DAEHNKE, INLOW & GRECO**

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
Nevada Bar No. 10748
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on this 13th day of June, 2024, a true and correct copy of RESPONDENT ANNABEL ELIZABETH BARBER, M.D.'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE OF THE STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. (2ND REQUEST) PURSUANT TO NRS 622a.360(2)(b) was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Charles B. Woodman, Esq. Woodman Law Group 548 W. Plumb Lane, Suite B Reno, NV 89509 hardywoodmanlaw@msn.com tiffany@woodmanlawgroup.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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Exhibit A

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 22-11660-1**

FILED
SEP 20 2022
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 Donald K. White, J.D., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018. He presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he

///

[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 Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Col. Eric D. Wade (Ret.).

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

had acquired short gut syndrome. Upon healing from those surgeries Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

4. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laproscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

5. During the surgery on February 22, 2019, Respondent made multiple failed attempts to gain access to the peritoneum due to the scar tissue. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures. Respondent then closed the incision and discharged Patient A without having fixed the inguinal hernia. There was no documentation of the injury in the operative note which was unintelligibly written.

6. On March 28, 2019, Patient A presented to a different hospital where it was discovered the midline wound was draining bowel contents into the abdominal cavity. Patient A was diagnosed with three (3) small bowel fistulas, and he was adamant that he did not want to be treated by Respondent again.

7. Patient A experienced complications from the bowel fistulas five (5) months after the initial surgery by Respondent, including being placed on a feeding tube (TPN), deep vein thrombosis, and he had to be followed by wound care until his wounds eventually healed in March 2020.

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.

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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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laproscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

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.

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 legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

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 her and give her notice that she 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;

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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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 23rd day of September, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE, J.D.
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, 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 20th day of September, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

Exhibit B

Amanda Rosenthal

From: Patricia Daehnke
Sent: Friday, October 13, 2023 10:55 PM
To: NM G; Donald K. White
Cc: Meg Byrd; Amanda Rosenthal; Lacey Ambro; Patricia Daehnke
Subject: RE: Request to Dismiss or Continue - Dr. Annabel Barber
Attachments: Barber order.docx

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Good evening all,

Attached is the draft Order for review. Please confirm receipt and advise if you have any difficulty accessing.

Have a great weekend.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
patricia.daehnke@cdiglaw.com | www.cdiglaw.com

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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Friday, October 13, 2023 1:35 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; NM G <nmg416@gmail.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: RE: Request to Dismiss or Continue - Dr. Annabel Barber

Hello Ms. Daehnke,

I'm just checking on the status of the draft of the Order, as I have not received it yet. Also just making sure I didn't miss an email.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Thursday, October 5, 2023 8:37 PM
To: NM G <nmg416@gmail.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Good evening,

We will provide the draft as directed in Word to Mr. White for review.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On Oct 5, 2023, at 4:54 PM, NM G <nmg416@gmail.com> wrote:

Good Afternoon All-

Don, that would be fine. Just keep it in Word please for my edits.

At the risk of stating the obvious and as a reminder, this is an order that will summarize positions rather than an opportunity to re-argue your respective positions.

Thank you for your assistance.

Kind regards,

--Nancy
Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Wed, Oct 4, 2023 at 3:54 PM Donald K. White <dwhite@medboard.nv.gov> wrote:

Hello all,

The IC objects to the procedure suggested for the drafting of the "Order." Generally the Hearing Officer drafts the Decision and Recommendations with regards to motions. In the alternative, if the Hearing Officer is going to task Respondent's counsel with drafting that, counsel for the IC would like ample opportunity to review the draft prior to the Hearing Officer's review and signature.

Sincerely,

Don

Donald K. White, J.D.

Senior Deputy General Counsel

Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, NV 89521

775.324.9355

dwhite@medboard.nv.gov

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From: NM G <nmg416@gmail.com>
Sent: Monday, October 2, 2023 9:58 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Donald K. White <dwhite@medboard.nv.gov>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good Morning All-

After spending time reviewing this matter and considering Respondent's Motion to Dismiss, the IC's Opposition and Respondent's Reply, and acknowledging the practical consequence of this decision, I reach the following conclusion: there is a clear conflict of interest in this matter, and the integrity of the process is called into question when one of the members of the IC was involved in Patient A's medical treatment at issue, no matter how limited or how small any pecuniary interest. The process is indeed tainted and due process is consequently compromised.

Without more, this in no way assumes any malfeasance or improper conduct on the part of the Board, the IC or Dr. Ahsan, but assumes at least a failure to conduct an adequate conflict check. In our own professional lives, there are many attorneys or parties that we may know, but it incumbent upon us to check, and, if there is a connection or relationship even unconnected to the case at hand, recuse ourselves or disclose and give the party an opportunity to waive any possible conflict--or not. This should be no different. Dr. Barber was neither informed of Dr. Ahsan's involvement in the underlying medical case nor offered the opportunity to waive and proceed with the case. This wasn't even a case where Dr. Ahsan treated Patient A in an unrelated matter, but he was actually directly involved in the medical process leading to Dr. Barber's treatment of and surgery on Patient A which led to the investigation and the Complaint being filed. In order to uphold the constitutional requirement of due process, any matter such as this should balance protection of the public with a completely unbiased and impartial proceeding. The Undersigned does not participate in speculation but cannot imagine any scenario that any physician, on the Board or otherwise, would demand less. Even the appearance of a conflict may undermine the public's faith in its institutions that exist to protect it.

As such, I find it appropropriate to grant Respondent's Motion to Dismiss.

As I heard no objections to my earlier email of September 26 regarding the drafting of an Order in light of my current circumstances, I direct Counsel for the Respondent to please draft an Order reflecting the law and facts, using her Reply as a guide, in Word format so that I may edit.

Thank you both for your excellent work.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Tue, Sep 26, 2023 at 3:16 PM NM G <nmg416@gmail.com> wrote:

Good Afternoon, All-

Please provide any updates regarding scheduling in this matter and I am doing the same. I have looked through our communications and did not see any follow-up to our August 28 email exchange, but I will (reluctantly) share that Covid finally caught up to me, and I want to make sure that I did not miss anything the past few weeks.

With respect to the pending motion, I have finally been able to review same. However, in order to keep this matter on schedule, and unless there is some objection, I may issue a summary decision and possibly request that counsel for the prevailing party draft the order such as we all have experienced in a courtroom setting.

Thank you for your input and consideration.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Mon, Aug 28, 2023 at 10:25 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

Good evening,

Dr. Barber is available. Dr. Baskies was checking with his family. I will follow up in the morning.

Thank you for checking in.

Tricia Daehnke

Collinson, Daehnke, Inlow & Greco

Sent from my IPhone

On Aug 28, 2023, at 10:20 PM, NM G <nmg416@gmail.com> wrote:

Ms. Daehnke, have you been able to confirm the new hearing dates with your client and witnesses?

Thank you for any update.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Wed, Aug 23, 2023 at 11:31 AM Meg Byrd <mbyrd@medboard.nv.gov> wrote:

Thank you Ms. Ghusn, please forward an order for the briefing schedule and I will get this on file and served.

Thank you,

Meg

From: NM G <nmg416@gmail.com>
Sent: Wednesday, August 23, 2023 10:37 AM
To: Donald K. White <dwhite@medboard.nv.gov>; Patricia.daehnke@CDIGlaw.com
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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https://us02web.zoom.us/rec/share/BMTnywIu40XVRMk7-6HDQBOjNnFCUGEdUBmrQWgw0wzyZtJUd6ALzSBrBXVEJSTc.HIqTvGRteP1XGMgW?startTime=1692808820000
Passcode: %x%?e00D

Good Morning again, Mr. White and Ms. Daehnke-

The following is a quick summary of the results after our meeting via *Zoom,* with the link to the recording, above:

1. Dr. Barber's hearing is postponed upon request for more thorough briefing;
2. 8/30/23--Respondent's Motion
3. 9/13/23 --IC's Opposition
4. 9/20/23--Respondent's Reply/Submission
5. 10/4/23--Hearing Officer's decision
6. Tentative dates for rescheduled hearing: 11/20-21

As agreed, I will issue an Amended Scheduling Order when hearing dates are confirmed.

Thank you both for your input and civility in this matter.

Kind regards,

--*Nancy Moss Ghusn, Esq.*

Administrative Hearing Officer

On Wed, Aug 23, 2023 at 9:39 AM NM G <nmg416@gmail.com> wrote:

> Mr. White, we can and I expect we will do both.
>
> Please log on--audio is fine.

--NMG

On Wed, Aug 23, 2023 at 9:36 AM Donald K. White <dwhite@medboard.nv.gov> wrote:

> Dear Ms. Ghusn,
>
> You were going to afford counsel more time which I am using right now. The IC respectfully requests that this preliminary issue be argued at the Board's location with all parties present, including a court reporter (who is already here), for a clean record.
>
> Thank you,
>
> Don
>
> **Donald K. White, J.D.**
>
> Senior Deputy General Counsel
>
> Nevada State Board of Medical Examiners
>
> 9600 Gateway Drive
>
> Reno, NV 89521
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> **775.324.9355**
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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Wednesday, August 23, 2023 9:31 AM
To: NM G <nmg416@gmail.com>; Donald K. White <dwhite@medboard.nv.gov>
Cc: Deonne Contine <dcontine@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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I am waiting on Zoom. I prefer we proceed with the call as scheduled by the hearing officer.

Tricia Daehnke

Collinson, Daehnke, Inlow & Greco

On Aug 23, 2023, at 9:11 AM, Donald K. White <dwhite@medboard.nv.gov> wrote:

Dear Ms. Ghusn,

The IC requests that this preliminary matter be decided on the record with a court reported present. The IC suggests that we present arguments in person at the Board in the conference room where the hearing is scheduled to take place, but that we do this at 10:30 am.

I am currently drafting my response to an email/motion that Ms. Daehnke sent last night at 10:16 pm. I will need some more time this morning to oppose Dr. Barber's arguments.

Thank you,

Don

Donald K. White, J.D.

Senior Deputy General Counsel

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9600 Gateway Drive

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From: NM G <nmg416@gmail.com>
Sent: Tuesday, August 22, 2023 10:59 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good Evening/Morning-

Having reviewed the emails from and motion of Ms. Daehnke tonight, and given the basis of the motion and the late hour, it is clearly necessary to at least postpone the start of Dr. Barber's hearing tomorrow morning until this issue is resolved. We could meet at the Board offices at some point, but I would first like to give Mr. White the opportunity to respond.

I will look for Mr. White's response tomorrow morning and will send a *Zoom* link for a teleconference at the already scheduled start time of 9:30 and decide where to go from there. Mr. White, feel free to request more time.

Thank you.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Tue, Aug 22, 2023 at 10:15 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

Dear Ms. Ghusn,

Please let this email serve as Dr. Barber's request to dismiss the complaint or continue the hearing tomorrow to allow investigation of and evaluation regarding a conflict of interest in this matter. Dr. Chowdhury H. Ahsan treated Patient A on February 26, 2019 at University Medical Center. Dr. Barber was the admitting physician for this admission, and Dr. Barber treated Patient A during the same time frame. Dr. Ahsan has personal information about this case from treating Patient A and his involvement in his care. Dr. Ahsan was a member of the 3-person Investigative Committee that authorized the Complaint against Dr. Barber, which involves in part this admission. It is unknown whether Dr. Ahsan disclosed this conflict of interest, or whether the Board was aware of this conflict of interest.

Pursuant to NRS 630.085, each member of the Board shall comply with the provisions of NRS 281A.500. NRS 281A.500 provides that public officers must file an acknowledgment of the ethical standards which must be followed, as set forth in NRS Chapter 281A. NRS 281A.420(1) states that a public officer shall not vote or otherwise act upon a matter in which the public officer has a significant pecuniary interests or which would reasonably be affected by the public officer's commitment in a private capacity to the interests of another person. A pecuniary interest is defined as "any beneficial or detrimental interest in a matter that consists of or is measured in money or is otherwise related to money, including, without limitation...[a]nything of economic value. . ." NRS 281A.139. NRS 281A.420 serves to ensure that its public officers "avoid conflicts between [their] private interests and those of the general public whom [they] serve[ ]." *Carrigan v. Comm'n on Ethics of State*, 129 Nev. 894, 906, 313 P.3d 880, 888 (2013). The state has an important interest in avoiding conflicts of interest and self-dealing by public officials entrusted with making decisions affecting its citizens. *Id*.

A physician's license to practice medicine is a property right, and her right to earn a living is a liberty interest, and neither may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d 506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366

(9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy." *Stretten,* 537 F.2d at 366 (emphasis added). Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971).

"The level of due process that must be provided in a particular government proceeding depends on the effect that the proceeding will have on a constitutionally protected interest. When a government agency is conducting proceedings, due process mandates that the protections afforded depend on whether the proceedings result in a binding adjudication or a determination of legal rights, in which case due process protections are greater. Determining whether particular due process protections must be provided requires consideration of the constitutional interest at stake, the type of proceeding being conducted, and the potential that such protections will be unduly burdened by the proceeding. *Hernandez v. Bennett-Haron*, 128 Nev. 580, 587, 287 P.3d 305, 310–11 (2012), citing *Hannah v. Larche*, 363 U.S. 420, 442, 80 S.Ct. 1502, 4 L.Ed.2d 1307 (1960).

"[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "[W]here one member of a tribunal is actually biased, or where circumstances create the appearance that one member is biased, the proceedings violate due process. The plaintiff need not demonstrate that the biased member's vote was decisive or that his views influenced those of other members. Whether actual or apparent, bias on the part of a single member of a tribunal taints the proceedings and violates due process." *Stivers*, 71 F.3d at 748 (emphasis added).

In this case, Dr. Ahsan was a treating provider of Patient A and has a pecuniary interest related to the treatment of Patient A. Furthermore, as a treating physician, his commitments as a treating physician of Patient A seriously call into question whether his participation in this matter was unbiased and whether his participation was a violation of the ethical rules and Dr. Barber's Due Process rights. Dr. Ahsan participated in the decision to authorize the filing of the Complaint. Dr. Ahsan has also presumably been involved with prior settlement proposals and discussions. However, there was no disclosure of his personal involvement with Patient A's care and treatment. Dr. Barber respectfully requests this matter be dismissed due to the existence of a conflict which may well void the whole process.

Given the timing of this discovery, it seems appropriate at a minimum to allow a continuance for further evaluation. This issue goes well beyond the appearance of impropriety. I apologize for the late request, but this was just discovered this evening.

Thank you in advance.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
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Nancy Moss Ghusn

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Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 22-11660-1** **ORDER GRANTING ANNABEL ELIZABETH BARBER, M.D.'S MOTION TO DISMISS**

Respondent Annabel Elizabeth Barber, M.D.'s Motion to Dismiss seeks dismiss of the Complaint filed on September 20, 2022 based on alleged due process violations due to the fact that Investigative Committee member cardiologist Chowdhury H. Ahsan, M.D. treated Patient A.

Dr. Barber's Motion was served first by email on August 22, 2023, and then at a hearing on August 23, 2023 a briefing schedule for Dr. Barber's Motion was set.

The Hearing Officer has reviewed the Motion, Opposition, Reply, and exhibits on file and hereby finds and orders as follows:

FINDINGS

1. A party may file the following prehearing motions in an administrative proceeding: 1) a motion requesting, for good cause, the recusal of a member of the hearing panel or a member of the regulatory body from participation in this case; and 2) "with leave of the . . . hearing panel or officer, any other motion requesting appropriate action or relief before the date of the hearing." NRS

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622A.360(b), (f).

2. Although a prehearing motion must be filed with the regulatory body 10 days before the date of the hearing (see NRS 622A.360), NRS 622A.360(5) specifically allows additional motions to be made after the commencement of the hearing. NRS 622A.360(5)(b) states that after the commencement of the hearing a party may file a motion "with leave of the . . . hearing panel or officer, any other motion requesting appropriate action or relief during the hearing." NRS 622A.360(5)(b).

3. In this case, Respondent discovered the conflict of interest on August 22, 2023, the night before the formal hearing was to begin. Respondent's counsel notified counsel for the Investigative Committee. Thereafter, counsel for Respondent sent an email to the Hearing Officer in the form of a "Motion to Dismiss." After review of the email, the Hearing Officer determined that further discussion was necessary, and a hearing was set to discuss the Motion to Dismiss and request for a continuance of the Hearing the next morning, on August 23, 2023, the date the Hearing was scheduled to commence.

4. On the morning of August 23, 2023, the Hearing Officer and the parties met by Zoom and discussed Respondent's Motion to Dismiss and to continue the hearing.

5. At the August 23, 2023 hearing, the Hearing Officer ruled that this was an issue that should be briefed further by all parties, and that a continuance of the hearing was therefore appropriate, to allow further briefing by all parties and thereafter a decision on Dr. Barber's Motion.

6. Based on these circumstances, the Hearing Officer expressly granted leave for Dr. Barber to file the Motion to Dismiss as set forth in NRS 622A.360.

7. Respondent Dr. Barber's Motion to Dismiss is not a Motion for Summary Judgment. Documents were attached to the Motion to provide information to the Hearing Officer regarding the nature of the alleged conflict of interest. The

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Motion did not ask the Hearing Officer to address the merits of the Investigative Committee's allegations. The Hearing Officer has not formed any conclusions regarding the merits of the Investigative Committee's allegations.

8. The Hearing Officer has authority to grant a Motion to Dismiss. NRS 622A.360 specifically provides provisions for parties to "request a ruling" from the hearing officer on "any issue of law or procedure in a case," by filing motions as set forth in NRS 622A.360. Pursuant to NRS 622A.360(4), the hearing officer "shall rule" on any prehearing motions. NRS 622A.360(6)(a) allows a party to make a motion for dismissal after the prosecution has concluded the presentation of his or her case in chief, based on the failure of the prosecutor to meet the burden of proof. All of these provisions explicitly recognize the authority of a hearing officer to "rule on" issues of law, including the issues of law raised on Respondent's Motion, and also recognizes the Hearing Officer's authority to dismiss a charging document.

9. NAC 630.470, which states that a "hearing officer may not dismiss the complaint," is contradictory to the provisions of NRS 622A.360, which authorizes the hearing officer to make rulings on issues of law and to make rulings on motions to dismiss. Although statutes should be given their plain meaning, a hallmark of statutory interpretation is that statutory interpretation should avoid absurd or unreasonable results. *See Sheriff v. Smith*, 91 Nev. 723, 733, 542 P.2d 440, 443 (1975); *Berkson v. LePome*, 126 Nev. 492, 497, 245 P.3d 560, 563 (2010); *State v. Tatalovich*, 309 P.3d 43, 44 (2013). Pursuant to the provisions of NRS Chapter 622A, a Hearing Officer may grant a Motion to Dismiss, and any interpretation otherwise of the conflicting language in NAC 630470 renders an absurd and unreasonable result.

10. A physician's license to practice medicine is a property right, and this right to earn a living is a liberty interest, and neither a property right nor liberty interest

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may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d 506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366 (9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy." *Stretten*, 537 F.2d at 366. Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971).

11. When the government makes a "charge against [someone] that might seriously damage his standing and associations in his community" and "'(w)here a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential.'" *Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 573, 92 S. Ct. 2701, 2707, 33 L. Ed. 2d 548 (1972) (internal quotation omitted).

12. "[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "[W]here one member of a tribunal is actually biased, or where circumstances create the appearance that one member is biased, the proceedings violate due process. A party need not demonstrate that the biased member's vote was decisive or that his views influenced those of other members. Whether actual or apparent, bias on the part of a single member of a tribunal taints the proceedings and violates due

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process." *Stivers*, 71 F.3d at 748.

13. The United States Supreme Court has held that a state licensing tribunal violates due process when its members have a pecuniary interest in the proceedings before them. *Gibson v. Berryhill*, 411 U.S. 564, 578-79, 93 S.Ct. 1689, 1697-98, 36 L.Ed.2d 488 (1973); *see also Stivers v. Pierce,* 71 F.3d 732, 742 (9th Cir. 1995). "Not only is a biased decisionmaker constitutionally unacceptable but 'our system of law has always endeavored to prevent even the probability of unfairness.'" *Matter of Ross*, 99 Nev. 1, 7–8, 656 P.2d 832, 836 (1983), *quoting Gibson.*

14. Even a single Board member with possible bias against the licensee taints the entire Board's decision-making process, denying due process regardless of whether the bias affected the correctness of the decision. *See Crump v. Bd. of Educ. of Hickory Admin. Sch. Unit*, 392 S.E.2d 579 (N.C. 1990). Moreover, both actual bias and the mere appearance of partiality due to an adjudicator's pecuniary or personal interest violate due process. *Stivers*, 71 F.3d at 741.

15. The Nevada Supreme Court has held that the Investigative Committee process constitutes the investigatory stage of the administrative process through the issuance of the formal Complaint. *Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 713, 429 P.3d 650, 654 (2018). In *Sarfo*, the Nevada Supreme Court held that a physician's due process rights do not attach to the administrative agency's fact-finding role. *Id*. However, in this case, unlike *Sarfo*, a formal Complaint has been filed, implicating Respondent's due process rights. In *Sarfo*, the Court cited to *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007), stating that this case stood for the proposition that "subpoenas issued pursuant to the department of Public Health's investigation do not implicate due process unless and until the department files a formal complaint." *Id*.

16. In Nevada, public officers, such as Nevada State Board of Medical Examiners

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Board members, have certain ethical duties. Pursuant to NRS 281A.020(1)(a), a "public office is a public trust and shall be held for the sole benefit of the people." Pursuant to NRS 281A.020(1)(b), a "public officer or employee must commit himself or herself to avoid conflicts between the private interests of the public officer or employee and those of the general public whom the public officer or employee serves."

17. NRS 630.085 provides that "[e]ach member of the Board shall comply with the provisions of NRS 281.500." NRS 281.500(1) provides that "[o]n or before the date on which a public officer swears or affirms the oath of office, the public officer must be informed of the statutory ethical standards and the duty to file an acknowledgement of the statutory ethical standards in accordance with this section . . ." NRS 281A.500(3)(a) provides that each public officer shall acknowledge that the officer has received, read and understands the statutory ethical standards.

18. NRS 281.420(1)(b) provides that a public officer shall not approve, disapprove, vote, abstain from voting or otherwise act upon a matter in which the public officer or employee has a significant pecuniary interest. Furthermore, NRS 281.420(1)(c) provides that a public officer shall not approve, disapprove, vote, abstain from voting or otherwise act upon a matter in which the public officer or employee would reasonably be affected by the public officer's or employee's commitment in a private capacity to the interests of another person.

19. The Investigative Committee's Opposition to Dr. Barber's Motion to Dismiss does not dispute Investigative Committee member Chowdhury H. Ahsan, M.D.'s involvement with Patient A's care and treatment. The Investigative Committee has not disclosed whether Dr. Ahsan disclosed his involvement in Patient A's care and treatment, or whether he disclosed the renumeration he received for the care and treatment. Dr. Ahsan's involvement with Patient A's

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care and treatment was not disclosed to Respondent by the Investigative Committee.

20. After review of the briefing, the Hearing Officer determines there is a clear conflict of interest in this matter, and the integrity of the process is called into question when one of the members of the Investigative Committee was involved in Patient A's medical treatment at issue, no matter how limited or how small any pecuniary interest. The process is indeed tainted and due process is consequently compromised.

21. Without more, this in no way assumes any malfeasance or improper conduct on the part of the Board, the Investigative Committee or Dr. Ahsan, but assumes at least a failure to conduct an adequate conflict check. It is incumbent upon each party involved in the process to check for conflicts, and, if there is a connection or relationship even unconnected to the case at hand, recuse or disclose the potential conflict and give the party an opportunity to waive any possible conflict, or to not waive the conflict. The Investigative Committee process should be no different.

22. Dr. Barber was neither informed of Dr. Ahsan's involvement in the underlying medical case nor offered the opportunity to waive and proceed with the case. This was not even a case where Dr. Ahsan treated Patient A in an unrelated matter, but he was actually directly involved in the medical process leading to Dr. Barber's treatment of and surgery on Patient A which led to the investigation and the Complaint being filed. In order to uphold the constitutional requirement of due process, any matter such as this should balance protection of the public with a completely unbiased and impartial proceeding. The Hearing Officer does not participate in speculation but cannot imagine any scenario that any physician, on the Board or otherwise, would demand less. Even the appearance of a conflict may undermine the public's faith in its institutions that exist to protect it.

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ORDER

IT IS HEREBY ORDERED that Annabel Elizabeth Barber, M.D.'s Motion to Dismiss is GRANTED. IT IS FURTHER ORDERED that the Complaint filed on September 20, 2022 against Respondent Annabel Elizabeth Barber, M.D. is dismissed.

IT IS SO ORDERED.

_____

Approved as to form and content: DATED: October _____, 2023 INVESTIGATIVE COMMITTEE FOR THE NEVADA STATE BOARD OF MEDICAL EXAMINERS By_____ Donald K. White Nevada Bar No. 10467 Nevada State Board of Medical Examiners 9600 Gateway Drive, Reno, NV 89521 *Attorney for Investigative Committee of the Nevada State Board of Medical Examiners*	Submitted by: DATED: October _____, 2023 COLLINSON, DAEHNKE, INLOW & GRECO By_____ Patricia Egan Daehnke Nevada Bar No. 4976 Amanda E. Rosenthal Nevada Bar No. 10748 2110 E. Flamingo Road, Suite 212 Las Vegas, NV 89119 *Attorneys for Respondent*

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Exhibit C

FILED
AUG 31 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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Annabel Elizabeth Barber, M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against:	**Case No. 22-11660-1**
ANNABEL ELIZABETH BARBER, M.D.	**ANNABEL ELIZABETH BARBER, M.D.'S MOTION TO DISMISS**
Respondent.	

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Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby moves to dismiss the Complaint filed by the Investigative Committee of the Nevada State Board of Medical Examiners on September 20, 2022. This Motion is brought pursuant to NRS 622A.360(2)(b) and NRS 622A.360(2)(f), the attached Memorandum of Points and Authorities, and any argument that the Hearing Officer or panel will allow upon a hearing in this matter.

Dated: August 30, 2023

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*
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Annabel Elizabeth Barber, M.D.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The instant Complaint against Respondent Annabel Barber, M.D. was filed on September 20, 2022 by the Investigative Committee of the Nevada State Board of Medical Examiners. Exhibit A, Complaint. Respondent Dr. Barber hereby moves to dismiss the Complaint in this matter, as her due process rights have been violated because the Investigative Committee's investigation of this matter has been tainted by an undisclosed conflict of interest. Specifically, Investigative Committee member Chowdhury H. Ahsan, M.D. treated Patient A during the same time frame as Dr. Barber. Specifically, he interpreted an echocardiogram at the request of the surgical team. As a treating physician of Patient A, Dr. Ahsan has first-hand knowledge of Patient A's medical care and treatment, and also had access to information in Patient A's medical records prior to the time any investigation was started in this matter. As a treating physician of Patient A, Dr. Ahsan also has a pecuniary interest in this matter, and has a commitment in a private capacity to Patient A, in fact a fiduciary duty, as his treating physician.

It is unknown whether Dr. Ahsan ever reported this conflict. However, the Investigative Committee and the Board never informed Dr. Barber of this conflict, nor did they preclude Dr. Ahsan from participating in this matter. Instead, they allowed Dr. Ahsan to participate in this matter and recommend disciplinary proceedings in the form of a formal Complaint, despite the clear conflict of interest. This conflict has tainted the investigative process and any adjudication in this matter, and is a violation of Dr. Barber's due process rights. As such, Dr. Barber respectfully requests that the Complaint be dismissed. Should the Board wish to pursue this matter further, Dr. Barber respectfully requests that the Hearing Officer require the Board to assemble a new Investigative Committee in this matter to complete a de novo review, to determine whether a Complaint should be re-filed. Anything less is a violation of Dr. Barber's due process rights and will result in an unfair and improper result.

///

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II. HISTORY OF RELEVANT CARE AND TREATMENT

Patient A first saw Respondent Annabel Barber, M.D. on December 27, 2018 at UNLV. Exhibit B, December 27, 2018 note. He had been referred to Dr. Barber for a left inguinal hernia repair. *Id.* Patient A was born with an omphalocele and had a reconstruction as a newborn. *Id.* He later had a large amount of his small bowel removed. *Id.* Dr. Barber noted Patient A's surgical history of right hernia repair, omphalocele repair which required multiple surgeries, and his small intestine surgery at around 30 years of age when he had 2/3 of his small bowel removed. *Id.* After a physical exam, Dr. Barber planned to obtain a CT scan to define the anatomy better, and in order to determine whether laparoscopic or open repair of the hernia would be appropriate. *Id.* Dr. Barber also started patient A on Juven to maximize healing. *Id.*

The CT scan was performed on January 15, 2019. Exhibit C, CT scan report. The impression was that the left inguinal canal was patulous and contained fat. *Id.* A slight bulge was noted at the base of the umbilicus. *Id.*

Dr. Barber requested that Patient A obtain medical clearance for surgery. Patient A had medical clearance performed by Jonathan Chiang, M.D. and cardiologist Sanjay Vohra, M.D. Exhibit D, preoperative clearance. Dr. Vohra noted that Patient A was cleared to proceed with the planned surgery from a cardiac standpoint. *Id.*

On February 22, 2019, Patient A presented to Las Vegas Surgery Center for a planned laparoscopic left inguinal hernia repair with mesh. He signed an Informed Consent form, authorizing Dr. Barber to proceed with a laparoscopic left inguinal hernia repair. Exhibit E, Informed Consent. He initialed to indicate that the nature, purpose, and possible complications of the procedure had been described, the risks and benefits reasonably expected, and the alternative methods of treatment had been explained to him. *Id.*

On February 22, 2019, Dr. Barber proceeded with the planned laparoscopic surgery. Exhibit F, February 22, 2019 Operative Report. A trocar was advanced into the abdominal cavity, but no visualization could be obtained. *Id.* As such, the trocar was removed and placed in a different location. *Id.* Visualization still could not be obtained, and the trocar was

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removed and placed in the midline. *Id.* At this time, Dr. Barber suspected a small bowel injury, so a mini-laparotomy was performed, and a small bowel injury was confirmed and documented by Dr. Barber. *Id.* The small bowel injury was repaired. *Id.* However, Dr. Barber was unable to proceed with the hernia repair. *Id.* Patient A was discharged home after surgery to follow up with Dr. Barber. *Id.*

On February 25, 2019, Patient A presented to University Medical Center with leakage at his abdominal incision site. Dr. Barber was consulted, and on February 25, 2019, Dr. Barber performed an exploratory laparotomy, small-bowel resection, and negative pressure wound dressing application. Exhibit G, February 25, 2019 Operative Note.

On February 25, 2019, general surgeon Kyle Mock, M.D. ordered an echocardiogram to evaluate Patient A's LV function. Exhibit H, Echocardiogram Report. On February 26, 2019, cardiologist Chowdhury H. Ahsan, M.D. interpreted the echocardiogram and signed his report. *Id.*

To Respondent's knowledge, Dr. Ahsan did not further treat Patient A. However, Dr. Barber continued to treat Patient A during this admission at University Medical Center, performing additional procedures. In particular, on February 27, 2019, Dr. Barber performed an abdominal wound washout and wound vac change. Exhibit I, February 27, 2019 Operative Note.

Patient A was discharged from University Medical Center on March 10, 2019. His Discharge Summary was co-signed by Dr. Barber. Exhibit J, Discharge Summary.

Dr. Barber saw Patient A in her office on March 21, 2019. He did not return thereafter for further treatment with Dr. Barber.

III. PROCEDURAL HISTORY

On October 28, 2019, approximately eight months after Dr. Barber's February 22, 2019 surgery, the Nevada State Board of Medical Examiners ("the Board") initiated their investigation in this matter, and sent correspondence to Dr. Barber requesting a response. Exhibit K, Investigation Letter. As a part of their investigation, the Board requested and on November 21, 2019 obtained medical records from University Medical Center regarding

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Patient A. Exhibit L, University Medical Center Custodian of Records Certificates. Included within these medical records are records indicating that Chowdhury H. Ahsan, M.D was a treating provider of Patient A.

On September 20, 2022, the Investigative Committee filed their Complaint in this matter. Exhibit A. The Complaint indicates that the Investigative Committee at the time the formal Complaint was authorized for filing was composed of Boad members Bret W. Frey, M.D. Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Col Eric D. Wade (Ret). Exhibit A at footnote 1. The Complaint alleges two counts against Respondent Dr. Barber: 1) Malpractice pursuant to NRS 630.301(4) and 2) Failure to Maintain Proper Medical Records pursuant to NRS 630.3062(1)(a). *See* Exhibit A.

The Hearing in this matter was scheduled for August 23 – 24, 2023. In preparation for the hearing, while on the airplane to Reno on the evening of August 22, 2023, counsel for Dr. Barber discovered the medical record indicating that Dr. Ahsan, a member of the Investigative Committee, was a treating provider of Patient A. Counsel for Dr. Barber spoke with counsel for the Investigative Committee about the conflict. Counsel for the Investigative Committee indicated he did not believe it was a conflict and the hearing could continue. On the evening of August 22, 2023, after speaking with counsel for the Investigative Committee, counsel for Dr. Barber made a brief Motion to Continue the Hearing and/or to Dismiss the Complaint based on the conflict that had been discovered. The Hearing Officer scheduled a Zoom conference for the morning of August 23, 2023.

On the morning of August 23, 2023, the parties conducted a Zoom conference with the hearing officer to discuss the appropriate next steps in regards to Dr. Barber's Motion. As a result of the conference, the Hearing Officer granted Dr. Barber's request to continue the Hearing in this matter, and set a briefing schedule regarding Dr. Barber's Motion to Dismiss. The Hearing in this matter was tentatively rescheduled for November 20-21, 2023. Dr. Barber's Motion to Dismiss is therefore being filed herein pursuant to the briefing schedule.

IV. REQUESTED RELIEF

Pursuant to NRS 622A.360(b), a party in a proceeding before a regulatory body may

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file a "motion requesting, for good cause, the recusal of the hearing officer, a member of the hearing panel or a member of the regulatory body from participation in the case." Furthermore, pursuant to NRS 622A.360(f), a party may file, with leave of the hearing panel officer, "any other motion requesting appropriate action or relief." Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing.

In this case, Dr. Barber seeks recusal of Investigative Committee member Chowdhury H. Ahsan, M.D., who treated Patient A and was part of the Investigative committee that recommended filing the Complaint to proceed with discipline in this matter. Given the taint of Dr. Ahsan's undisclosed conflict in this matter, Dr. Barber seeks dismissal of the Complaint and an Order that the Board appoint a new Investigative Committee to conduct a de novo investigation in this matter before proceeding with filing of a new Complaint, if any.

V. LEGAL STANDARDS

NRS 630.050 provides that the "Board of Medical Examiners consists of nine members appointed by the Governor." In this case, Chowdhury H. Ahsan, M.D. is a member of the Medical Board, whose term expires on June 30, 2025. Exhibit M, Board Members.

In Nevada, public officers, such as Nevada State Board of Medical Examiners Board members, have certain ethical duties. Pursuant to NRS 281A.020(1)(a), a "public office is a public trust and shall be held for the sole benefit of the people." Pursuant to NRS 281A.020(1)(b), a "public officer or employee must commit himself or herself to avoid conflicts between the private interests of the public officer or employee and those of the general public whom the public officer or employee serves." The Nevada Commission on Ethics has explained:

> The apparent intent of the provisions of NRS Chapter 281 [now NRS Chapter 281A] . . . is to prevent public officers and employees from becoming involved in situations generating conflicts between private and public interests so as to preserve and enhance impartiality of public office and faith in the integrity of government. Policy objectives for ethics in government laws in general include:
>
> • Impartiality, fairness and equality of treatment toward those dealing with government.

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• Assurance that decisions of public importance will not be influenced by private considerations.
• Maintenance of public confidence in government (wherein enters the matters of appearances).
• Prevention of use of public office for private gain.

A conflict of interest (either actual or potential) is a situation requiring a public officer to serve two masters, presenting a potential; rather than an actuality, of wrongdoing. The wrongdoing does not have to actually occur in order for a prohibited conflict to exist. A public official may have done no wrong in the ordinary sense of the word, but a conflict of interest may put him in danger of doing wrong. It is avoiding even the potential of doing wrong which is the focus of ethics in government laws.

For this purpose, ethics in government laws identify certain types of conflicts of interest and prohibit conduct by public officials that would allow these conflicts to affect decisions of the public official...

In re Alworth, Comm'n Op. No. 19-049A (2021), In *re Public Officer*, Comm'n Op. No. 99-57 (2000), at p. 3, cited by *In re Dressler*, Comm'n Op. No. 00-12 (2000), *In re Public Officer*, Comm'n Op. No. 01-14 (2001) and *In re Public Officer*, Comm'n Op. No. 02-01 (2002).

NRS 630.085 provides that "[e]ach member of the Board shall comply with the provisions of NRS 281.500." NRS 281.500(1) provides that "[o]n or before the date on which a public officer swears or affirms the oath of office, the public officer must be informed of the statutory ethical standards and the duty to file an acknowledgement of the statutory ethical standards in accordance with this section . . ." NRS 281A.500(3)(a) provides that each public officer shall acknowledge that the officer has received, read and understands the statutory ethical standards.

NRS 281.420(1) provides, in relevant part:

[A] public officer or employee shall not approve, disapprove, vote, abstain from voting or otherwise act upon a matter:
(b) In which the public officer or employee has a significant pecuniary interest[1]; . . .
(c) Which would reasonably be affected by the public officer's or

[1] NRS 281A.139 defines a "pecuniary interest" as "any beneficial or detrimental interest in a matter that consists of or is measured in money or is otherwise related to money, including, without limitation...[a]nything of economic value. . ."

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> employee's commitment in a private capacity[2] to the interests of another person; . . .
> without disclosing information concerning . . . the significant pecuniary interest, the commitment in a private capacity to the interests of the other person . . . that is sufficient to inform the public of the potential effect of the action or abstention . . . upon the public officer's or employee's significant pecuniary interest, upon the person to whom the public officer or employee has a commitment in a private capacity . . . Such a disclosure must be made at the time the matter is considered. If the public officer or employee is a member of a body which makes decisions, the public officer or employee shall make the disclosure in public to the chair and other members of the body. If the public officer or employee is not a member of such a body and holds an appointive office, the public officer or employee shall make the disclosure to the supervisory head of the public officer's or employee's organization . . .

NRS 281A.420 serves to ensure that public officers "avoid conflicts between [their] private interests and those of the general public whom [they] serve." *Carrigan v. Comm'n on Ethics of State*, 129 Nev. 894, 906, 313 P.3d 880, 888 (2013). The State has an important interest in avoiding conflicts of interest and self-dealing by public officials entrusted with making decisions affecting its citizens. *Id.*

The Nevada State Board of Medical Examiners has filed a disciplinary Complaint against Respondent Dr. Barber in this matter, seeking to impose discipline on Dr. Barber's license to practice medicine in Nevada. The United States Constitution guarantees that "[n]o person shall be…deprived of life, liberty, or process without due process of law." U.S. Const. amend. V. This protection is incorporated at the state level through the Fourteenth Amendment (U.S. Const. amend. XIV) and the Constitution of the State of Nevada (Nev. Const. art. I, § 8).

A physician's license to practice medicine is a property right, and this right to earn a living is a liberty interest, and neither a property right nor liberty interest may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d

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[2] NRS 281A.065 defines "commitment in a private capacity" to the interests of another person to mean, among others, a commitment "to the employer of the public officer or employee," "to a person with whom the public officer or employee has a substantial and continuing business relationship," or "to anyone with whom the public officer has any other commitment, interest or relationship that is substantially similar to a commitment, interests or relationship described . . ."

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506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366 (9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy." *Stretten,* 537 F.2d at 366. Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971).

When the government makes a "charge against [someone] that might seriously damage his standing and associations in his community" and "'(w)here a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential.'" *Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 573, 92 S. Ct. 2701, 2707, 33 L. Ed. 2d 548 (1972) (internal quotation omitted). "[T]he right to be heard before being condemned to suffer grievous loss of any kind, even though it may not involve the stigma and hardships of a criminal conviction, is a principle basic to our society." *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 U.S. 123, 168, 71 S. Ct. 624, 646, 95 L.Ed. 817 (Frankfurter, J., concurring). The harm resulting to the holder of a professional license due to the filing of an ill-founded complaint can be irreparable. *Sheppard v. Bd. of Dentistry*, 385 So. 2d 143, 145 (Fla. App. 1980). Public disclosure of an administrative complaint is premised [ ] on strict statutory compliance to safeguard due process concerns. *Salameh v. Fla. Dep't of Health*, 325 So. 3d 349, 355 (Fla. App. 2021) (concurrence).

"[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "[W]here one member of a tribunal is actually biased, or where circumstances create

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the appearance that one member is biased, the proceedings violate due process. A party need not demonstrate that the biased member's vote was decisive or that his views influenced those of other members. Whether actual or apparent, bias on the part of a single member of a tribunal taints the proceedings and violates due process." *Stivers*, 71 F.3d at 748.

The United States Supreme Court has held that a state licensing tribunal violates due process when its members pecuniary interest in the proceedings before them. *Gibson v. Berryhill*, 411 U.S. 564, 578-79, 93 S.Ct. 1689, 1697-98, 36 L.Ed.2d 488 (1973); *see also Stivers v. Pierce*, 71 F.3d 732, 742 (9th Cir. 1995). In *Gibson*, the Court considered revocation proceedings by an optometry licensing board. The licensees in the revocation proceedings were optometrists employed by an optometry company, while the members of the licensing board were self-employed optometrists. The district court had found that, if the optometry company were forced to shut down, the members of the Board would benefit from the business. The Supreme Court noted that "it is sufficiently clear that those with substantial pecuniary interest in legal proceedings should not adjudicate these disputes." *Gibson*, at 579, citing *Tumey v. Ohio*, 273 U.S. 510 (1927). The Supreme Court upheld the district court's conclusion that the board members' had sufficient pecuniary interest such that denying licenses to competitors constituted a *per se* violation of the right to due process. "Not only is a biased decisionmaker constitutionally unacceptable but 'our system of law has always endeavored to prevent even the probability of unfairness.'" *Matter of Ross*, 99 Nev. 1, 7–8, 656 P.2d 832, 836 (1983), *quoting Gibson*.

Even a single Board member with possible bias against the licensee taints the entire Board's decision-making process, denying due process regardless of whether the bias affected the correctness of the decision. *See Crump v. Bd. of Educ. of Hickory Admin. Sch. Unit*, 392 S.E.2d 579 (N.C. 1990) (discussing proceedings against a teacher). "[W]hile the influence of any single participant in this process can never be measured with precision, experience teaches us that each member's involvement plays a part in shaping the court's ultimate disposition. The participation of a judge who has a substantial interest in the outcome of a case of which he knows at the time he participates *necessarily* imports a bias into the

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deliberative process. This deprives litigants of the assurance of impartiality that is the fundamental requirement of due process." *Aetna Life Ins. Co. v. Lavoie*, 475 U.S. 813, 831, 106 S. Ct. 1580, 1590, 89 L. Ed. 2d 823 (1986) (Brennan, J., concurring). Moreover, both actual bias and the mere appearance of partiality due to an adjudicator's pecuniary or personal interest violate due process. *Stivers*, 71 F.3d at 741.

The Nevada Supreme Court held the Investigative Committee process constitutes the investigatory stage of the administrative process through the issuance of the formal Complaint. *Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 713, 429 P.3d 650, 654 (2018). The Nevada Supreme Court in *Sarfo* ruled the Investigative Committee did not implicate the physician's right to be heard because the Investigative Committee was "statutorily prohibited from later adjudicating [the complaint] themselves." *Sarfo, supra*, 134 Nev. at 713. However, NRS 630.311(2) provides that a formal complaint may only be filed "after conducting an investigation," empowering the Investigative Committee as a prosecutorial or quasi-judicial body to "indict... [or] make determinations depriving anyone of his life, liberty, or property." Furthermore, the Investigative Committee holds power over whether to reject settlement proposals or recommend settlement, thereby empowering them to make determinations that deprive a licensee of their life, liberty, and property. In *Hernandez v. Bennett-Haron*, 128 Nev. 580, 592, 287 P.3d 305, 314 (2012), relied upon by the *Sarfo* court, the Court made a distinction that due process is required where a panel makes recommendations to the law enforcement body. In this case, the Investigative Committee makes recommendations regarding the filing of the disciplinary Complaint. Furthermore, the Boad considers the Investigative Committee to be a decisionmaker, stating on their website: "The Investigative Committee MUST review each case. This committee is comprised of members of the Nevada State Board of Medical Examiners and is the authority and decision-making body over investigations." Exhibit N, Investigative Division, Frequently Asked

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Questions. Furthermore, as discussed above, the Investigative Committee makes recommendations regarding settlement, and has authority to reject settlement proposals. Any rejection of, or recommendation for settlement is authority over the licensees' life, liberty, and property. Additionally, unlike Sarfo, where no formal disciplinary Complaint had been filed, the Investigative Committee in this case has recommended a formal Complaint, and a formal Complaint has been filed, thereby implicating Respondent's due process rights. As such, the actual or perceived conflict of an Investigative Committee Member in launching a formal disciplinary proceedings of a licensee violates due process as much as the bias of an adjudicating Board Member would. As the Federation of State Medical Boards ("FSMB") states,

> Whatever the complaint, physicians are afforded the right of due process as a state medical board investigates an allegation of unprofessional conduct. Due process asserts that an individual is innocent until proven guilty. This principle applies to formal hearings and judicial procedures that the medical board conducts. Boards must adhere to established rules and principles to ensure that a physician is not treated unfairly, arbitrarily or unreasonably.

Exhibit O, Federation of State Medical Boards, About Physician Discipline.

Whenever a person with a pecuniary interest or private commitment is involved in decision-making, the affected person is denied due process of law. "Every procedure which would offer a possible temptation to the average man as a judge to forget the burden of proof required to convict the defendant, or which might lead him not to hold the balance nice, clear, and true between the state and the accused denies the latter due process of law." *Tumey v. State of Ohio*, 273 U.S. 510, 532, 47 S. Ct. 437, 444 (1927). "The Due Process Clause entitles a person to an impartial and disinterested tribunal in both civil and criminal cases. Not only is a biased decisionmaker constitutionally unacceptable but our system of law has always endeavored to prevent even the probability of unfairness." *Matter of Ross*, 99 Nev. at 7, 656 P.2d at 835 (internal quotations omitted).

The United States Supreme Court emphasized: "The requirement of neutrality has

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been jealously guarded by this Court." *Marshall v. Jerrico, Inc.*, 446 U.S. 238, 242, 100 S.Ct. 1610, 1613 (1980). As the Nevada Supreme Court held, "Just as fairness requires an absence of actual bias in the trial of cases, fairness also requires an absence of actual bias in the investigation of cases." *Del Papa v. Steffen*, 112 Nev. 369, 382, 915 P.2d 245, 253 (1996) (internal quotation omitted). If an Investigative Committee member has a pecuniary interest or private commitment in the matter, it creates "a situation which would offer a possible temptation to the average man as judge not to hold the balance nice, clear and true between the State and the accused. Such a situation amounts to a violation of due process and will not be permitted. *Id.* at 382, 253 (internal quotation omitted).

"[I]t is difficult if not impossible to measure the impact that one member's views have on the process of collective deliberation. Each member contributes not only his vote but also his voice to the deliberative process." *Stivers*, 71 F.3d at 747. Particularly on a three-member Investigative Committee, "a single person's bias is likely to have a profound impact on the decisionmaking process." *Id.*

VI. ARGUMENT

Investigative Committee member Chowdhury H. Ahsan, M.D. treated Patient A on February 26, 2019 at University Medical Center, during the same time that Respondent Dr. Barber treated Patient A. Dr. Ahsan interpreted Patient A's echocardiogram on February 26, 2019 at the request of the general surgery service, in preparation for further care and treatment, including a surgery performed by Dr. Barber on February 27, 2019. Pursuant to NRS 630.020, the "practice of medicine" means "to diagnose, treat, correct, prevent, or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental," and "to apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions." In this case, Dr. Ahsan practiced medicine in regards to Patient A, by assisting with diagnosis and by applying principles or techniques of medical science in relation to the interpretation of Patient A's echocardiogram. The physician-patient relationship is "fiduciary in nature." *Massey v. Litton*, 99 Nev. 723, 728, 669 P.2d 248, 252 (1953). When Dr. Ahsan treated Patient A, he created a "commitment in a

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private capacity" to the interests of Patient A. Furthermore, Dr. Ahsan was presumably paid for his care and treatment of Patient A, creating a pecuniary interest in this matter. Pursuant to NRS 281.420(1), Dr. Ahsan was precluded from approving, disapproving, voting, abstaining from voting, or otherwise acting in this matter without disclosing information concerning his conflict. It is unknown whether Dr. Ahsan disclosed the conflict. However, what is known is that the Investigative Committee and the Board never informed Respondent Dr. Barber of the conflict. Instead, the Investigative Committee authorized the filing of the Complaint in this matter, while a member of the Investigative Committee had first-hand knowledge of the issues in this case. Furthermore, Dr. Ahsan has been involved in considering whether to accept or reject Respondent Dr. Barber's settlement proposals. Dr. Ahsan's first-hand knowledge of this matter and personal involvement in the care and treatment, including his own fiduciary duty to Patient A, has irrevocably tainted this matter, such that Dr. Barber's due process rights have been violated and the Complaint must be dismissed.

Respondent Dr. Barber respectfully requests that the Complaint be dismissed, and the Board be ordered to assemble a new Investigative Committee to review this matter de novo, should the Board wish to proceed further. Simply swapping out Dr. Ahsan for another Board member will not correct the issue. Dr. Barber is entitled to a fair process from the outset, without the taint of a conflict of interest. Given the liberty and property interests at stake for Dr. Barber, this is the only correct result.

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VII. CONCLUSION

Dr. Barber has the right to have her case investigated and adjudicated by unbiased parties. The process in this case has been tainted, and the Complaint should be dismissed. The Board should be ordered to assemble a new Investigative Committee, should they so choose, to conduct a de novo investigation in this matter to determine whether to proceed with re-filing a Complaint. Dr. Barber's Due Process rights have been violated absent any other result.

Dated: August 30, 2023

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*
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CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of August, 2023, a true and correct copy of ANNABEL ELIZABETH BARBER, M.D.'S MOTION TO DISMISS was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Nancy L. Moss Gushn, Esq. 675 W. Moana Lane, Suite 107 Reno, NV 89509 nmg416@gmail.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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Exhibit D

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 22-11660-1**

FILED

SEP 13 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' OPPOSITION TO RESPONDENT'S MOTION TO DISMISS

The Investigative Committee (IC) for the Nevada State Board of Medical Examiners (Board), by and through its attorney, Donald K. White, Senior Deputy General Counsel, hereby files its Opposition to Respondent's Motion to Dismiss served on August 30, 2023.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

On September 20, 2022, the IC filed a formal Complaint against Respondent alleging violations of the Medical Practice Act with respect to a left inguinal hernia surgery she attempted to perform on Patient A on February 22, 2019. The complaint clearly states that it includes the IC's "charges and allegations," and requests, in-part, that a time and place for a formal hearing be scheduled, thus acknowledging that the asserted facts will be scrutinized through the adversarial process. Respondent's due process rights were not implicated prior to the filing of the Complaint, *Sarfo v. Bd. of Med. Exam'rs*, 134 Nev. 709, 429 P.3d 650 (2018), and consistent with the governing procedures, *see* NRS 630.339 et seq., a Hearing Officer has been appointed to oversee the proceedings.

Respondent has filed a motion to dismiss the complaint, by incorrectly asserting and accusing one of the members of the IC of having a conflict of interest by spinning spurious conclusions attempting to conjure up a due process violation in this matter. However, Dr. Ahsan

merely interpreted an echocardiogram and never actually saw Patient A. Respondent has received, and will continue to receive, all due process to which she is entitled.

II. ARGUMENT

A. Respondent's Motion is Not Allowed Pursuant to NRS 622A.360.

The types of prehearing motions that may be brought in administrative proceedings, such as this, are limited. Specifically, NRS 622A.360(2) states:

> A party may file *only* the following prehearing motions:
>
> (a) A motion requesting a continuance or an extension of time.
> (b) A motion requesting, for good cause, the recusal of the hearing officer, a member of the hearing panel or a member of the regulatory body from participation in the case.
> (c) A motion requesting the separation of consolidated cases.
> (d) A motion requesting a more definite statement regarding the allegations in the charging document on the ground that there is not enough information in the charging document to formulate a defense.
> (e) *A motion requesting dismissal of the charging document for failure to state facts which, if true, would form a sufficient basis for discipline.*
> (f) *With leave of the regulatory body or hearing panel or officer, any other motion requesting appropriate action or relief before the date of the hearing.*

(Emphases added.) In setting forth such a list, the Legislature has excluded other prehearing motions. *See Galloway v. Truesdell*, 83 Nev. 13, 26, 422 P.2d 237, 246 (1967) (recognizing Nevada's consistent application of the maxim "the expression of one thing is the exclusion of another").

Subsection (e) of NRS 622A.360(2) sets forth the sole basis on which a motion to dismiss at this stage of the proceedings can be brought, namely, if it asserts that the complaint fails to set forth facts that, if true, would not constitute a basis for discipline. Respondent's motion is not based on such an assertion, but rather argues that the complaint should be dismissed for alleged violations of her right to due process, and requests consideration of an improper argument, essentially rendering it a motion for summary judgment, *see Gallen v. Eighth Judicial Dist. Ct.*, 112 Nev. 209, 911 P.2d 858 (1996), which is clearly not permitted at this stage of the proceeding,

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when there are not yet any facts properly placed on the record.[1] While Nevada law assuredly provides for due process in this proceeding, a prehearing motion arguing that it has been denied here is premature.

Due process attaches upon the filing of the formal complaint, *see Sarfo*, 134 Nev. 709, 429 P.3d 650, and thus arguments regarding proceedings prior to the filing of the complaint are unavailing. Additionally, "it is the opportunity to prepare a defense that defines due process" in an administrative proceeding. *Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy*, 124 Nev. 701, 712, 191 P.3d 1159, 1167 (2008) (citing *Nevada State Apprenticeship Council v. Joint Apprenticeship & Training Comm.*, 94 Nev. 763, 765, 587 P.2d 1315, 1317 (1978)). Thus, a process that ensures that a respondent is apprised of the charges against them and the factual bases underlying those charges, and in which the administrative body follows its established procedural guidelines, provides the required due process contemplated under the law. *See id.* at 711-12, 191 P.3d at 1166-67. These authorities recognize that due process must be applied, as an administrative matter proceeds, after the filing of the complaint, and thus a motion to dismiss at this juncture is improper.

Respondent attempts to circumvent the limitation on NRS 622A.360(2)(e) motions by asserting that her motion is brought pursuant to subsections (b) and (f) of NRS 622A.360(2), which allows a motion requesting, for good cause, the recusal of the hearing officer, a member of the hearing panel or a member of the regulatory body from participation in the case, and a motion requesting "appropriate action" with leave of the hearing officer, respectively. Respondent did not request such leave prior to filing the motion and does not request such leave within the motion itself. However, even if Respondent had properly requested such leave, the authorities discussed above make clear that the relief she seeks is not appropriate at this stage of the proceeding. Because Respondent's motion to dismiss is procedurally impermissible, it should be denied.

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[1] The IC disputes every factual assertion in Respondent's motion and reserves the right to dispute each assertion in more detail should the Hearing Officer so request. The IC also objects to all exhibits attached to Respondent's motion and requests that they be stricken from the record because they have not been properly admitted in this case.

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B. Even if Respondent's Motion Were Permitted, it Lacks Merit.

Even if a prehearing motion to dismiss on due process grounds were permissible, Respondent's motion lacks merit. The IC agrees that Respondent is entitled to due process in this proceeding. *Dutchess Bus. Servs., Inc.*, 124 Nev. at 711, 191 P.3d at 1166 ("Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply."). As noted above, in an administrative proceeding, "it is the opportunity to prepare a defense that defines due process," and a process where a respondent is apprised of the charges against them and the factual bases underlying them, and where established procedural guidelines are followed, the required due process is provided. *See id.* at 711-12, 191 P.3d at 1166-67.

1. Respondent's Motion to Dismiss is Untimely and Not Permitted by Regulation.

Respondent submitted her motion to dismiss, albeit informally in an email, at 10:15 p.m., the night before the hearing was to commence. Many months prior to the hearing, the hearing officer in this matter issued a Second Amended Scheduling Order (Order), which the Board filed on April 24, 2023. This Order resulted from a status conference that was held via *Zoom* on April 21, 2023. In that order, the hearing officer wrote that "counsel for the parties have also represented that they do not anticipate that any prehearing motions will be filed." Despite those representations by counsel, motion work is occasionally necessary when unanticipated issues arise. However, the IC provided all of their evidence to Respondent's counsel on February 21, 2023, so any attempt to assert that the informal motion to dismiss was necessary in an email at 10:15 p.m. the night before the hearing on August 23, 2023, is untimely and improper. Based on the delay of the motion, it should be denied.

Moreover, and most importantly, the Motion to Dismiss must be preemptively stricken and/or denied because the Board, panel, or the Hearing Officer may not dismiss a complaint pursuant to NAC 630.470(5). Thus, the hearing officer lacks authority to entertain Respondent's motion to dismiss, and it must be stricken and/or denied.

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2. Due Process Does Not Attach Until the Formal Complaint is Filed.

Respondent argues that this matter must be dismissed because Dr. Ahsan "treated" Patient A and then subsequently approved the filing of the formal Complaint as a member of the IC. She cites no relevant authority for this proposition because there is none. In fact, the Nevada Supreme Court has categorically foreclosed this argument by its recent decision in *Sarfo v. State of Nevada, Board of Medical Examiners*, 134 Nev. Adv. Op. 85 (Nov. 1, 2018). In that case, the Court examined "whether a physician's due process rights attach at the investigation stage of a complaint made to the Nevada State Board of Medical Examiners." *Id.* at 2. The Court concluded that "a physician's due process rights do not attach to the administrative agency's fact-finding role." *Id.* Thus, it is irrelevant that Dr. Ahsan interpreted an echocardiogram and then much later in time approved the filing of a formal Complaint during the investigative phase, because Respondent's due process rights – notice and an opportunity to be heard – do not commence at that phase.

It is not until a formal complaint is filed that due process rights attach, and Respondent's due process rights are being scrupulously observed. The IC's counsel timely disclosed nearly six thousand (6,000) pages of investigative documents to Respondent in its disclosures on February 21, 2023, including everything received from Patient A's hospital stay, which resulted from Respondent's failed attempts to surgically repair a left inguinal hernia and then perforated Patient A's bowel, even though NRS 622A.330(1) only requires the disclosure of the documents and other evidence "intended to be presented by the prosecutor in support of the case and a list of proposed witnesses." (Emphasis added.) Likewise, NRS 630.336(4) makes the investigative materials of the Board confidential, and only those "documents and information considered by the Board when considering whether to impose discipline are public records." NRS 630.336(5). A vast majority of the documentation is not relevant to the time frame at issue in this case: December 27, 2018 through February 22, 2019, and particularly February 22, 2019.

3. There is No Conflict of Interest.

Respondent devotes pages of her motion to conjuring up an alleged conflict of interest that does not exist under applicable law. NRS 281A.420(1)(b) provides in pertinent part,

[e]xcept as otherwise provided in this section, a public officer or employee shall not approve, disapprove, vote, abstain from voting or otherwise act upon a matter: (b) [i]n which the public officer or employee has **a significant pecuniary interest**.... (Emphasis added). "Pecuniary interest" by definition is any beneficial or detrimental interest in a matter that consists of or is measured in money or is otherwise related to money, including, without limitation: 1) anything of economic value; and 2) payments or other money which a person is owed or otherwise entitled to by virtue of any statute, regulation, code, ordinance or contract or other agreement. *See* NRS 281A.139.

There is simply no evidence or any way to argue that Dr. Ahsan had any significant beneficial or detrimental interest in this matter consisting of money or anything of economic value, when he merely interpreted an echocardiogram of Patient A, while he was in the hospital for a perforated bowel caused by Respondent. Moreover, Dr. Ahsan did not have a significant pecuniary interest, nor any pecuniary interest at all, when he was one of three (3) members who all approved filing of the formal Complaint in this matter. The correct time to apply NRS 281A.420(1)(b) is when he acted in his proper capacity as a member of the IC. It is virtually impossible to argue that Dr. Ahsan had a significant pecuniary interest when he was part of the investigation into this matter and approved the filing of the formal Complaint along with the other two (2) members of the IC, and before due process had attached.

Respondent's various insinuations about Dr. Ahsan are just that, unfounded and baseless insinuations. The insinuations are merely made because Respondent thinks that Dr. Ahsan may realize an attenuated and unmeasurable pecuniary gain because he interpreted an echocardiogram. While more than such a tenuous interest would be required to support any relief, *Natchez v. State*, 102 Nev. 247, 251, 721 P.2d 361, 363 (1986) ("Mere membership in a professional organization which has responsibility for prosecution, under peer disciplinary procedures, does not indicate a disqualifying bias or interest on the part of the judge or other adjudicator sufficient to violate due process."); *Gilman v. Nev. State Bd. of Vet. Med. Examr's*, 120 Nev. 263, 269, 89 P.3d 1000, 1004 (2004) (noting that the "presumption of honesty and integrity [that] cloaks those who serve as adjudicators may be overcome by showing a conflict of

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interest, but "no bias may be inferred if the pecuniary interest is too remote to create a possible temptation to convict"), disapproved on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014), these speculations are of no consequence because Dr. Ahsan does not have a conflict of interest and does not have a significant pecuniary interest in this matter.

Additionally, *Gibson* is not applicable because in that case the Board was comprised of members who were optometrists in private practice, who had a lot to gain, pecuniarily, if they revoked in an adjudication, the licenses of the licensees who were employed by an optometry company. Respondent's argument is severely misplaced because Dr. Ahsan is a cardiologist who specializes in cardiovascular diseases and Respondent specializes in abdominal, colorectal, and general surgery. Dr. Ahsan was one of many medical providers on a vast team who provided "treatment" to Patient A and merely interpreted an echocardiogram. Obviously, Dr. Ahsan does not work in the same medical field as Respondent and has absolutely nothing to gain, monetarily or otherwise, if the Respondent is disciplined or not. Notably, Dr. Ahsan was only one (1) of three (3) members who authorized filing of the formal Complaint in this matter against Respondent. In her motion to dismiss, Respondent seeks recusal of Dr. Ahsan. It should be noted, that Dr. Ahsan will not, and was never going to, participate in the adjudication, as he would already be recused from that task as a member of the IC who filed the formal Complaint, per Nevada Statute. *See* NRS 630.352(1).

Respondent did not cite any relevant authority in her argument that IC members can reject a settlement proposal because there is none – the IC is under no obligation, constitutionally or otherwise, to provide an offer or accept a counteroffer.

Respondent appears to completely misquote NRS 630.311(2) and also misinterprets *Hernandez v. Bennett-Haron*, which actually states, "[t]hus, under *Hannah, Jenkins,* and *Aponte,* the inquest process constitutes an investigatory, rather than an adjudicatory, proceeding. As a result, due process protections are not triggered by the inquest process." *Hernandez v. Bennett-Haron*, 128 Nev. 580, 592–93, 287 P.3d 305, 314 (2012).

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III. CONCLUSION

For the foregoing reasons, Respondent's "Motion to Dismiss for Due Process Clause Violations" must be denied.

DATED this 13th day of September, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 13th day of September, 2023, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' OPPOSITION TO RESPONDENT'S MOTION TO DISMISS** via US Certified Mail to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. & Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

Tracking No.: 9171 9690 0935 0255 6839 01

And by electronic mail to:

NANCY MOSS GHUSN, ESQ
Nmg416@gmail.com
Hearing Officer

DATED this 13th day of September, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

Exhibit E

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Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 22-11660-1** **ANNABEL ELIZABETH BARBER, M.D.'S REPLY IN SUPPORT OF MOTION TO DISMISS**

Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby files this Reply in Support of her Motion to Dismiss filed on August 31, 2023.

Dated: September 20, 2023

COLLINSON, DAEHNKE, INLOW & GRECO

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Respondent Dr. Barber filed her Motion to Dismiss after discovering that one of Patient A's treating providers, cardiologist Chowdhury H. Ahsan, M.D., is a member of the Investigative Committee that recommended the filing of the formal Complaint in this matter. Given the serious implications of this conflict in light of the fact that this Investigative Committee seeks to impose discipline on Dr. Barber, close scrutiny of this issue is appropriate and warranted prior to proceeding to the Formal Hearing in this matter. At the hearing on August 23, 2023 where Dr. Barber's preliminary Motion was discussed, the Hearing Officer agreed and granted Dr. Barber permission to file further points and authorities and set a briefing schedule to allow Dr. Barber's Motion to be heard.

Rather than focus on the substance of Respondent's Motion to Dismiss, the Investigative Committee spends the majority of their Opposition arguing about procedural issues and alleged procedural defects with Respondent's Motion. A summation of the Investigative Committee's arguments is that Respondent has no rights until a Complaint is filed, and even after a Complaint is filed, Respondent has no authority to challenge the Board's charging documents, and the hearing officer has no authority to grant Respondent's Motion to Dismiss. The Investigative Committee's arguments make clear that the Investigative Committee, and thereby the Board, are of the opinion that they can do whatever they want during the investigation phase, without any recourse, even if a flawed investigation resulted in the filing of a formal Complaint. As cited by the Investigative Committee, "[a]lthough proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." *Dutchess Bus. Servs., Inc.*, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008). Fundamental fairness dictates that Respondent Dr. Barber is entitled to an investigation that is not marred by an undisclosed conflict of interest. Respondent Dr. Barber respectfully requests that the Complaint be dismissed.

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II. ARGUMENT

A. The Hearing Officer Granted Leave for Respondent to File this Motion and Respondent's Motion is Permitted

The Investigative Committee argues that Respondent lacks authority to file her Motion to Dismiss and therefore the Motion should be denied. This is incorrect.

NRS 622A.360 sets forth the types of motions that may be made in an administrative proceeding such as this. Of note, a party may file the following prehearing motions: 1) a motion requesting, for good cause, the recusal of a member of the hearing panel or a member of the regulatory body from participation in this case; and 2) "with leave of the . . . hearing panel or officer, any other motion requesting appropriate action or relief before the date of the hearing." NRS 622A.360(b), (f). Although a prehearing motion must be filed with the regulatory body 10 days before the date of the hearing (see NRS 622A.360), NRS 622A.360(5) specifically allows additional motions to be made after the commencement of the hearing. In particular, NRS 622A.360(5)(b) states that after the commencement of the hearing a party may file a motion "with leave of the . . . hearing panel or officer, any other motion requesting appropriate action or relief during the hearing." NRS 622A.360(5)(b).

In this case, Respondent discovered the conflict of interest at issue in preparing for the hearing, the night before the formal hearing was to begin. As soon as the discovery was made, Respondent's counsel notified counsel for the Investigative Committee. Thereafter, counsel for Respondent sent an email to the Hearing Officer in the form of a "Motion to Dismiss." *See* Exhibit A, August 22, 2023 email. After review of the email, the Hearing Officer determined that further discussion was necessary, and a hearing was set to discuss the Motion to Dismiss and request for a continuance of the hearing the next morning, on August 23, 2023, the date the Hearing was scheduled to commence. *See* Exhibit A. On the morning of August 23, 2023, the Hearing Officer and the parties met by Zoom and discussed the procedural issues and how to proceed, and a recording was made of the Zoom hearing. Exhibit A, August 23, 2023 email referencing attached recording. At the August 23, 2023 hearing, the Hearing Officer ruled that this was an issue that should be briefed further by all

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parties, and that a continuance of the hearing was therefore appropriate, to accommodate a decision on Dr. Barber's Motion.

The Investigative Committee's Opposition entirely fails to reference the hearing that was held on August 23, 2023, the discussions the parties had with the Hearing Officer, or the result of that hearing, which was that the Hearing Officer expressly granted Respondent authority to file a formal Motion to Dismiss based on the alleged conflict of interest. Instead, the Investigative Committee argues that Respondent's Motion was untimely because it was submitted in an email at 10:15 p.m. the night before the hearing, rather than months prior. Although the Motion to Dismiss was not filed 10 days prior to the hearing, it was filed as soon as possible given the timing of the discovery of the conflict. Furthermore, since the Hearing in this matter was scheduled for August 23, 2023, Respondent's Motion to Dismiss is appropriate pursuant to NRS 622A.360(5)(b), as the Hearing Officer granted Respondent leave to file the Motion at the outset of the hearing in this matter. It is disingenuous for the Investigative Committee to argue that Respondent had no authority to file her Motion to Dismiss. The record must be clear that Respondent requested leave and the Hearing Officer granted leave for Respondent to file this Motion – and for the Investigative Committee to file opposition.

Furthermore, the Investigative Committee's argument that Respondent's Motion is essentially a Motion for Summary Judgment is an improper characterization of Respondent's Motion. Respondent Dr. Barber filed her Motion to Dismiss based on the conflict of interest of Dr. Ahsan, which was not disclosed by the Investigative Committee. There is nothing in Respondent's Motion which asks the Hearing Officer to address the merits of the Investigative Committee's allegations of malpractice or improper recordkeeping as alleged in the Complaint. Instead, Respondent's Motion requests "appropriate action or relief" based on the due process issues and conflict of interest, which has tainted the process in this matter and demands dismissal of the Complaint as set forth in Respondent's Motion.

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B. The Hearing Officer has Authority to Rule on Respondent's Motion and Dismiss the Complaint

Next, the Investigative Committee argues that the Hearing Officer in this matter has no authority to dismiss the Complaint. However, NRS 622A.360 specifically provides provisions for parties to "request a ruling" from the hearing officer on "any issue of law or procedure in a case," by filing motions as set forth in NRS 622A.360. Pursuant to NRS 622A.360(4), the hearing officer "shall rule" on any prehearing motions. Furthermore, NRS 622A.360(6)(a) allows a party to make a motion for dismissal after the prosecution has concluded the presentation of his or her case in chief, based on the failure of the prosecutor to meet the burden of proof. All of these provisions explicitly recognize the authority of a hearing officer to "rule on" issues of law, including the issues of law raised on Respondent's Motion, and also recognizes the Hearing Officer's authority to dismiss a charging document.

The Investigative Committee argues that NAC 630.470 states that a "hearing officer may not dismiss the complaint." However, this provision is contradictory to the provisions of NRS 622A.360, which authorizes the hearing officer to make rulings on issues of law and to make rulings on motions to dismiss. Although statutes should be given their plain meaning, a hallmark of statutory interpretation is that statutory interpretation should avoid absurd or unreasonable results. *See Sheriff v. Smith*, 91 Nev. 723, 733, 542 P.2d 440, 443 (1975); *Berkson v. LePome*, 126 Nev. 492, 497, 245 P.3d 560, 563 (2010); *State v. Tatalovich*, 309 P.3d 43, 44 (2013). Taking the Investigative Committee's argument that a hearing officer may not dismiss a Complaint to its logical conclusion would mean that the Nevada State Board of Medical Examiners has absolutely no oversight regarding its disciplinary process, and that Nevada physicians have no recourse in responding to a disciplinary Complaint absent proceeding through the hearing phase. If this were the intent of the statutes, there would be no need for provisions allowing for motions to be filed. Instead, it would simply be full steam ahead through the formal hearing.

The hearing officer is a necessary and important part of the disciplinary process, providing necessary checks and balances on all parties and helping to ensure proper

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procedures are followed, to ensure that all parties have the opportunity to be heard, and to ensure that decisions regarding the application of the law to the process are made by an impartial party. Arguing that a hearing officer may not dismiss a Complaint in response to a motion to dismiss results in a statutory interpretation that is absurd and unreasonable.

C. There is no Authority for the Board's Request to Strike the Exhibits Attached to the Motion

In footnote 1 of their Opposition, the Investigative Committee objects to all exhibits attached to Respondent's Motion and requests that they be stricken from the record because they have not been properly admitted in this case. However, the Investigative Committee offers no points and authorities to support this request. Furthermore, the Investigative Committee does not explain why the exhibits are improper, or why they should not be admitted, or how Respondent should have gone about admitting them. Instead, the Investigative Committee just asserts they should be stricken. If the exhibits are stricken, this weakens Respondent's ability for judicial review in the future, if necessary, as there will be nothing for a judicial officer to review, other than the arguments of the parties. The exhibits attached to Respondent's Motion are entirely appropriate and support the factual assertions and the arguments set forth in Respondent's Motion. Without points and authorities supporting that the exhibits should be stricken, and in light of the fact that the rules of evidence are significantly relaxed in disciplinary proceedings, this request should be denied. *See* NRS 630.346.

D. Respondent's Due Process Rights are Implicated Because a Complaint Has Been Filed

The Investigative Committee asserts that Respondent has no due process rights related to the conflict of interest with Dr. Ahsan because due process rights do not attach during the investigatory phase. The Investigative Committee relies entirely on *Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 713, 429 P.3d 650, 654 (2018), for this proposition. However, a review of the facts of *Sarfo* indicate that it is distinguishable from this case, as a disciplinary Complaint has been filed, unlike *Sarfo*. Respondent Dr. Barber is entitled to examine the

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entirety of the proceedings, given that a formal Complaint has been filed, implicating her due process rights. In this case, Dr. Barber asserts that the flawed Investigative Committee process resulted in the filing of a flawed Complaint, and dismissal is the appropriate remedy.

In *Sarfo*, Kofi Sarfo, M.D. received an inquiry letter from the Nevada State Board of Medical Examiners regarding a complaint that had been filed against him. 134 Nev. 709, 429 P.3d 650 (2018). The letter did not include the name of the complainant or specify the claims, and instead requested medical records for several of his patients to allow the Board to investigate the complaint. *Id*. Dr. Sarfo refused to comply and filed a writ petition seeking injunctive relief in the district court, arguing that the Board violated his due process rights by keeping the identity of the complainant and the allegations in the complaint confidential. *Id*.

In *Sarfo*, the Nevada Supreme Court explained:

> There are two types of complaints that come before the Board: a complaint initially generated by a member of the public and a formal complaint generated by the IC following the completion of its investigation. *See* NRS 630.311. Upon receipt of the initial complaint filed by a member of the public against a physician, the Board must designate an IC to "review each complaint and conduct an investigation to determine if there is a reasonable basis for the complaint." NRS 630.311(1). The IC has no disciplinary powers and can only file a formal complaint with the Board if it concludes that a complaint from a member of the public has a reasonable basis. NRS 630.311(2). Once a formal complaint has been filed, the adjudicative process begins, and the physician is provided with notice and an opportunity to be heard at a formal hearing. *See* NRS 630.339. Here, Dr. Sarfo is alleging a due process violation stemming from an initial complaint, not a formal complaint.

Id. The Court went on to analyze the facts and law, noting case law suggesting that due process does not attach in proceedings merely involving fact-finding or investigatory exercises, recognizing a distinction between fact-finding and adjudicatory roles. *Id*.

The proposition set forth by the Investigative Committee, that due process *never* attaches to anything that occurs during the investigatory phase, takes this general idea to an extreme result. In *Sarfo*, the Court cited to *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007), stating that this case stood for the proposition that "subpoenas issued pursuant to the department of Public Health's investigation do not implicate due process unless and until the department files a formal complaint." *Id*.

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Sarfo is distinguishable from the case at hand. In *Sarfo,* the Nevada Supreme Court addressed the issue while the matter was still in the investigatory phase. The Nevada Supreme Court did not address the distinctly different situation where an investigation has proceeded to a formal Complaint, with allegations of alleged due process violations made regarding the Board's investigation after the Complaint was filed. Although the Nevada Supreme Court noted that the Investigative Committee members ultimately do not adjudicate the matter, thereby supporting their conclusion that due process rights did not attach in Dr. Sarfo's case, the Nevada Supreme Court did not consider the separate situation where a formal Complaint has been filed and the Respondent challenges the Board's investigatory process. Respondent believes that a close analysis of the second situation would result in a different result in cases where a formal Complaint has been filed.

In this case, a formal Complaint has been filed. The Investigative Committee of the Nevada State Board of Medical Examiners is pursuing formal disciplinary action against Respondent, which implicates her due process rights. Even if the Investigative Committee does not ultimately decide whether discipline will be ordered, due process rights have attached to the Investigative Committee's investigatory process in this case because the Board has filed a formal Complaint. See *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007) (investigation does not implicate due process unless and until the department files a formal complaint). Arguing that there is no due process during the investigation phase, when a formal Complaint has been filed, results in the absurd result where a Respondent is never able to challenge anything the Investigative Committee does, no matter how inappropriate, or how it may have impacted, or tainted, the decision to file a formal Complaint. This is not the result contemplated by *Sarfo*, nor would this interpretation of the law adequately protect the due process rights of Respondent.

As noted in Respondent's Motion, the Investigative Committee considers whether to accept or reject settlement proposals. The Investigative Committee's power over proposed settlements, and whether to recommend or reject settlement proposals, certainly implicates Respondent's due process rights. If settlement proposals are rejected, a respondent is forced

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to proceed through a formal hearing, and incurs costs and attorneys' fees in the process. Furthermore, in proceeding to formal hearing, and if discipline is imposed, the Board seeks recovery of their own costs and fees, which were necessitated due to the Investigative Committee's rejection of settlement proposals. For instance, in settlements agreements filed as public record, the Investigative Committee often includes language similar to the following:

> Respondent understands and agrees that this Agreement, by and between Respondent and the IC, is not with the Board, and that the IC will present this Agreement to the Board for consideration in open session at a duly noticed and scheduled meeting. Respondent understands that the IC shall advocate for the Board's approval of this Agreement, but that the Board has the right to decide in its own discretion whether or not to approve this Agreement.

See Exhibit B, filed September 15, 2023 Settlement Agreement (redacted). By explicitly stating that the Investigative Committee will advocate for a settlement agreement, the Investigative Committee must acknowledge the impact their decisions have on the due process rights of Respondent. If the Investigative Committee does not advocate for a settlement, a Respondent's only recourse is to proceed through the formal hearing. If the Investigative Committee has a conflict of interest, it calls into question whether or not Respondent has been afforded due process in their dealings with the Investigative Committee in trying to resolve a case prior to hearing. The Investigative Committee implicitly controls the direction of the proceedings, and thereby implicates Respondent's due process rights.

E. Dr. Ahsan has a Conflict of Interest and his Participation in this Case Violated Respondent's Due Process Rights and the Complaint Should be Dismissed

The gravamen of Respondent's Motion to Dismiss is that as a treating physician of Patient A, Dr. Ahsan has a conflict of interest, as he has a pecuniary interest in Patient A's care and treatment, and he also has a "commitment in a private capacity" to Patient A as Patient A's treating physician. Dr. Ahsan's physician-patient relationship with Patient A was never disclosed. As Patient A's treating physician, Dr. Ahsan had first-hand knowledge of Patient A's care and treatment, and access to information outside the scope of the medical records. As Patient A's treating physician, Dr. Ahsan likely had conversations with Patient

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A's other treating physicians. This undisclosed conflict of interest has tainted the investigation in this matter, which resulted in the filing of a formal Complaint which was tainted as well, and therefore dismissal of the Complaint is the appropriate remedy.

Absent from the Investigative Committee's Opposition is any explanation regarding why it is appropriate for Dr. Ahsan to serve on the Investigative Committee when he is a treating provider of Patient A. Absent from the Opposition is any explanation as to whether the Investigative Committee was aware that Dr. Ahsan was a treating provider of Patient A. Absent from the Opposition is any explanation as to whether Dr. Ahsan was aware he was a treating provider of Patient A. Absent from the Opposition is any explanation as to whether Dr. Ahsan disclosed the conflict of interest to the Board. Absent from the Opposition is any explanation as to what involvement Dr. Ahsan had in the care and treatment of Patient A, including conversations he may have had with other providers. Absent from the Opposition is any explanation as to why the conflict, if known, was not disclosed to Respondent. Absent from the Opposition is any explanation as to how much Dr. Ahsan was paid for his care and treatment of patient A. Absent from the Opposition is any explanation if Dr. Ahsan has treated Patient A before or since the care and treatment at issue. Absent from the Opposition is any declaration by Dr. Ahsan that he does not have a conflict of interest. Absent from the Opposition is any declaration by Dr. Ahsan that he properly disclosed the conflict. Quite simply, the Investigative Committee has apparently determined that the issue of the alleged conflict of interest is so insignificant that they do not need to respond or provide any explanation for what occurred.

The only argument made by the Investigative Committee is that "Dr. Ahsan merely interpreted an echocardiogram and never actually saw Patient A." Opposition at 1:28-2:1. However, NRS 630.020 defines the "practice of medicine" as "to diagnose . . . any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality. . . .," including to perform these acts "by using equipment that transfers the information concerning the medical condition of the patient electronically, telephonically or by fiber optics . . ." Respondent doubts that the Investigative Committee

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would accept an explanation from a licensee that they were not practicing medicine or were not a treating provider because they "never actually saw" the patient. Dr. Ahsan is a treating physician of Patient A, whether he physically saw him or not. Furthermore, whether or not Dr. Ahsan was one of many medical providers who treated Patient A is also not relevant. He still treated Patient A. Pursuant to NRS 281.420(1), a public officer shall not act upon a matter when the public officer has a "commitment in a private capacity to the interests of another person," without disclosing that information. The Investigative Committee focuses solely on the "pecuniary interest" aspect but does not address why it was appropriate for Dr. Ahsan to participate in this matter when he has a private commitment to Patient A as his treating physician. At a minimum, this relationship should have been disclosed by Dr. Ahsan. It should have been disclosed by the Investigative Committee. It was not, and dismissal is the appropriate remedy.

Additionally, since filing the Motion to Dismiss, Respondent has also learned the Investigative Committee's expert witness in this matter, Nicholas Spoerke, M.D., is in the same practice group as Kyle Mock, M.D., the surgeon who ordered the echocardiogram, which was then interpreted by Dr. Ahsan. See Exhibit C, Investigative Committee Prehearing Disclosure, and Exhibit D, Western Surgical Group directory of physicians. This is further reason to dismiss the Complaint and require the Board to start the process over from scratch, to ensure the process and the Complaint stand the tests of due process.

The Investigative Committee argues only that there is no conflict of interest because any money Dr. Ahsan received for interpreting Patient A's echocardiogram was not a "significant pecuniary interest." However, the Investigative Committee has not provided any basis for this conclusion. There is no statement about how much Dr. Ahsan billed, or was paid, to interpret the echocardiogram. There is simply no way to determine whether the pecuniary interest was "significant" unless the Investigative Committee provides this information. The fact that they have failed to provide any information should be construed in favor of Respondent, whose due process rights are at stake.

/ / /

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VII. CONCLUSION

Dr. Barber has the right to have her case investigated and adjudicated by unbiased parties. The process in this case has been tainted, and the Complaint should be dismissed. The Board should be ordered to assemble a new Investigative Committee, should they choose, to conduct a de novo investigation in this matter to determine whether to proceed with re-filing a Complaint. Dr. Barber's Due Process rights have been violated absent any other result.

Dated: September 20, 2023

COLLINSON, DAEHNKE, INLOW & GRECO

By *_/s/ Patricia Egan Daehnke_*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
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2110 E. Flamingo Road, Suite 212
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Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on this 20th day of September, 2023, a true and correct copy of ANNABEL ELIZABETH BARBER, M.D.'S REPLY IN SUPPORT OF MOTION TO DISMISS was served by email and Federal Express to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Nancy L. Moss Ghusn, Esq. 675 W. Moana Lane, Suite 107 Reno, NV 89509 nmg416@gmail.com

By /s/ Amanda E. Rosenthal
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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Exhibit F

Amanda Rosenthal

From: NM G <nmg416@gmail.com>
Sent: Thursday, November 16, 2023 1:55 PM
To: Patricia Daehnke
Cc: Donald K. White; Meg Byrd; Amanda Rosenthal; Lacey Ambro
Subject: Re: FW: Request to Dismiss or Continue - Dr. Annabel Barber

Follow Up Flag: Follow up
Flag Status: Flagged

Good Afternoon, All-

Ms. Daehnke, I agree, although I also did not impose a deadline on either one of you. I will note that you timely submitted your draft on October 13 subsequent to my October 2 email.
My "experiment" was meant to expedite matters while I was out sick and track a practice often used in court proceedings.
Mr. White, please submit your edits by 5:00 p.m. today or I will not consider them.
Thank you.
Nancy Moss Ghusn, Esq.
Administrative Hearing Officer

On Thu, Nov 16, 2023 at 1:04 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

> Good day, Hearing Officer Ghusn,
>
> Following up again on the status of the order.
>
> The order my office submitted tracked your ruling and order closely. If Mr. White is unable to give us his suggested edits today, my client would request a deadline be set. It may speed things up by setting a deadline as we are all busy this time of year and have to prioritize even simple matters when there is a deadline.
>
> Thank you in advance.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
patricia.daehnke@cdiglaw.com | www.cdiglaw.com

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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Thursday, November 9, 2023 8:15 PM
To: NM G <nmg416@gmail.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

Good evening Ms. Ghusn,

I have made the IC's edits. It will be proofed Monday morning and sent to you.

Take care,

Don

Donald K. White, J.D.

Senior Deputy General Counsel

Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, NV 89521

775.324.9355

dwhite@medboard.nv.gov

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From: NM G <nmg416@gmail.com>
Sent: Thursday, November 9, 2023 6:50 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good Evening,

I was just checking as well.

Mr. White, forgive me if I have missed an email. If nothing has been sent, please provide a status update as soon as possible as I was hoping to have the long weekend to work on and finish this up. Ms. Daehnke, as it has been almost a month, I must apologize that I didn't set a deadline, but I didn't think it necessary.

Thank you.

--NMG

On Thu, Nov 9, 2023 at 6:30 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

> Good evening,
>
> Just checking in case I missed anything....Has Don given us back any proposed edits?
>
> Tricia Daehnke
>
> Collinson, Daehnke, Inlow & Greco
>
> Sent from my IPhone
>
> On Oct 30, 2023, at 8:41 AM, NM G <nmg416@gmail.com> wrote:
>
> Perfect, thanks so much for the update.
>
> --NMG
>
> On Mon, Oct 30, 2023 at 11:39 AM Donald K. White <dwhite@medboard.nv.gov> wrote:
>
> Good morning Ms. Ghusn,

I have Ms. Daehnke's version and I am working on our edits. I'm hoping to have it done in the next couple of days.

Thank you,

Don

Donald K. White, J.D.

Senior Deputy General Counsel

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dwhite@medboard.nv.gov

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From: NM G <nmg416@gmail.com>
Sent: Thursday, October 26, 2023 2:49 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good Afternoon,

Mr. White, any update as to the status of this Order?

Thank you for your time.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Fri, Oct 13, 2023 at 10:55 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

> Good evening all,
>
> Attached is the draft Order for review. Please confirm receipt and advise if you have any difficulty accessing.
>
> Have a great weekend.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119

Phone: (702) 979-2132 | Facsimile: (702) 979-2133
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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Friday, October 13, 2023 1:35 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; NM G <nmg416@gmail.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: RE: Request to Dismiss or Continue - Dr. Annabel Barber

Hello Ms. Daehnke,

I'm just checking on the status of the draft of the Order, as I have not received it yet. Also just making sure I didn't miss an email.

Thank you,

Don

Donald K. White, J.D.

Senior Deputy General Counsel

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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Thursday, October 5, 2023 8:37 PM
To: NM G <nmg416@gmail.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good evening,

We will provide the draft as directed in Word to Mr. White for review.

Tricia Daehnke

Collinson, Daehnke, Inlow & Greco

Sent from my IPhone

On Oct 5, 2023, at 4:54 PM, NM G <nmg416@gmail.com> wrote:

Good Afternoon All-

Don, that would be fine. Just keep it in Word please for my edits.

At the risk of stating the obvious and as a reminder, this is an order that will summarize positions rather than an opportunity to re-argue your respective positions.

Thank you for your assistance.

Kind regards,

--Nancy

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Wed, Oct 4, 2023 at 3:54 PM Donald K. White <dwhite@medboard.nv.gov> wrote:

> Hello all,
>
> The IC objects to the procedure suggested for the drafting of the "Order." Generally the Hearing Officer drafts the Decision and Recommendations with regards to motions. In the alternative, if the Hearing Officer is going to task Respondent's counsel with drafting that, counsel for the IC would like ample opportunity to review the draft prior to the Hearing Officer's review and signature.
>
> Sincerely,
>
> Don
>
> **Donald K. White, J.D.**

Senior Deputy General Counsel

Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, NV 89521

775.324.9355

dwhite@medboard.nv.gov

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From: NM G <nmg416@gmail.com>
Sent: Monday, October 2, 2023 9:58 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Donald K. White <dwhite@medboard.nv.gov>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good Morning All-

After spending time reviewing this matter and considering Respondent's Motion to Dismiss, the IC's Opposition and Respondent's Reply, and acknowledging the practical consequence of this decision, I reach the following conclusion: there is a clear conflict of interest in this matter, and the integrity of the process is called into question when one of the members of the IC was involved in Patient A's medical treatment at issue, no matter how limited or how small any pecuniary interest. The process is indeed tainted and due process is consequently compromised.

Without more, this in no way assumes any malfeasance or improper conduct on the part of the Board, the IC or Dr. Ahsan, but assumes at least a failure to conduct an adequate conflict check. In our own professional lives, there are many attorneys or parties that we may know, but it incumbent upon us to check, and, if there is a connection or relationship even unconnected to the

case at hand, recuse ourselves or disclose and give the party an opportunity to waive any possible conflict--or not. This should be no different. Dr. Barber was neither informed of Dr. Ahsan's involvement in the underlying medical case nor offered the opportunity to waive and proceed with the case. This wasn't even a case where Dr. Ahsan treated Patient A in an unrelated matter, but he was actually directly involved in the medical process leading to Dr. Barber's treatment of and surgery on Patient A which led to the investigation and the Complaint being filed. In order to uphold the constitutional requirement of due process, any matter such as this should balance protection of the public with a completely unbiased and impartial proceeding. The Undersigned does not participate in speculation but cannot imagine any scenario that any physician, on the Board or otherwise, would demand less. Even the appearance of a conflict may undermine the public's faith in its institutions that exist to protect it.

As such, I find it appropropriate to grant Respondent's Motion to Dismiss.

As I heard no objections to my earlier email of September 26 regarding the drafting of an Order in light of my current circumstances, I direct Counsel for the Respondent to please draft an Order reflecting the law and facts, using her Reply as a guide, in Word format so that I may edit.

Thank you both for your excellent work.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Tue, Sep 26, 2023 at 3:16 PM NM G <nmg416@gmail.com> wrote:

> Good Afternoon, All-
>
> Please provide any updates regarding scheduling in this matter and I am doing the same. I have looked through our communications and did not see any follow-up to our August 28 email exchange, but I will (reluctantly) share that Covid finally caught up to me, and I want to make sure that I did not miss anything the past few weeks.

With respect to the pending motion, I have finally been able to review same. However, in order to keep this matter on schedule, and unless there is some objection, I may issue a summary decision and possibly request that counsel for the prevailing party draft the order such as we all have experienced in a courtroom setting.

Thank you for your input and consideration.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Mon, Aug 28, 2023 at 10:25 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

> Good evening,
>
> Dr. Barber is available. Dr. Baskies was checking with his family. I will follow up in the morning.
>
> Thank you for checking in.
>
> Tricia Daehnke
>
> Collinson, Daehnke, Inlow & Greco
>
> Sent from my IPhone
>
> On Aug 28, 2023, at 10:20 PM, NM G <nmg416@gmail.com> wrote:
>
> Ms. Daehnke, have you been able to confirm the new hearing dates with your client and witnesses?

Thank you for any update.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Wed, Aug 23, 2023 at 11:31 AM Meg Byrd <mbyrd@medboard.nv.gov> wrote:

> Thank you Ms. Ghusn, please forward an order for the briefing schedule and I will get this on file and served.
>
> Thank you,
>
> Meg

From: NM G <nmg416@gmail.com>
Sent: Wednesday, August 23, 2023 10:37 AM
To: Donald K. White <dwhite@medboard.nv.gov>; Patricia.daehnke@CDIGlaw.com
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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https://us02web.zoom.us/rec/share/BMTnywIu40XVRMk7-6HDQBOjNnFCUGEdUBmrQWgw0wzyZtJUd6ALzSBrBXVEJSTc.HIqTvGRteP1XGMgW?startTime=1692808820000
Passcode: %x%?e00D

Good Morning again, Mr. White and Ms. Daehnke-

The following is a quick summary of the results after our meeting via *Zoom,* with the link to the recording, above:

1. Dr. Barber's hearing is postponed upon request for more thorough briefing;
2. 8/30/23--Respondent's Motion
3. 9/13/23 --IC's Opposition
4. 9/20/23--Respondent's Reply/Submission
5. 10/4/23--Hearing Officer's decision
6. Tentative dates for rescheduled hearing: 11/20-21

As agreed, I will issue an Amended Scheduling Order when hearing dates are confirmed.

Thank you both for your input and civility in this matter.

Kind regards,

--*Nancy Moss Ghusn, Esq*.

Administrative Hearing Officer

On Wed, Aug 23, 2023 at 9:39 AM NM G <nmg416@gmail.com> wrote:

> Mr. White, we can and I expect we will do both.

Please log on--audio is fine.

--NMG

On Wed, Aug 23, 2023 at 9:36 AM Donald K. White <dwhite@medboard.nv.gov> wrote:

> Dear Ms. Ghusn,
>
> You were going to afford counsel more time which I am using right now. The IC respectfully requests that this preliminary issue be argued at the Board's location with all parties present, including a court reporter (who is already here), for a clean record.
>
> Thank you,
>
> Don
>
> **Donald K. White, J.D.**
>
> Senior Deputy General Counsel
>
> Nevada State Board of Medical Examiners
>
> 9600 Gateway Drive
>
> Reno, NV 89521
>
> **775.324.9355**
>
> **dwhite@medboard.nv.gov**
>
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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Wednesday, August 23, 2023 9:31 AM
To: NM G <nmg416@gmail.com>; Donald K. White <dwhite@medboard.nv.gov>
Cc: Deonne Contine <dcontine@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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I am waiting on Zoom. I prefer we proceed with the call as scheduled by the hearing officer.

Tricia Daehnke

Collinson, Daehnke, Inlow & Greco

> On Aug 23, 2023, at 9:11 AM, Donald K. White <dwhite@medboard.nv.gov> wrote:
>
> Dear Ms. Ghusn,
>
> The IC requests that this preliminary matter be decided on the record with a court reported present. The IC suggests that we present arguments in person at the Board in the conference room where the hearing is scheduled to take place, but that we do this at 10:30 am.
>
> I am currently drafting my response to an email/motion that Ms. Daehnke sent last night at 10:16 pm. I will need some more time this morning to oppose Dr. Barber's arguments.
>
> Thank you,
>
> Don

Donald K. White, J.D.

Senior Deputy General Counsel

Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, NV 89521

775.324.9355

dwhite@medboard.nv.gov

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From: NM G <nmg416@gmail.com>
Sent: Tuesday, August 22, 2023 10:59 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Meg Byrd <mbyrd@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>
Subject: Re: Request to Dismiss or Continue - Dr. Annabel Barber

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Good Evening/Morning-

Having reviewed the emails from and motion of Ms. Daehnke tonight, and given the basis of the motion and the late hour, it is clearly necessary to at least

postpone the start of Dr. Barber's hearing tomorrow morning until this issue is resolved. We could meet at the Board offices at some point, but I would first like to give Mr. White the opportunity to respond.

I will look for Mr. White's response tomorrow morning and will send a *Zoom* link for a teleconference at the already scheduled start time of 9:30 and decide where to go from there. Mr. White, feel free to request more time.

Thank you.

Kind regards,

Nancy Moss Ghusn, Esq.

Administrative Hearing Officer

On Tue, Aug 22, 2023 at 10:15 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

> Dear Ms. Ghusn,
>
> Please let this email serve as Dr. Barber's request to dismiss the complaint or continue the hearing tomorrow to allow investigation of and evaluation regarding a conflict of interest in this matter. Dr. Chowdhury H. Ahsan treated Patient A on February 26, 2019 at University Medical Center. Dr. Barber was the admitting physician for this admission, and Dr. Barber treated Patient A during the same time frame. Dr. Ahsan has personal information about this case from treating Patient A and his involvement in his care. Dr. Ahsan was a member of the 3-person Investigative Committee that authorized the Complaint against Dr. Barber, which involves in part this admission. It is unknown whether Dr. Ahsan disclosed this conflict of interest, or whether the Board was aware of this conflict of interest.
>
> Pursuant to NRS 630.085, each member of the Board shall comply with the provisions of NRS 281A.500. NRS 281A.500 provides that public officers must file

an acknowledgment of the ethical standards which must be followed, as set forth in NRS Chapter 281A. NRS 281A.420(1) states that a public officer shall not vote or otherwise act upon a matter in which the public officer has a significant pecuniary interests or which would reasonably be affected by the public officer's commitment in a private capacity to the interests of another person. A pecuniary interest is defined as "any beneficial or detrimental interest in a matter that consists of or is measured in money or is otherwise related to money, including, without limitation...[a]nything of economic value. . ." NRS 281A.139. NRS 281A.420 serves to ensure that its public officers "avoid conflicts between [their] private interests and those of the general public whom [they] serve[ ]." *Carrigan v. Comm'n on Ethics of State*, 129 Nev. 894, 906, 313 P.3d 880, 888 (2013). The state has an important interest in avoiding conflicts of interest and self-dealing by public officials entrusted with making decisions affecting its citizens. *Id*.

A physician's license to practice medicine is a property right, and her right to earn a living is a liberty interest, and neither may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d 506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366 (9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession <u>without the burden of an unjustified label of infamy</u>." *Stretten,* 537 F.2d at 366 (emphasis added). Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971).

"The level of due process that must be provided in a particular government proceeding depends on the effect that the proceeding will have on a constitutionally protected interest. When a government agency is conducting proceedings, due process mandates that the protections afforded depend on whether the proceedings result in a binding adjudication or a determination of legal rights, in which case due process protections are greater. Determining whether particular due process protections must be provided requires consideration of the constitutional interest at stake, the type of proceeding being conducted, and the potential that such protections will be unduly burdened by the proceeding. *Hernandez v. Bennett-Haron*, 128 Nev. 580, 587, 287 P.3d 305, 310–11 (2012), citing *Hannah v. Larche*, 363 U.S. 420, 442, 80 S.Ct. 1502, 4 L.Ed.2d 1307 (1960).

"[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "[W]here one member of a tribunal is actually biased, or where circumstances create the appearance that one member is biased, the proceedings violate due process. The plaintiff need not demonstrate that the biased member's vote was decisive or that his views influenced those of other members. Whether actual or apparent, bias on the part of a single member of a tribunal taints the proceedings and violates due process." *Stivers*, 71 F.3d at 748 (emphasis added).

In this case, Dr. Ahsan was a treating provider of Patient A and has a pecuniary interest related to the treatment of Patient A. Furthermore, as a treating physician, his commitments as a treating physician of Patient A seriously call into question whether his participation in this matter was unbiased and whether his participation was a violation of the ethical rules and Dr. Barber's Due Process rights. Dr. Ahsan participated in the decision to authorize the filing of the Complaint. Dr. Ahsan has also presumably been involved with prior settlement proposals and discussions. However, there was no disclosure of his personal involvement with Patient A's care and treatment. Dr. Barber respectfully requests this matter be dismissed due to the existence of a conflict which may well void the whole process.

Given the timing of this discovery, it seems appropriate at a minimum to allow a continuance for further evaluation. This issue goes well beyond the appearance of impropriety. I apologize for the late request, but this was just discovered this evening.

Thank you in advance.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
patricia.daehnke@cdiglaw.com | www.cdiglaw.com

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Nancy Moss Ghusn

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Nancy Moss Ghusn

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Nancy Moss Ghusn

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Nancy Moss Ghusn

Exhibit G

Amanda Rosenthal

From: Mercedes Fuentes <fuentesm@medboard.nv.gov>
Sent: Thursday, November 16, 2023 4:28 PM
To: NM G; Patricia Daehnke; Amanda Rosenthal; Lacey Ambro
Cc: Donald K. White; Meg Byrd; Deonne Contine
Subject: Order for Dismissal without Prejudice - Anabel Barber, M.D., Case No. 22-11660-1
Attachments: Order for Dismissal Without Prejudice.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Good Afternoon All,

Please see the attached file-stamped copy of the **Order for Dismissal Without Prejudice**, filed November 16, 2023. Please let me know if you have any trouble opening attached.

Respectfully,

Mercedes Fuentes
Legal Assistant to:
Sarah A. Bradley, J.D., MBA, Deputy Executive Director
William P. Shogren, Deputy General Counsel
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive, Reno, NV 89521
Tel: (775) 324-9380
Fax: (775) 688-2321
fuentesm@medboard.nv.gov

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.,** **Respondent.**	**Case No. 22-11660-1** FILED NOV 16 2023 NEVADA STATE BOARD OF MEDICAL EXAMINERS By:

ORDER FOR DISMISSAL WITHOUT PREJUDICE

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners filed a formal Complaint against Annabel Elizabeth Barber, M.D., (Respondent), on September 20, 2022, alleging two (2) violations of the Nevada Medical Practice Acts, including: one (1) count of NRS 630.301(4) Malpractice (Count I) and one (1) count of NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records (Count II). After consideration of all the circumstances and facts surrounding this case, the IC has determined that it is just and proper to dismiss, without prejudice, the aforementioned formal Complaint.

IT IS HEREBY ORDERED that the formal Complaint filed in Case No. 22-11660-1 against Respondent, Annabel Elizabeth Barber, M.D., is hereby dismissed without prejudice.

DATED this 16th day of November, 2023.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

BRET W. FREY, M.D.
Chairman of the Investigative Committee

Exhibit H

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 17 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018, when he presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Respondent ordered a CT scan "to define anatomy better."

///

///

[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., 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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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Nevada State Board of Medical Examiners
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Reno, Nevada 89521
(775) 688-2559

4. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he had acquired short bowel syndrome.

5. Upon healing from those surgeries, Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

6. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laparoscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

7. Upon information and belief, during the surgery on February 22, 2019, Respondent made an attempt to gain laparoscopic access to the peritoneum via the right lower quadrant. When Respondent was unable to gain peritoneal access, it appears from her operative note that she tried to gain access via the left lower quadrant but was also unsuccessful. It appears, upon information and belief, that Respondent then attempted to access the peritoneum via a midline incision and immediately noticed that she had injured Patient A's bowel.

8. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision.

9. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures.

10. Respondent then closed the incision and discharged Patient A without having repaired Patient A's left inguinal hernia.

11. There was no documentation of the injury in the operative note which was unintelligibly written.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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Nevada State Board of Medical Examiners
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Reno, Nevada 89521
(775) 688-2559

14. 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."

15. 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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

16. 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

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

18. 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.

19. Respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

20. 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 her and give her notice that she 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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@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

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 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AURY NAGY, M.D.
Chairman of the Investigative Committee

Exhibit I

Amanda Rosenthal

From: NM G <nmg416@gmail.com>
Sent: Friday, December 1, 2023 2:49 PM
To: Deonne Contine
Cc: Patricia Daehnke; Sarah A. Bradley; Donald K. White; Amanda Rosenthal; Lacey Ambro; Meg Byrd
Subject: Re: Dr. Annabel Barber Motion to Dismiss - Order

Good Afternoon, All-

I appreciate and understand Ms. Daehnke's concerns and requests. Although we may not all agree on the process taken, and I may be more cautious allowing extensions of time in the future, that case is closed and I no longer have any jurisdiction or authority over the matter. Practically speaking, the dismissal sought by the Respondent was achieved although by other means.

I am also in no position to even comment on any other matters, such as service of process of a subsequent related case.

I would like to thank counsel and staff for their courteous and professional conduct during the preceding case, and wish everyone a healthy and peaceful holiday season.

Kind regards,

Nancy Moss Ghusn, Esq.
Administrative Hearing Officer

On Wed, Nov 29, 2023 at 11:42 AM Deonne Contine <dcontine@medboard.nv.gov> wrote:

> Hello all:
>
> The IC has voluntarily dismissed the case and the docket is closed. Nothing further can be filed in the matter.
>
> Deonne
>
> **From:** Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
> **Sent:** Tuesday, November 28, 2023 9:50 PM
> **To:** NM G <nmg416@gmail.com>
> **Cc:** Donald K. White <dwhite@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Deonne Contine

<dcontine@medboard.nv.gov>
Subject: RE: Dr. Annabel Barber Motion to Dismiss - Order

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Hearing Officer Ghusn,

Thank you for letting us know.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
patricia.daehnke@cdiglaw.com | www.cdiglaw.com

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From: NM G <nmg416@gmail.com>
Sent: Tuesday, November 28, 2023 9:02 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Donald K. White <dwhite@medboard.nv.gov>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Deonne Contine

<dcontine@medboard.nv.gov>
Subject: Re: Dr. Annabel Barber Motion to Dismiss - Order

Ms. Daehnke-

I have received and was waiting to see if there was any response to your email. However, I am considering this matter.

--NMGhusn, Esq.

Administrative Hearing Officer

On Mon, Nov 27, 2023 at 2:05 PM Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

> Dear Hearing Officer Ghusn,
>
> On behalf of Respondent Dr. Barber, we respectfully request that an Order be entered on Dr. Barber's Motion to Dismiss in this matter. As you know, Respondent provided the draft Order consistent with your ruling on October 13, 2023. Thereafter, Mr. White requested time to provide the IC's proposed edits to the Order. On October 30, 2023, Mr. White advised he was working on edits, and was hoping to have it done in the next couple of days. On November 9, 2023, Mr. White advised he had made the edits, and they would be "proofed Monday morning and sent [November 13]." As you know, no edits were ever provided.
>
> On November 16, 2023, we received an "Order for Dismissal Without Prejudice" stating that "after consideration of all the circumstances and facts surrounding this case, the IC has determined that it is just and proper to dismiss, without prejudice, the aforementioned formal Complaint." Apparently, on November 17, 2023, one day after the "dismissal" of the prior Complaint, the IC filed a new Complaint against Dr. Barber regarding the same allegations. Dr. Barber was served with the Complaint on Thanksgiving evening at home on November 22, 2023. My office was not served with the complaint nor with even a courtesy copy.
>
> Counsel for the IC had the draft Order for over a month. Counsel for the IC repeatedly represented that he would provide draft edits to the Order. Counsel for the IC never indicated that he did not intend to provide edits to the Order, but instead intended simply to dismiss the Complaint once the "new"

Complaint was ready to be filed. In delaying, and in promising to provide edits which were never provided, the IC has deprived Respondent the right to have a record on the issue before the Hearing Officer, which involves her due process concerns. Respondent has been deprived of having an Order on issues decided in her favor, to be used as necessary to defend against continued due process concerns involving this new Complaint in judicial proceedings in the future.

Respondent is greatly concerned by the process taken by the IC regarding the Order on Respondent's Motion. Respondent respectfully requests that you enter an Order on her Motion to Dismiss, so that the record is clear, and Respondent's due process rights are protected.

Thank you for your time and consideration.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
patricia.daehnke@cdiglaw.com | www.cdiglaw.com

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--

Nancy Moss Ghusn

--
Nancy Moss Ghusn

Exhibit J

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED

FEB 29 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of Charges and Complaint Against ANNABEL ELIZABETH BARBER, M.D., Respondent.	**CASE NO.: 23-11660-1**

NOTICE AND ORDER RESCHEDULING PRE-HEARING AND HEARING

TO: DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 GATEWAY DRIVE
RENO, NV 89521

ANNABEL ELIZABETH BARBER, M.D., c/o PATRICIA EGAN DAEHNKE, ESQ., COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. FLAMINGO ROAD, SUITE 212
LAS VEGAS, NV 89119

On Tuesday, February 27, 2024, a telephonic conference was conducted in this matter. Donald White was present on behalf of the Investigative Committee in the conference room of the Nevada State Board of Medical Examiners, and Patricia Daehnke and Amanda Rosenthal appeared telephonically on behalf of Annabel Elizabeth Barber, M. D. The undersigned Hearing Officer appeared telephonically as well. The parties agreed to new dates for the pre-hearing conference, exchange of documents, and the hearing date.

Accordingly, in compliance with NAC 630.465, **a pre-hearing conference will be conducted on Thursday, May 2, 2024 commencing at 2:00 P.M.,** in the conference room at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. The conference to be attended by the parties in person or by counsel,[1] will be conducted before the undersigned hearing officer to assure that all written information and documentation to be presented by the parties at the formal hearing is fully and completely exchanged.

[1]Respondent or Respondent's counsel may participate in the pre-hearing conference by telephone if prior arrangements are made with counsel for Investigative Committee.

At the pre-hearing conference each party is to provide the other party with a copy of the list of witnesses they intend to call to testify, including their qualifications, as well as a brief summary of their 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. **All motions are to be filed no later than Friday, May 24, 2024 by 5:00 P.M. Responses to motions are to be filed by Friday May 31, 2024 by 5:00 P.M.**

The formal hearing in this matter is hereby scheduled for Tuesday, June 4, 2024, commencing at 9:00 A.M. and continuing on Wednesday, June 5, 2024, commencing at 9:00 A.M., at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. Respondent must be present at the hearing in person. Following the hearing, the hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. **NAC 630.470.**

Any other hearings previously set in this matter which conflict with the hearing schedule set out herein are vacated.

It is further ordered that legal counsel for the Investigative Committee and Respondent or Respondent's counsel shall keep this hearing officer advised of each issue which has been resolved by negotiation or stipulation, or any other change in the status of this case.

DATED this 28 day of February, 2024

CHARLES B. WOODMAN, ESQ., Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

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 document addressed as follows:

DONALD K. WHITE, SENIOR DEPUTY GENERAL COUNSEL
NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 GATEWAY DRIVE
RENO, NV 89521

ANNABEL ELIZABETH BARBE, M.D.
c/o PATRICIA EGAN DAEHNKE, ESQ.
COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. FLAMINGO ROAD, SUITE 212
LAS VEGAS, NV 89119

DATED this 21st day of February, 2024.

MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners

Exhibit K

Amanda Rosenthal

From: Patricia Daehnke
Sent: Tuesday, May 28, 2024 1:49 PM
To: Amanda Rosenthal; Lacey Ambro
Subject: Fwd: Dr. Barber - Case No. 23-11660-1 - Motion to Continue
Attachments: Motion to Continue Hearing.pdf

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

Begin forwarded message:

From: "Donald K. White" <dwhite@medboard.nv.gov>
Date: May 28, 2024 at 1:37:56 PM PDT
To: Charles Woodman <hardywoodmanlaw@msn.com>, Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: FW: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good afternoon everyone,

Please allow me to withdraw the Motion to Continue (which was emailed and not filed on Friday, May 24, 2024).

I just spoke with Dr. Spoerke and he is available on June 4, 2024.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Donald K. White
Sent: Friday, May 24, 2024 6:31 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>

Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Hello Mr. Woodman and Ms. Daehnke,

Attached is a Motion to Continue the hearing currently set for June 4-5, 2024. As you will read, I have had much difficulty contacting the IC's expert, Dr. Nicholas Spoerke, and therefor I'm unable to confirm his availability for the hearing.

I would have informed you of this earlier, but I was holding out hope that I would have spoken with him by now. This is also the same reason I did not reach out to you, Ms. Daehnke, for a possible stipulation to continue.

Board staff who have the ability to file documents have gone home for the weekend, so this will be filed on Tuesday, May 28, 2024.

Hope everyone has a safe and relaxing Memorial Day weekend.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

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

MOTION TO CONTINUE HEARING

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through counsel, Donald K. White, Senior Deputy General Counsel for the Board, and attorney for the IC, respectfully moves for a continuance of the hearing currently set to commence June 4, 2024. In support of this motion the IC states:

1. The formal Complaint in this matter was filed on November 17, 2023.
2. Respondent's Answer to the Complaint was filed on December 12, 2023.
3. An Early Case Conference was held on February 27, 2023.
4. On April 30, 2024, counsel for the IC attempted to contact the IC's expert, Dr. Nicholas Spoerke, but was unable to make contact with him.
5. On May 2, 2024, the Prehearing Conference was held telephonically (the IC timely submitted its exhibits and Prehearing Conference Statement pursuant to NAC 630.465), wherein counsel for the IC briefly mentioned that he was having difficulty contacting Dr. Spoerke and would inform the Respondent and Mr. Charles Woodman, Hearing Officer, if Dr. Spoerke's availability could present a problem pursuant to the hearing dates.
6. On May 14, 2024, counsel for the IC called again and was able to speak briefly with Dr. Spoerke regarding his availability for the hearing set for June 4-5, 2024.

Dr. Spoerke did not have his schedule available, so he was not able to confirm his availability.

7. On May 16, 2024, counsel for the IC emailed Dr. Spoerke inquiring once again about his availability for the hearing. As of the writing of this motion, counsel for the IC has received no response from his email to Dr. Spoerke.

8. On May 21, 2024, counsel for the IC again called Dr. Spoerke and received no response.

9. On May 23, 2024, Monica Gustafson, Senior Investigator for the Board, attempted to contact Dr. Spoerke. Upon information and belief, and as of the writing of this motion, Ms. Gustafson has not received a response from Dr. Spoerke.

10. As of the writing of this motion, and since counsel for the IC has not had any correspondence with Dr. Spoerke since May 14, 2024, and therefore does not know Dr. Spoerke's availability, counsel does not have at this time a proposed new date to hold the hearing on this matter.

11. This motion is made for good cause and not for purpose of delay, harassment or any other improper or illegal purpose, but has been necessitated by counsel's inability to contact Dr. Spoerke to confirm his availability to testify at the hearing currently set for June 4-5, 2024.

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

Based on the foregoing, the Investigative Committee submits that good cause exists to grant this motion and to continue the hearing currently set for June 4-5, 2024, to two consecutive dates convenient for all parties, their witnesses, and Mr. Woodman.

DATED this _____ day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@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 L

Amanda Rosenthal

From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 10:05 AM
To: Patricia Daehnke
Cc: Amanda Rosenthal; Lacey Ambro; Meg Byrd
Subject: RE: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Follow Up Flag: Follow up
Flag Status: Flagged

Good morning Tricia,

We have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Sunday, June 2, 2024 4:45 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Hi Don,

You could send over a paper copy to me at my hotel or we can send a secure link in the morning so the file can be downloaded whichever you prefer.

Tricia Daehnke

Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On Jun 2, 2024, at 4:36 PM, Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

Good afternoon Don,

I am getting ready for the hearing and don't see that you have produced either investigative file in this matter. I checked and the board did not provide the investigative file from the case that was dismissed nor the current case. Please provide a copy of the investigative file.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On May 31, 2024, at 10:47 AM, Donald K. White <dwhite@medboard.nv.gov> wrote:

Good morning Mr. Woodman,

Thank you for checking on this. I'm forwarding the email below again. I withdrew my motion since I was able to correspond with Dr. Spoerke, and he confirmed that he is available for the hearing.

Sincerely,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Donald K. White
Sent: Tuesday, May 28, 2024 1:38 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: FW: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good afternoon everyone,

Please allow me to withdraw the Motion to Continue (which was emailed and not filed on Friday, May 24, 2024).

I just spoke with Dr. Spoerke and he is available on June 4, 2024.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Donald K. White
Sent: Friday, May 24, 2024 6:31 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Hello Mr. Woodman and Ms. Daehnke,

Attached is a Motion to Continue the hearing currently set for June 4-5, 2024. As you will read, I have had much difficulty contacting the IC's expert, Dr. Nicholas Spoerke, and therefor I'm unable to confirm his availability for the hearing.

I would have informed you of this earlier, but I was holding out hope that I would have spoken with him by now. This is also the same reason I did not reach out to you, Ms. Daehnke, for a possible stipulation to continue.

Board staff who have the ability to file documents have gone home for the weekend, so this will be filed on Tuesday, May 28, 2024.

Hope everyone has a safe and relaxing Memorial Day weekend.

Thank you,
Don

Donald K. White, J.D.
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Nevada State Board of Medical Examiners
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Exhibit M

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

FILED

JUN - 3 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1** **ANNABEL ELIZABETH BARBER, M.D.'S REQUEST FOR PRODUCTION OF PUBLIC RECORDS AND/OR PRODUCTION OF THE INVESTIGATIVE FILE**

Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby submits this Request for copies of all documents and evidence relied upon by the Investigative Committee of the Nevada State Board of Medical Examiners in filing the November 16, 2023 Complaint in this matter, including expert reports and opinions of Nicholas Spoerke, M.D., pursuant to NRS 239.010(1), NRS 622A.330, and NRS 630.336(5). To the extent this Request is deemed a Motion, it is filed pursuant to NRS 622A.360(2)(f) and leave is requested of the Hearing Officer to file this Motion. This Request is also based on the attached Memorandum of Points and Authorities and any argument that the Hearing Officer or panel will allow upon a hearing in this matter.

Dated: June 3, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
Nevada Bar No. 10748
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The instant Complaint against Respondent Annabel Barber, M.D. was filed on November 16, 2023 by the Investigative Committee of the Nevada State Board of Medical Examiners. However, the Nevada State Board of Medical Examiner's investigation of this matter began a long time prior, on October 28, 2019. Once a formal Complaint was filed in this matter, the Investigative file became subject to production to Respondent pursuant to principles of statutory construction and basic guarantees of fairness and due process. Respondent Dr. Barber is entitled to review all of the evidence and information the Investigative Committee has considered in this matter, in order to properly defend against those issues which form the basis of the Formal Complaint in this matter. Furthermore, it is anticipated that the Investigative Committee will list their Investigator as a witness in this matter, and will have the Investigator testify as to portions of the Investigative file in this matter. Therefore, by designating the Investigator as a witness to testify regarding the Investigative file, Respondent is entitled to review of the Investigative file. Furthermore, the Investigative Committee will call expert witness Nicholas Spoerke, M.D. to testify in this matter. Similarly, Respondent is entitled to review of his expert report and opinions, and that matters considered by him. Production of the Investigative file in this matter is necessary in order to allow Respondent to fairly prepare for the June 4-5, 2024 Hearing in this matter and to anticipate the testimony that may be offered by the Investigator and Dr. Spoerke. Respondent Dr. Barber respectfully requests an Order requiring the Investigative Committee to produce their complete Investigative file in this matter, including the report of Dr. Spoerke and/or his opinions.

II. PROCEDURAL HISTORY

The factual basis of the formal Complaint in this matter relates to Respondent Dr. Barber's preoperative decision making and her performance of an attempted laparoscopic left inguinal hernia repair on February 22, 2019. On October 28, 2019, the Nevada State Board of Medical Examiners sent correspondence to Dr. Barber initiating their investigation in this

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TEL. (702) 979-2132 | FAX (702) 979-2133

matter. Exhibit A. On November 17, 2023, the Investigative Committee filed their Complaint in this matter.[1] Exhibit B. In their Prehearing Conference Statement, the Investigative Committee listed Investigator Monica Gustafson as a witness to testifying regarding the "documentary evidence obtained during the investigation of this case" and to testify "regarding the investigation of this matter." Exhibit C. The Investigative Committee also listed expert Nicholas Spoerke, M.D. to testify regarding his "medical review of this matter and the applicable standard of care." *Id.*

On June 2, 2024, Respondent's counsel emailed Don White, counsel for the Investigative Committee to request the investigative file in this matter. Exhibit D. On June 3, 2024, Don White advised counsel that "we have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file." *Id.* Given the June 4-5, 2024 Hearing in this matter, Respondent wishes to bring this matter to the Hearing Officer's attention and request a ruling on this issue of law and these evidentiary issues prior to the commencement of the Hearing on this matter. Should the Hearing Officer want further/more extensive briefing, Respondent will provide such.

III. AUTHORITY FOR THIS REQUEST / MOTION

Pursuant to NRS 622A.320, "**[a]t any time** after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses." Pursuant to NRS 622A.320, on June 2, 2024, Respondent made a written request to counsel for the Investigative Committee for a copy of the investigative file in this matter. Counsel for the

---

[1] This is the second Complaint the Investigative Committee has filed against Respondent regarding her care and treatment of Patient A. The first Complaint, case 22-11660-1, was dismissed by Hearing Officer Nancy Moss Ghusn when she granted Respondent's Motion to Dismiss after it was discovered that Investigative Committee Choudhury Ahsan, M.D. had treated Patient A, and also served on the Investigative Committee that recommended filing a Complaint. However, the Investigative Committee requested the ability to comment on the proposed Order, but never provided comment, and then dismissed the Complaint on November 16, 2023 without an Order being entered on Respondent's Motion to Dismiss. This Complaint was filed on November 17, 2023.

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

Investigative Committee indicated the investigative file would not be produced.

To the extent the Hearing Officer believes this request should be filed a as a Motion, pursuant to NRS 622A.360(f), a party may file, with leave of the hearing panel officer, "any other motion requesting appropriate action or relief." Pursuant to NRS 622A.360(4), the regulatory body or hearing panel or officer shall rule on any prehearing motion before or on the date of the hearing. However, NRS 622A.360 specifically provides provisions for parties to "request a ruling" from the hearing officer on "any issue of law or procedure in a case," by filing motions as set forth in NRS 622A.360. To the extent the Hearing Officer determines that Respondent's request is more properly styled as a Motion, Respondent respectfully requests leave to file this Motion as Respondent believes this is a matter of great importance and substantially impacts her due process rights and ability to prepare to defend against the evidence and testimony that may be presented at the Hearing in this matter on June 4-5, 2024.

IV. ARGUMENT

The Nevada State Board of Medical Examiners has filed a disciplinary Complaint against Respondent Dr. Barber in this matter, seeking to impose discipline on Dr. Barber's license to practice medicine in Nevada. The United States Constitution guarantees that "[n]o person shall be...deprived of life, liberty, or process without due process of law." U.S. Const. amend. V. This protection is incorporated at the state level through the Fourteenth Amendment (U.S. Const. amend. XIV) and the Constitution of the State of Nevada (Nev. Const. art. I, § 8).

A physician's license to practice medicine is a property right, and this right to earn a living is a liberty interest, and neither a property right nor liberty interest may be impaired without due process of law. *Tate v. State, Bd. of Med. Exam'rs*, 131 Nev. 675, 681, 356 P.3d 506, 511 (2015); *Minton v. Bd. of Med. Examiners*, 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994), disapproved of on other grounds by *Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014); *Stretten v. Wadsworth Veterans Hosp.*, 537 F.2d 361, 366 (9th Cir. 1976). "The 'liberty interest' is the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy."

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Stretten, 537 F.2d at 366. Due process protections apply to a liberty interest as much as to a property interest: "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential." *Wisconsin v. Constantineau*, 400 U.S. 433, 437, 91 S. Ct. 507, 510, 27 L. Ed. 2d 515 (1971); *see also Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 573, 92 S. Ct. 2701, 2707, 33 L. Ed. 2d 548 (1972) (internal quotation omitted).

"[T]he Due Process Clause prevents the state from depriving a plaintiff of a protected property interest without 'a fair trial in a fair tribunal.'" *Stivers v. Pierce*, 71 F.3d 732, 741 (9th Cir. 1995), *citing In re Murchison*, 349 U.S. 133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 942 (1955). "Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." *Dutchess Bus. Servs. v. Nev. State Bd. Of Pharm.*, 124 Nev. 701, 711 (2008) (citing *Givins Constr. v. State Contractors' Bd.*, 107 Nev. 281, 283, 809 P.2d 1268, 1270 (1991); *McClelland v. Andrus*, 606 F.2d 1278, 1285 (D.C. Cir. 1979), *Silverman v. Commodity Futures Trading Com'n*, 549 F.2d 28, 33 (7th Cir. 1977)). Administrative parties must give notice to the defending party of "the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it. *Dutchess Bus. Servs. V. Nev. State Bd. Of Pharm.*, 124 Nev. 701, 711 (2008) (citing *Bowman Tanspo. v. Ark.-Best Freight System*, 419 U.S. 281, 288 n. 4 (1974); *Nevada St. Apprenticeship v. Joint Appreh.*, 94 Nev. 763, 765, 587 P.2d 1315, 1317 (1978).

The Nevada Supreme Court has held the Investigative Committee process constitutes the investigatory stage of the administrative process through the issuance of the formal Complaint. *Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 713, 429 P.3d 650, 654 (2018). In *Sarfo*, Kofi Sarfo, M.D. received an inquiry letter from the Nevada State Board of Medical Examiners regarding a complaint that had been filed against him. 134 Nev. 709, 429 P.3d 650 (2018). The letter did not include the name of the complainant or specify the claims, and instead requested medical records for several of his patients to allow the Board to investigate the complaint. *Id.* Dr. Sarfo refused to comply and filed a writ petition seeking injunctive

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relief in the district court, arguing that the Board violated his due process rights by keeping the identity of the complainant and the allegations in the complaint confidential. *Id.*

In *Sarfo*, the Nevada Supreme Court explained:

> There are two types of complaints that come before the Board: a complaint initially generated by a member of the public and a formal complaint generated by the IC following the completion of its investigation. *See* NRS 630.311. Upon receipt of the initial complaint filed by a member of the public against a physician, the Board must designate an IC to "review each complaint and conduct an investigation to determine if there is a reasonable basis for the complaint." NRS 630.311(1). The IC has no disciplinary powers and can only file a formal complaint with the Board if it concludes that a complaint from a member of the public has a reasonable basis. NRS 630.311(2). **Once a formal complaint has been filed, the adjudicative process begins, and the physician is provided with notice and an opportunity to be heard at a formal hearing. *See* NRS 630.339.** Here, Dr. Sarfo is alleging a due process violation stemming from an initial complaint, not a formal complaint.

Id. (Emphasis added). The Court went on to analyze the facts and law, noting case law suggesting that due process does not attach in proceedings merely involving fact-finding or investigatory exercises, recognizing a distinction between fact-finding and adjudicatory roles. *Id.* In *Sarfo*, the Court cited to *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007), stating that this case stood for the proposition that "subpoenas issued pursuant to the department of Public Health's investigation do not implicate due process unless and until the department files a formal complaint." *Id.* (Emphasis added).

Sarfo is distinguishable from the case at hand. In *Sarfo,* the Nevada Supreme Court addressed the issue while the matter was still in the investigatory phase. The Nevada Supreme Court did not address the distinctly different situation where an investigation has proceeded to a formal Complaint. Although the Nevada Supreme Court noted that the Investigative Committee members ultimately do not adjudicate the matter, thereby supporting their conclusion that due process rights did not attach in Dr. Sarfo's case, the Nevada Supreme Court did not consider the separate situation where a formal Complaint has been filed and the Respondent seeks discovery or information to protect her due process rights in relation to the formal hearing. Respondent believes that a close analysis of the second

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situation would result in a different result in cases where a formal Complaint has been filed.

In this case, a formal Complaint has been filed. The Investigative Committee of the Nevada State Board of Medical Examiners is pursuing formal disciplinary action against Respondent, which implicates her due process rights. Even if the Investigative Committee does not ultimately decide whether discipline will be ordered, due process rights have attached to the Investigative Committee's investigatory process in this case because the Board has filed a formal Complaint. See *In re petition of Att'y Gen. for Investigative Subpoenas*, 736 N.W.2d 594, 602 (Mich. Ct. App. 2007) (investigation does not implicate due process unless and until the department files a formal complaint). Therefore, Respondent is entitled to discovery of the investigative file to allow her to meaningfully prepare for the Hearing and to protect her due process rights.

NRS 622A.330 provides, in relevant part:

> 1. At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses.
> 2. The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case. The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee.

Furthermore, NRS 630.336(4)-(5) provides:

> 4. . . . a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential.
>
> 5. The formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records.

Finally, NAC 630.465(3) provides that "[a]ll 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."

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The Investigative file in this matter is a government record. Pursuant to NRS 239.0107(1)a), a government entity must provide access of copies of records. Any denial of the request based on confidentiality must be in writing and must include a citation to the specific statute of legal authority that makes the requested records confidential. NRS 239.0107(1)(d).

Although statutes should be given their plain meaning, a hallmark of statutory interpretation is that statutory interpretation should avoid absurd or unreasonable results. *See Sheriff v. Smith*, 91 Nev. 723, 733, 542 P.2d 440, 443 (1975); *Berkson v. LePome*, 126 Nev. 492, 497, 245 P.3d 560, 563 (2010); *State v. Tatalovich*, 309 P.3d 43, 44 (2013). Pursuant to NRS 630.336(5), the formal Complaint or other document filed by the NBME to initiate disciplinary action and all documents and information considered by the Board when determining to impose discipline are public records." A formal Complaint has been filed in this matter. Now that a Complaint has been filed, the Investigative file is open to Respondent, and should be produced. Furthermore, the Investigative file and the opinions of Dr. Spoerke are evidence that the Investigative Committee intends to admit at the Hearing in this matter. Therefore, the plain language of NAC 630.465(3) requires that the Investigative Committee provide the evidence which will be admitted – including the Investigative file and the opinions of Dr. Spoerke. Arguing that Respondent is not entitled to the Investigative file or the opinions of Dr. Spoerke when her license in livelihood is on the line results in an absurd and unreasonable result.

Pursuant to NRS 622A.330(1), the Investigative Committee has an independent duty to provide Respondent with a copy of the Investigative file, including Dr. Spoerke's reports and opinions, in order to allow her to meaningfully prepare for the Hearing. Pursuant to NRS 622A.330, Respondent Dr. Barber has a right to the production of documents or other evidence intended to be presented by the prosecutor in support of the IC's case. Although NRS 630.336(4) provides that documents compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential, NRS 630.336(5) provides that all documents considered by the Board when determining whether to impose discipline

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are public records. Therefore, although the Investigative file may remain confidential if a formal Complaint is never filed, by implication, once the decision to move forward with formal discipline is made and a formal Complaint is filed, the Investigative file loses the protection of confidentiality. Furthermore, pursuant to NAC 630.456(3), the Investigative Committee must provide the evidence that will be admitted at the Hearing.

In this case, the Investigative Committee has disclosed investigator Monica Gustafson to verify evidence obtained during the investigation of the case and to testify regarding the investigation of this matter, including correspondence received from Dr. Davis and Dr. Javed during the course of the investigation. Given that the Investigator will be testifying regarding the investigation and will be verifying evidence obtained during the investigation, Respondent Dr. Barber is entitled to production of the Investigative file before the Hearing, to allow her to prepare for this testimony. Furthermore, by disclosing a part of the Investigative file (the letters of Dr. Javed and Dr. Davis), the Board has waived any right to claim the investigative file is confidential. The Investigative Committee cannot pick and choose which portions of the investigative file Respondent is entitled to. Furthermore, the Investigative Committee has disclosed expert witness Nicholas Spoerke, M.D. However, the Investigative Committee has not provided his expert report or any information regarding the substance of his opinions, which would allow Respondent to meaningfully prepare to cross-examine Dr. Spoerke. Failure to provide Respondent with the investigative file and expert reports/opinions is a violation of Respondent's due process rights, and ensures that Respondent will not receive a fair hearing in this matter. Dr. Spoerke will undoubtedly rely on materials from the investigative file to support his opinions as set forth in NRS 622A.330. Therefore, the investigative file is discoverable and must be produced.

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V. CONCLUSION

Based on the foregoing, Respondent Dr. Barber requests that the Investigative Committee provide a copy of the Investigative file, including Dr. Spoerke's expert report and opinions, prior to the commencement of the June 4-5, 2024 Hearing in this matter.

Dated: June 3, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
Nevada Bar No. 10748
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of June, 2024, a true and correct copy of ANNABEL ELIZABETH BARBER, M.D.'S REQUEST FOR PRODUCTION OF PUBLIC RECORDS AND/OR PRODUCTION OF THE INVESTIGATIVE FILE was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Charles B. Woodman, Esq. Woodman Law Group 548 W. Plumb Lane, Suite B Reno, NV 89509 hardywoodmanlaw@msn.com tiffany@woodmanlawgroup.com

By /s/ Lacey Ambro
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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Exhibit A

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

October 28, 2019

Annabel Barber, M.D.
1701 W. Charleston Blvd., Suite 490
Las Vegas, NV 89102

RE: BME CASE #: 19-19059
PATIENT: [redacted]

Dear Dr. Barber:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges you provided substandard medical care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. The patient presented to you on or around February 22, 2019, for a hernia repair surgery.
2. The patient had undergone six previous surgeries, including the removal of two thirds of his small intestine, prior to presenting to you for surgery.
3. You disregarded the patient's requests that you enter through the groin for his hernia surgery and not touch his adhesions.
4. You entered through the patient's abdomen. By entering through the abdomen you perforated the remaining one third of the patient's small intestine, causing the small intestine's contents to spill into the patient's stomach cavity.
5. The contents of the intestines resulted in the patient suffering with near death sepsis, two blood transfusions, five additional surgical procedures, three fistulas, open wounds, total parenteral nutrition, migraine headaches and excruciating pain.

It is further alleged:

1. The patient is irreparably disabled and unable to work.
2. Due to the perforation you inflicted, you had to remove more of the patient's small intestines.
3. The patient only gave consent for you to enter through the groin during his hernia repair surgery, not through the abdomen. You did not adhere to proper consent from the patient nor did you consider the patient's pertinent medical history of six previous surgeries and adhesions.
4. Furthermore, you never repaired the hernia.
5. The patient has felt undue pain and his quality of life has suffered.

Received 11/18/2019

6. Therefore your care and treatment of the patient may have fallen below the standard of care.

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 the allegations noted above, as well as complete health care records for the aforesaid patient. Please provide 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.

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: **NAC 630.040; NAC 630.620 (2); NRS 630.301 (4),(8); NRS 630.306 (1)(f), (1)(g), (1)(p).**

Respectfully,

Monica C. Gustafson, CMBI
Senior Investigator

Exhibit B

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: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
NOV 17 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Annabel Elizabeth Barber, 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. 8247). Respondent was originally licensed by the Board on July 1, 1997.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. The first clinical visit to see Respondent by Patient A was on December 27, 2018, when he presented to UNLV surgery clinic with a complaint of a left inguinal hernia. Respondent ordered a CT scan "to define anatomy better."

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[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., 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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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Nevada State Board of Medical Examiners
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Reno, Nevada 89521
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4. Patient A had an extensive history of abdominal surgeries due to a birth defect and a prior bowel obstruction. The past surgeries caused Patient A to lose a large portion of his small bowel and, because of this, he had acquired short bowel syndrome.

5. Upon healing from those surgeries, Patient A developed surgical scar tissue within the abdominal cavity which was communicated to Respondent by Patient A upon his first visit.

6. On February 22, 2019, Patient A was admitted for surgery by Respondent for a laparoscopic inguinal hernia repair, which is contraindicated for a person that has severe scar tissue from prior abdominal surgeries.

7. Upon information and belief, during the surgery on February 22, 2019, Respondent made an attempt to gain laparoscopic access to the peritoneum via the right lower quadrant. When Respondent was unable to gain peritoneal access, it appears from her operative note that she tried to gain access via the left lower quadrant but was also unsuccessful. It appears, upon information and belief, that Respondent then attempted to access the peritoneum via a midline incision and immediately noticed that she had injured Patient A's bowel.

8. Respondent then attempted to gain access through a midline incision which injured the bowel during the incision.

9. Once Respondent identified the injury, she attempted to close the small bowel using an endo-GIA stapling device and reinforcing sutures.

10. Respondent then closed the incision and discharged Patient A without having repaired Patient A's left inguinal hernia.

11. There was no documentation of the injury in the operative note which was unintelligibly written.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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14. 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."

15. 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 she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

16. 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

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

18. 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.

19. Respondent failed to maintain legible and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions and Patient A's extensive medical history when she treated Patient A.

20. 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 her and give her notice that she 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;

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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

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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Nevada State Board of Medical Examiners
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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 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

Exhibit C

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED

MAY 0 1 2024

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

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 Notice and Order Rescheduling Pre-hearing and Hearing filed on February 29, 2024.

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. Monica Gustafson, Investigator
Nevada State Board of Medical Examiners

Ms. Gustafson is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

b. Annabel Elizabeth Barber, M.D.

Dr. Barber 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. Nicholas Spoerke, M.D., FACS

Dr. Spoerke is a Board-Certified General and Critical Care Surgeon and is licensed to practice medicine in the State of Nevada. Dr. Spoerke 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 her prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons she 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, Order and Response to Allegation Letter	001-048
2	Dr. Davis's Request Letter and Statement of Treatment	049-079
3	Dr, Javed's 2nd Request & Request Letters and Statements	080-083
4	Las Vegas Surgery Center – Request Letter and Records	084-132
5	CV of Nicholas Spoerke, M.D., FACS	133-0136
6	Diagnostics from University Medical Center	137
7	Diagnostic Films from Spring Valley Hospital	138

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 before the Prehearing Conference.

DATED this 1st day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 1st day of May, 2024, 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 FedEx Priority Overnight, postage pre-paid, to the following parties:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. and Amanda Rosenthal, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119

CHARLES B. WOODMAN, ESQ.
548 W. Plumb Lane, Suite B
Reno, NV 89501

Rosenthal Tracking No.: 776191169029

Woodman Tracking No.: 776191295761

With courtesy copy by email to:

Patricia Daehnke, Esq., at [Patricia.Daehnke@cdiglaw.com]
Charles B. Woodman Esq. at [hardywoodmanlaw@msn.com]

DATED this 1st day of May, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

Exhibit D

Amanda Rosenthal

From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 10:05 AM
To: Patricia Daehnke
Cc: Amanda Rosenthal; Lacey Ambro; Meg Byrd
Subject: RE: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good morning Tricia,

We have complied with both NRS 622A.330 and NAC 630.465, and we will not be turning over the entire investigative file.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Sunday, June 2, 2024 4:45 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Re: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

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Hi Don,

You could send over a paper copy to me at my hotel or we can send a secure link in the morning so the file can be downloaded whichever you prefer.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On Jun 2, 2024, at 4:36 PM, Patricia Daehnke <Patricia.Daehnke@cdiglaw.com> wrote:

Good afternoon Don,

I am getting ready for the hearing and don't see that you have produced either investigative file in this matter. I checked and the board did not provide the investigative file from the case that was dismissed nor the current case. Please provide a copy of the investigative file.

Tricia Daehnke
Collinson, Daehnke, Inlow & Greco
Sent from my IPhone

On May 31, 2024, at 10:47 AM, Donald K. White <dwhite@medboard.nv.gov> wrote:

Good morning Mr. Woodman,

Thank you for checking on this. I'm forwarding the email below again. I withdrew my motion since I was able to correspond with Dr. Spoerke, and he confirmed that he is available for the hearing.

Sincerely,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Donald K. White
Sent: Tuesday, May 28, 2024 1:38 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: FW: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Good afternoon everyone,

Please allow me to withdraw the Motion to Continue (which was emailed and not filed on Friday, May 24, 2024).

I just spoke with Dr. Spoerke and he is available on June 4, 2024.

Thank you,

Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Donald K. White
Sent: Friday, May 24, 2024 6:31 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>
Subject: Dr. Barber - Case No. 23-11660-1 - Motion to Continue

Hello Mr. Woodman and Ms. Daehnke,

Attached is a Motion to Continue the hearing currently set for June 4-5, 2024. As you will read, I have had much difficulty contacting the IC's expert, Dr. Nicholas Spoerke, and therefor I'm unable to confirm his availability for the hearing.

I would have informed you of this earlier, but I was holding out hope that I would have spoken with him by now. This is also the same reason I did not reach out to you, Ms. Daehnke, for a possible stipulation to continue.

Board staff who have the ability to file documents have gone home for the weekend, so this will be filed on Tuesday, May 28, 2024.

Hope everyone has a safe and relaxing Memorial Day weekend.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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Exhibit N

Amanda Rosenthal

From: Charles Woodman <hardywoodmanlaw@msn.com>
Sent: Monday, June 3, 2024 4:02 PM
To: Donald K. White
Cc: Patricia Daehnke; Meg Byrd; Lacey Ambro; Amanda Rosenthal
Subject: Re: Barber M.D. - Request to Stay Proceedings

Thanks for clarifying Mr. White. And the clarification points out my problem with the IC's position. The IC beleives it has the ability to pick and choose which documents are public and which stay hidden in their file. Doesn't make any sense to me. Especially in light of the following:

NRS 622A.330 Discovery; limitations on interrogatories and depositions.

1. At any time *after being served with the charging document*, *the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses*.

2. **The investigative file for the case is not discoverable *unless* the prosecutor intends to present materials from the investigative file as evidence in support of the case.** *The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case*, whether or not acquired through a subpoena related to the investigation of the licensee.

and

NRS 630.336 Confidentiality of certain proceedings, reports, complaints, investigations, records and other information; exceptions.

* * *

3. Except as otherwise provided in NRS 239.0115, the following ***may*** *be kept confidential*:

(a) Any statement, evidence, credential or other proof submitted in support of or to verify the contents of an application;

(b) Any report concerning the fitness of any person to receive or hold a license to practice medicine, perfusion or respiratory care; and

(c) Any communication between:

(1) The Board and any of its committees or panels; and

(2) The Board or its staff, investigators, experts, committees, panels, hearing officers, advisory members or consultants and counsel for the Board.

4. **Except as otherwise provided in subsection 5** and NRS 239.0115, a complaint filed with the Board pursuant to NRS 630.307*, all documents and other information filed with the complaint and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential*.

5. The formal complaint or other document filed by the Board to initiate disciplinary action *and all documents and information considered by the Board when determining whether to impose discipline are public records*.

This position undermines faith in the system.

Charles B. Woodman
The Law Offices of Charles B. Woodman
548 W. Plumb Lane, Suite B
Reno, NV 89509

775-786-9800

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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 3:55 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: RE: Barber M.D. - Request to Stay Proceedings

Mr. Woodman,

That is correct that the IC does not believe that its investigative file is public record and will refuse to disclose the part of the file protected by NRS 630.336. The only part that becomes public record is what is marked and admitted at the hearing.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Charles Woodman <hardywoodmanlaw@msn.com>
Sent: Monday, June 3, 2024 3:47 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Re: Barber M.D. - Request to Stay Proceedings

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So we have another impasse. Mr. White is proposing a stay for the following reason (I believe - Mr. White correct me /clarify if necessary):

There are two writs currently pending in the Washoe District Court on this issue: the IC does not believe its investigative file is public record. I disagree. We know from past experience (including in a case I just heard last week) that the IC will defy my order to produce what I tell them to produce. Until the writs are adjudicated,

we are burning time and fees going to hearing that don't make sense as the IC is going to continue to refuse to produce its file unless the court tells them they have to.

How does Respondent's counsel respond to a proposed stay?

Charles B. Woodman
The Law Offices of Charles B. Woodman
548 W. Plumb Lane, Suite B
Reno, NV 89509

775-786-9800

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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 2:56 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Barber M.D. - Request to Stay Proceedings

Hello Mr. Woodman,

In light of the fact that the Board currently has two Writs in District Court involving the same issue (disclosing the investigative file), I propose that this hearing should be stayed until a judge sorts out the issues in those matters, since they are identical to the very new issue in this matter.

Then there is a probability that Dr. Barber's case can be heard on its merits.

Respectfully, I am not presuming how you might rule, Mr. Woodman, but I know from those other matters that this has become a complicated issue and I want to avoid expending more costs and resources if it's not necessary at this time.

Please stay the proceedings until the subject matter of the Writs is resolved and we have a clear path forward. Once the subject of the Writs has been resolved, we can then set a status conference to move Dr. Barber's case forward. If you are inclined to grant the stay, please issue an order confirming the same.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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Exhibit O

Amanda Rosenthal

From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 4:14 PM
To: Charles Woodman; Patricia Daehnke
Cc: Meg Byrd; Lacey Ambro; Amanda Rosenthal
Subject: RE: Barber M.D. - Request to Stay Proceedings

That sounds fine, Mr. Woodman. However, Dr. Barber's Request for Production of Public Records and/or Production of the Investigative File should be held in abeyance until after this matter is heard on its merits. At a time when counsel for the IC has time to respond, or at least until June 10, 2024. Pursuant to your Amended Scheduling Order, "[a]ll motions are to be filed no later than Friday, May 24, 2024 by 5:00 P.M. Dr. Barber filed her request today – 10 days past the deadline to file motions.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
775.324.9355
dwhite@medboard.nv.gov

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From: Charles Woodman <hardywoodmanlaw@msn.com>
Sent: Monday, June 3, 2024 4:03 PM
To: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Donald K. White <dwhite@medboard.nv.gov>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Re: Barber M.D. - Request to Stay Proceedings

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That works. We'll go on the record at 9:00 tomorrow.

Charles B. Woodman
The Law Offices of Charles B. Woodman
548 W. Plumb Lane, Suite B
Reno, NV 89509

775-786-9800

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From: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>
Sent: Monday, June 3, 2024 3:58 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>; Donald K. White <dwhite@medboard.nv.gov>
Cc: Meg Byrd <mbyrd@medboard.nv.gov>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: RE: Barber M.D. - Request to Stay Proceedings

Good Afternoon Hearing Officer Woodman,

On behalf of Respondent Dr. Barber, we object to any continuation or stay of the Hearing. Dr. Barber has spent significant money out of pocket to prepare for this Hearing, has traveled to Reno, and her expert is traveling from New Jersey for the Hearing. We will be prepared to proceed as necessary with the Hearing tomorrow and believe any discussions regarding this issue should be made on the record tomorrow so we can preserve the record for future appeal as necessary.

Patricia Egan Daehnke | Founding Partner
Collinson, Daehnke, Inlow & Greco – Attorneys at Law
2110 E. Flamingo Road, Suite 212, Las Vegas, NV 89119
Phone: (702) 979-2132 | Facsimile: (702) 979-2133
patricia.daehnke@cdiglaw.com | www.cdiglaw.com

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From: Charles Woodman <hardywoodmanlaw@msn.com>
Sent: Monday, June 3, 2024 3:47 PM
To: Donald K. White <dwhite@medboard.nv.gov>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; Lacey Ambro <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Re: Barber M.D. - Request to Stay Proceedings

So we have another impasse. Mr. White is proposing a stay for the following reason (I believe - Mr. White correct me /clarify if necessary):

There are two writs currently pending in the Washoe District Court on this issue: the IC does not believe its investigative file is public record. I disagree. We know from past experience (including in a case I just heard last week) that the IC will defy my order to produce what I tell them to produce. Until the writs are adjudicated, we are burning time and fees going to hearing that don't make sense as the IC is going to continue to refuse to produce its file unless the court tells them they have to.

How does Respondent's counsel respond to a proposed stay?

Charles B. Woodman
The Law Offices of Charles B. Woodman
548 W. Plumb Lane, Suite B
Reno, NV 89509

775-786-9800

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From: Donald K. White <dwhite@medboard.nv.gov>
Sent: Monday, June 3, 2024 2:56 PM
To: Charles Woodman <hardywoodmanlaw@msn.com>
Cc: Patricia Daehnke <Patricia.Daehnke@cdiglaw.com>; Meg Byrd <mbyrd@medboard.nv.gov>; 'Lacey Ambro' <Lacey.Ambro@cdiglaw.com>; Amanda Rosenthal <Amanda.Rosenthal@cdiglaw.com>
Subject: Barber M.D. - Request to Stay Proceedings

Hello Mr. Woodman,

In light of the fact that the Board currently has two Writs in District Court involving the same issue (disclosing the investigative file), I propose that this hearing should be stayed until a judge sorts out the issues in those matters, since they are identical to the very new issue in this matter.

Then there is a probability that Dr. Barber's case can be heard on its merits.

Respectfully, I am not presuming how you might rule, Mr. Woodman, but I know from those other matters that this has become a complicated issue and I want to avoid expending more costs and resources if it's not necessary at this time.

Please stay the proceedings until the subject matter of the Writs is resolved and we have a clear path forward. Once the subject of the Writs has been resolved, we can then set a status conference to move Dr. Barber's case forward. If you are inclined to grant the stay, please issue an order confirming the same.

Thank you,
Don

Donald K. White, J.D.
Senior Deputy General Counsel

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775.324.9355
dwhite@medboard.nv.gov

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Exhibit P

Amanda Rosenthal

From: Deonne Contine <dcontine@medboard.nv.gov>
Sent: Monday, June 3, 2024 7:52 PM
To: Patricia Daehnke; Charles Woodman; Amanda Rosenthal
Cc: Meg Byrd; Mercedes Fuentes; tiffany; Lacey Ambro; Donald K. White
Subject: Motion to Recuse Hearing Officer Woodman
Attachments: Barber Motion to Recuse Woodman.pdf

Importance: High

Hello all:

Attached is a courtesy copy of a motion for Mr. Woodman's recusal in this case. We will file and have served first thing in the morning.

Deonne

****

Deonne E. Contine
General Counsel
Nevada State Board of Medical Examiners
Telephone: (775) 324-9349
dcontine@medboard.nv.gov

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

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.,** **Respondent.**	**Case No. 23-11660-1**

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. PURSUANT TO NRS 622A.360(2)(b)

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through counsel, Deonne E. Contine, General Counsel for the Board, and attorney for the IC, respectfully moves for recusal of hearing officer Charles Woodman, Esq. ("Woodman") from the instant action based on the following:

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Motion to Recuse Woodman from hearing this case is filed because of a difference between Woodman and the IC and Board regarding an interpretation of NRS 630.336 and NRS 622A.330 which has led to court intervention and Woodman's reaffirming his intention to apply his interpretation prior to the court considering the Petitions for Writ of Mandamus filed by the Board on April 17 and May 31, 2024, in which Woodman is the Respondent.

While it is understood that Woodman disagrees because he feels it is not fair to limit discovery in administrative proceedings, the Board's position is that its interpretation is consistent with Nevada statutory and case law. In fact, previously, a different hearing officer has issued an order consistent with the Board's understanding.[1] Additionally, as this disagreement relates to confidential, non-discoverable information that cannot be made confidential again once it is out in

[1] See attached Order Denying Motion to Compel, filed July 15, 2022.

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the public, the Board must seek court determination prior to the disclosure of the documents. This is not an issue that the Board seeks to unfairly pursue because it wants to penalize or hide information from licensees. The Board must follow its statutory provisions and cannot arbitrarily decide as it see fits when to apply and when not to apply its governing provisions.

II. PROCEDURAL FACTS

On April 17, 2024, the Board, filed its Petition for Writ of Mandamus against Hearing Officer Charles Woodman ("Woodman"), ("Board's Petition, case number CV24-00838") seeking a writ ordering Woodman to rescind a Summary Prehearing Order filed April 11, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file in the Matter of Charges and Complaint Against: SAMUEL RODOLFO CHACON, M.D. The Chacon matter which was set to go to hearing before Woodman on May 13, 2024, was stayed pending resolution of the Board's Petition, case number CV24-00838.

On May 31, 2024, the Board, filed its Petition for Writ of Mandamus against Woodman, ("Board's Petition, case number CV24-01206") seeking a writ ordering Woodman to rescind an Order on Prehearing Motions filed May 29, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file related to the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C.

The Board's Petition, case number CV24-01206, was filed after Woodman ordered the case against McCleve to proceed to a hearing over the objections of the IC's counsel on May 30, 2024, the first day of the hearing on the formal complaint against McCleve. The IC suggested that the formal complaint against McCleve should be stayed pending resolution of the legal issues in Board's Petition, case number CV24-00838. Alternatively, IC counsel suggested that Woodman stay his Order on Prehearing Motions, take evidence as provided by the parties pursuant to NAC 630.465 in the McCleve case, and make his recommendations to the Board after hearing the case against McCleve on the merits and reserve determination on the legal issue to the appropriate forum, the court.

During oral argument at the McCleve's hearing regarding production of the investigative file, it was discussed that the IC would need to seek further Court intervention at which time

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Woodman inquired whether the Board would appeal the matter if it was not successful in district court. Counsel for the IC refused to share attorney client discussions or litigation strategies with Woodman who is the respondent in the writ proceedings.

Woodman denied any continuance request by the IC notwithstanding that the IC maintained that the underlying legal issue must be decided by the court before the IC would produce the legal file as he had determined. Finally, Woodman further escalated issues at the McCleve hearing when he directed a Board witness to answer questions regarding IC proceedings, dismissing the objection of counsel, that IC proceedings are confidential based on NRS 630.311(3), not the confidentiality provisions on which he had previously decided.

Woodman, at the end of the morning session of the McCleve hearing on May 30, 2024, entertained an oral motion by McCleve to dismiss the formal complaint against him. Thereafter, Woodman stated that he would grant the motion to dismiss, wrap the case and send his recommendation to the Board that the case does not go any further. Woodman terminated the proceeding without hearing the case on the merits but not before a soliloquy admonishing the IC's counsel and the Board for not providing discovery to McCleve even though that issue is a subject of the writ petitions which are based on alleged erroneous decisions.

In his soliloquy Woodman referenced the Board's General Counsel directly regarding the intent to file the writ – calling the Board's action unconscionable and stating that in the real world of civil and criminal law - they would laugh at the Board. He further advised counsel to go to court to ask that the writ be combined with the writ that is already pending. He also admonished the Board accusing it of not being fair because the Board will not stipulate around our statutory duties and noted his belief that the Board must be doing something wrong because he has heard Board cases for years and this issue has never come up.

III. LEGAL ARGUMENT

NRS 622A.360(2)(b) provides for a motion requesting, for good cause, the recusal of the hearing officer from participation in a case. While a recusal motion may be made to a hearing officer, panel or the regulatory body, by its plain language, the provision requires the person hearing the matter to determine whether they should recuse themselves. *See also Crandell v.*

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Pennsbury Tp. Bd. of Supervisors, 985 A.2d 288, 296 (2009) ("Recusal motions are directed in the first instance to the official whose recusal is sought, for that official's self-assessment"). Black's Law Dictionary defines good cause as a legally sufficient ground or reason for granting the request. While this is not a judicial proceeding, NRS 1.230(1) provides guidance here in that a judge shall not act in a proceeding when he entertains actual bias or prejudice for or against one of the parties to the action.

The party seeking recusal must show that a judge is biased but if a judge's impartiality might reasonably be questioned, then the judge should recuse himself. *See* NCJC Rule 2.11(A). *See also Roe v. Roe*, 535 P.3d 274, 291, 139 Nev. Adv. Op. 21 (holding that ultimately the judge should be disqualified if "a reasonable person, knowing all the facts, would harbor reasonable doubts about the [judge's] impartiality"). *Id., citing Ybarra v. State*, 127 Nev. 47, 51, 247 P.3d 269, 272 (2011).

In this case, Woodman has demonstrated that he is biased against the Board in the handling of the disciplinary proceeding of McCleve because he continues to apply his interpretation of the law and uses his power as the hearing officer to seek to have Board cases dismissed without being heard on the merits of the complaint. The Board as of today has filed two petitions for writ of mandamus against Mr. Woodman challenging his interpretation of the Board's statutes and he is currently the Respondent in those proceedings pending in the Second Judicial Court.

The second writ petition was filed on May 31, 2024, which was precipitated by his desire to dismiss the case against McCleve prior to hearing the case on the merits because the Board did not comply with his decision that is currently being challenged and pending in court. Without the actual authority to grant dismissal[2], he indicated on the record of the McCleve hearing that he would wrap this hearing and send his recommendations to the Board that this case does not go any further. He

[2] Notably, Woodman has no authority as a hearing officer to dismiss a case on the grounds requested here (i.e. failure to provide confidential non discoverable information). A request for a motion to dismiss is permitted by NRS 622A, if the complaint filed to initiate disciplinary proceedings fails to state facts which, if true, would form a sufficient basis for discipline. Any findings and recommendations of the hearing officer are only final if approved by the regulatory body which may approve, modify, reject, remand, order trial de novo, or take any other action it deems appropriate. For this reason, IC counsel requested that the hearing on the merits go forward, and Woodman could provide his opinion on the legal issue of confidential discovery in his recommendations after hearing all the evidence.

used time on the record to excoriate the Board for its unfairness while never citing any legal provisions in support of his harsh critique.

The disagreement Woodman has with the Board and its counsel regarding the interpretation of the legal provisions has escalated to the point where Woodman cannot hide his biased. Notwithstanding that Woodman's interpretation of the Board's statutory provision has been pending in the Second Judicial District Court since April 17, 2024, he issued the same decision in yet a second matter on May 29, 2024, then determined that a matter should be dismissed prior to hearing any evidence. He rejected a request to continue the McCleve hearing pending the determination on the pending writ proceedings in the Chacon matter which further demonstrates that his decision making is unreasoned and unbiased as waiting for court input is appropriate in the case where a writ has been filed challenging his statutory interpretation.

Finally, Woodman has already demonstrated his intent to apply his same reasoning to the instant matter, continues to accuse the Board of wrongdoing – i.e. hiding information from licenses - as opposed to seeking determination on an issue of statutory construction - and therefore he should recuse himself.

Woodman inappropriately sought attorney client information from IC counsel regarding the IC's intentions in the Chacon litigation in which he is the Respondent, and the Board is the Petitioner, while at the same time holding the power as a hearing officer in the McCleve case. Woodman also inquired whether the Board would name McCleve as a party in subsequent writ proceedings and then counseled McCleve's attorney to seek intervention in the writ proceeding.

Woodman did not take the time on the record during the McCleve hearing to delineate the legal principles on which his decisions were based. Instead, he laid out his grievances toward the Board (specifically that it is outrageous, unconscionable, and unfair). Any reasonable person witnessing his verbal abuse and personal attacks of the Board at the McCleve hearing would harbor reasonable doubts about his impartiality[3].

/ / /

/ / /

[3] The Board will supplement this request to complete the record pending receipt of the final transcript of the May 30, 2024, hearing in the matter of the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C.

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IV. CONCLUSION

Woodman's feelings and opinions are conclusory - he just does not feel that the Board is fair. His tone, forum, and timing of comments at the McCleve hearing raise questions of his impartiality in considering the disciplinary hearings of the IC. Accordingly, the IC requests that Woodman recuse himself from the instant matter.

DATED this 3rd day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

Deonne E. Contine
General Counsel
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Attorney for the Investigative Committee

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

FILED

JUL 15 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against

ERIC JOSEPH PIPPI, PA-C,

Respondent.

Case No. 22-48045-1

Hearing Date: July 26 - 27, 2022 @ 8:30 a.m.

ORDER DENYING MOTION TO COMPEL

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

On June 7, 2022, Respondent filed a Motion to Compel (the "Motion") by which he seeks documents that were the subject of a prior "Deposition Subpoena and Subpoena Duces Tecum" (the "Subpoena"). The Subpoena was quashed on the basis set forth in the Order Quashing "Deposition Subpoena and Subpoena Duces Tecum" provided herewith as **Exhibit 1** and incorporated herein by reference (the "Subpoena Order"). By and through the Motion, Respondent argues that, based upon "[b]asic notions of due process and fair play," he is entitled to the production of documents pertaining to the Nevada State Board of Medical Examiners' (the "Board") "decision to discipline Respondent." Motion, p. 1, lines 9-11. Respondent premises this statement upon an allegation of selective enforcement, indicating that Respondent is entitled to

know "whether the Board engaged in arbitrary and selective prosecution." Motion, p. 2, lines 23-25.

The Investigative Committee of the Nevada State Board of Medical Examiners (the "IC") has opposed the Motion, arguing that the Moton is duplicative of the Subpoena, which was already quashed, and that the discovery Respondent is seeking is not permitted in the context of the administrative hearing and its statutory and administrative structure, which themselves ensure due process.

In reply, Respondent argues that case law relied upon by the IC, namely Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), is inapplicable to pending proceedings (versus an investigation into possible proceedings), and that deprivation of the discovery requested will be prejudicial to Respondent and, therefore, contrary to his due process rights.

The majority of the legal analysis relevant to the Motion was previously addressed in the Subpoena Order, which has been incorporated herein by reference. Based upon the analysis therein, which covers the statutory and administrative basis for denying the Motion, it remains that production of the requested documentation cannot be compelled.[1] To the extent additional arguments are made in the Motion with respect to NRS 630.336(5), case law, due process, and selective enforcement, they are addressed as follows.

NRS 630.336(4) provides, in relevant part, "a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint[,] and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential." The following section of that statute, NRS 630.336(5), provides that "[t]he formal complaint or other document filed by the Board to initiate

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[1] A portion of this argument as made by Respondent in the Motion and addressed in the Subpoena Order relies upon NAC 630.470(4), which Respondent advocates "provides that pre-hearing depositions of witnesses and parties may not be taken and no formal discovery conducted, *unless the Hearing Officer allows it.*" Motion, p. 3, lines 26-28 (original emphasis). However, NAC 630.470(4) actually provides, "[p]rehearing depositions of witnesses and parties may not be taken and no formal discovery of evidence, except as otherwise provided in NAC 630.465, will be allowed." NAC 630.465 provides only for the exchange of a list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness, as well as for the production of all evidence, except rebuttal evidence. As such, a hearing officer does not have discretion to allow pre-hearing depositions and formal discovery as Respondent advocates.

disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records."[2] In support of his argument, Respondent relies upon the latter language in subsection 5 that references as public "documents and information considered by the Board when determining whether to impose discipline are public records."

When considering the two provisions, subsection 4 and subsection 5, they establish that investigative documents are not public save and except for if they are relied upon by the Board when determining whether to impose discipline.[3] To that end, what is submitted to the Board in its determination to impose discipline are the documents that consist of the record before the hearing officer and the hearing officer's synopsis of the testimony taken, which includes a recommendation on the veracity of witnesses. NAC 630.470. As such, any documents outside of the evidentiary hearing record and the submission of from the hearing officer, which is likewise based upon the evidentiary hearing record, remain confidential pursuant to subsection 4 and are not discoverable. Thus, reliance upon NRS 630.336(5) is unavailing to compel the production of such documentation.

In consideration of Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), Respondent is correct that Sarfo addressed the confidentiality of an investigative file with respect to the investigative phase and prior to the filing of a formal complaint. Sarfo nonetheless made it clear that the confidentiality provisions apply to a responding licensee and such confidentiality provisions, by their terms, continue past the investigatory phase. Therefore, the

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[2] A complaint as contemplated by NRS 630.307 and as referenced in subsection 4 is the grievance submitted to the Board that is reviewed and investigated as a preface to what may result in a formal complaint lodged pursuant to NRS 630.399. A complaint lodged pursuant to NRS 630.339 is specifically referenced in the statutory scheme as a "formal complaint" as reflected in subsection 5.

[3] If "disciplinary action" and the "imposition of discipline" were similarly defined; for example, if the "imposition of discipline" could encompass instigating disciplinary action, the limitations of NRS 630.336(4) would be rendered meaningless, which would be contrary to rules of statutory interpretation. Further, "imposition of discipline" is referenced in NRS 630.352, which indicates that, at the conclusion of a hearing on the formal complaint, the Board shall vote to "impose discipline" or, alternatively, dismiss the charges if the Board determines that no violation has occurred. Thus, the terms are exclusive and while the disciplinary hearing is a disciplinary action, the imposition of discipline is the step considered after the conclusion of the hearing if the charges stemming from the formal complaint are substantiated.

question that remains is whether a responding licensee remains subject to such confidentiality after a formal complaint is filed based upon considerations of due process.

"Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008). To effectuate this, "[a]dministrative bodies must follow their established procedural guidelines and give notice to the defending party of 'the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it." Id.

To facilitate notice of formal allegations brought against a respondent in a matter deemed sufficient to allow a responding party to defend, NRS 630.339 establishes that the formal complaint must: 1) include a written statement setting forth the charges alleged and setting forth in concise and plain language each act or omission of the respondent upon which the charges are based; 2) be prepared with sufficient clarity to ensure that the respondent is able to prepare a defense; and 3) specify any applicable law or regulation that the respondent is alleged to have violated. In this respect, the Nevada Supreme Court has recognized that so long as these standards are met, the minimum standard of due process with regard to notice are met. Dutchess Bus. Servs., Inc., 124 Nev. at 711, 191 P.3d at 1166 (2008) (the filing and service of accusations against a licensee that sets forth in writing the charges alleged and the acts or omission with which the respondent is charged such that the respondent may prepare a defense comports with due process).

In the formal complaint against Respondent, the IC alleges specific charges, those being Disciplinary Action by Another State Medical Board and Failure to Report Disciplinary Action. The basis of each charge is stated with sufficient clarity in that the circumstances underlying each of the charges is articulated, and each charge identifies the applicable law or regulation alleged to have been violate; in fact, the alleged violations have been thoroughly briefed by the parties by and through Respondent's Motion to Dismiss filed concurrently with the Motion. As such, pursuant to recognized standards of due process applicable to the instant proceeding,

Respondent's due process rights have been met and Respondent may not rely upon the same to overcome the applicable confidentiality provisions.

With respect to Respondent's allegation of selective enforcement, a *prima facia* showing must be made to support such a claim as was indicated in the Subpoena Order in the context of Respondent's discovery request. *See, e.g.,* People v. Tuck, 139 Cal. Rptr. 3d 407, 418 n. 4 (2012) (recognizing that an alleging party must make the necessary *prima facie* showing to justify discovery).

To expand upon this point, to support a claim of selective enforcement, a respondent bears the heavy burden of establishing, at least *prima facie*: 1) that, while others similarly situated have not generally been proceeded against because of conduct of the type forming the basis of the charge against respondent, respondent has been singled out for prosecution; and 2) that the government's discriminatory selection of respondent for prosecution has been invidious or in bad faith, i.e., based upon such impermissible considerations as race, religion, or the desire to prevent respondent's exercise of constitutional rights. *See* State v. Flynt, 407 N.E.2d 15, 17 (OH 1980), writ dismissed, 451 U.S. 619 (1981) (as cited in a medical board case: Brownlee v. State Med. Bd., 2013 WL 6021182, 2013-Ohio-4989).

Nevada articulates this standard in McDonald v. State, 477 P.3d 373 (Nev. App. 2020), which provides:

> To prevail on a selective prosecution claim the claimant must demonstrate that the prosecutorial policy had a discriminatory effect and it was motivated by a discriminatory purpose. United States v. Armstrong, 517 U.S. 456, 465 (1996). "A selective-enforcement claim requires essentially the same showing." United States v. Griffith, 928 F.3d 855, 866 (10th Cir. 2019). To establish a discriminatory effect[,] ... the claimant must show that similarly situated individuals ... were not prosecuted." United States v. Armstrong, 517 U.S. 456, 465 (1996). To show discriminatory purpose, a claimant must establish "that the decision-maker ... selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." Wayte, 470 U.S. at 610 (internal quotation marks omitted). "This standard is a 'demanding one.' " Griffith, 928 F.3d at 866. . . . Unless suspect classes are involved in the selective enforcement, the Equal Protection Clause is violated only if there is no rational basis to justify the selective enforcement. *See* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487-488 (1955).

In sum, "[s]elective enforcement is an equal protection term that applies when a law is selectively enforced based on an unjustifiably discriminatory classification such as race, religion, or some other arbitrary characteristic," nothing of which Respondent has alleged. Low Cost Pharmacy, Inc. v. Arizona State Bd. of Pharmacy, No. 1 CA-CV 07-0547, 2008 WL 2154793, at *9 (Ariz. Ct. App. May 20, 2008) (*citing* State v. Patton, 665 P.2d 587, 590 n. 6 (Ariz. App.1983) and Oyler v. Boyles, 368 U.S. 448, 456 (1962). It also remains that selective enforcement does not encompass mere selectivity of enforcement given that such selectivity has to be unconstitutionally discriminatory to be deemed to be a Constitutional violation. *See* State v. Howard, 337 S.E.2d 598, 601 (N.C. App. 1985) (*citing* People v. Utica Daw's Drug Co., 16 A.D.2d 12, 225 N.Y.S.2d 128, 4 A.L.R.3d 393 (1962)); *see also* People v. Toomey, 157 Cal. App. 3d 1, 12–13, 203 Cal. Rptr. 642 (Ct. App. 1984) ("'an equal protection violation does not arise whenever officials 'prosecute one and not [another] for the same act;' instead, the equal protection guarantee simply prohibits prosecuting officials from purposefully and intentionally singling out individuals for disparate treatment on an invidiously discriminatory basis.' 'Prosecutorial discretion permits the choice among possible defendants which to prosecute, whether to prosecute, and in what order to prosecute.'") (citations omitted).

Even further, as recognized in Williams v. State, 393 So. 2d 492, 494 (Ala. Crim. App. 1981), "the mere showing of selective enforcement of a statute, without more, is not constitutionally impermissible." Id. (*citing* Oyler v. Boles, 368 U.S. 448 (1962) for the proposition that the conscious exercise of some selectivity in enforcement is not in itself a constitutional violation; and, even though statistics might imply a policy of selective enforcement, it remains that the selection must be deliberately based upon an unjustifiable standard such as race, religion, or other arbitrary classification). The fact that some people escape prosecution under a statute is not a denial of equal protection unless selective enforcement of the statute is intentional or purposeful given that the determination to prosecute is within a prosecuting authority's discretion. *See* May v. People, 636 P.2d 672, 681–82 (Colo. 1981) (*citing* Yick Wo v. Hopkins, 118 U.S. 356 (1886); People v. District Court, 632 P.2d 1022 (Colo. 1981)).

Here, Respondent has made a blanket assertion that any and all information related to the Board's prosecution of such claims as those brought against Respondent should have to be produced "to ensure that the Board is not abusing its discretion by unfairly and selectively disciplining healthcare providers." Motion, p. 8, lines 4-9. Such an assertion does not address the relevant standards of selective enforcement, nor a mandated showing of unlawful discrimination, and is, therefore, insufficient to mandate the relief requested. As such, Respondent's Motion to Compel is DENIED.

DATED this 15th day of July 2022.

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 DENYING MOTION TO COMPEL addressed as follows:

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

DATED this 15th day of July, 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

Exhibit Q

OFFICE OF THE GENERAL COUNSEL
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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D., Respondent.**	**Case No. 23-11660-1**

FILED

JUN 04 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. PURSUANT TO NRS 622A.360(2)(b)

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) by and through counsel, Deonne E. Contine, General Counsel for the Board, and attorney for the IC, respectfully moves for recusal of hearing officer Charles Woodman, Esq. ("Woodman") from the instant action based on the following:

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Motion to Recuse Woodman from hearing this case is filed because of a difference between Woodman and the IC and Board regarding an interpretation of NRS 630.336 and NRS 622A.330 which has led to court intervention and Woodman's reaffirming his intention to apply his interpretation prior to the court considering the Petitions for Writ of Mandamus filed by the Board on April 17 and May 31, 2024, in which Woodman is the Respondent.

While it is understood that Woodman disagrees because he feels it is not fair to limit discovery in administrative proceedings, the Board's position is that its interpretation is consistent with Nevada statutory and case law. In fact, previously, a different hearing officer has issued an order consistent with the Board's understanding.[1] Additionally, as this disagreement relates to confidential, non-discoverable information that cannot be made confidential again once it is out in

[1] See attached Order Denying Motion to Compel, filed July 15, 2022.

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the public, the Board must seek court determination prior to the disclosure of the documents. This is not an issue that the Board seeks to unfairly pursue because it wants to penalize or hide information from licensees. The Board must follow its statutory provisions and cannot arbitrarily decide as it see fits when to apply and when not to apply its governing provisions.

II. PROCEDURAL FACTS

On April 17, 2024, the Board, filed its Petition for Writ of Mandamus against Hearing Officer Charles Woodman ("Woodman"), ("Board's Petition, case number CV24-00838") seeking a writ ordering Woodman to rescind a Summary Prehearing Order filed April 11, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file in the Matter of Charges and Complaint Against: SAMUEL RODOLFO CHACON, M.D. The Chacon matter which was set to go to hearing before Woodman on May 13, 2024, was stayed pending resolution of the Board's Petition, case number CV24-00838.

On May 31, 2024, the Board, filed its Petition for Writ of Mandamus against Woodman, ("Board's Petition, case number CV24-01206") seeking a writ ordering Woodman to rescind an Order on Prehearing Motions filed May 29, 2024, compelling disclosure of the Investigative Committee of the Board's confidential investigative file related to the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C.

The Board's Petition, case number CV24-01206, was filed after Woodman ordered the case against McCleve to proceed to a hearing over the objections of the IC's counsel on May 30, 2024, the first day of the hearing on the formal complaint against McCleve. The IC suggested that the formal complaint against McCleve should be stayed pending resolution of the legal issues in Board's Petition, case number CV24-00838. Alternatively, IC counsel suggested that Woodman stay his Order on Prehearing Motions, take evidence as provided by the parties pursuant to NAC 630.465 in the McCleve case, and make his recommendations to the Board after hearing the case against McCleve on the merits and reserve determination on the legal issue to the appropriate forum, the court.

During oral argument at the McCleve's hearing regarding production of the investigative file, it was discussed that the IC would need to seek further Court intervention at which time

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Woodman inquired whether the Board would appeal the matter if it was not successful in district court. Counsel for the IC refused to share attorney client discussions or litigation strategies with Woodman who is the respondent in the writ proceedings.

Woodman denied any continuance request by the IC notwithstanding that the IC maintained that the underlying legal issue must be decided by the court before the IC would produce the legal file as he had determined. Finally, Woodman further escalated issues at the McCleve hearing when he directed a Board witness to answer questions regarding IC proceedings, dismissing the objection of counsel, that IC proceedings are confidential based on NRS 630.311(3), not the confidentiality provisions on which he had previously decided.

Woodman, at the end of the morning session of the McCleve hearing on May 30, 2024, entertained an oral motion by McCleve to dismiss the formal complaint against him. Thereafter, Woodman stated that he would grant the motion to dismiss, wrap the case and send his recommendation to the Board that the case does not go any further. Woodman terminated the proceeding without hearing the case on the merits but not before a soliloquy admonishing the IC's counsel and the Board for not providing discovery to McCleve even though that issue is a subject of the writ petitions which are based on alleged erroneous decisions.

In his soliloquy Woodman referenced the Board's General Counsel directly regarding the intent to file the writ – calling the Board's action unconscionable and stating that in the real world of civil and criminal law - they would laugh at the Board. He further advised counsel to go to court to ask that the writ be combined with the writ that is already pending. He also admonished the Board accusing it of not being fair because the Board will not stipulate around our statutory duties and noted his belief that the Board must be doing something wrong because he has heard Board cases for years and this issue has never come up.

III. LEGAL ARGUMENT

NRS 622A.360(2)(b) provides for a motion requesting, for good cause, the recusal of the hearing officer from participation in a case. While a recusal motion may be made to a hearing officer, panel or the regulatory body, by its plain language, the provision requires the person hearing the matter to determine whether they should recuse themselves. *See also Crandell v.*

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Pennsbury Tp. Bd. of Supervisors, 985 A.2d 288, 296 (2009) ("Recusal motions are directed in the first instance to the official whose recusal is sought, for that official's self-assessment"). Black's Law Dictionary defines good cause as a legally sufficient ground or reason for granting the request. While this is not a judicial proceeding, NRS 1.230(1) provides guidance here in that a judge shall not act in a proceeding when he entertains actual bias or prejudice for or against one of the parties to the action.

The party seeking recusal must show that a judge is biased but if a judge's impartiality might reasonably be questioned, then the judge should recuse himself. *See* NCJC Rule 2.11(A). *See also Roe v. Roe*, 535 P.3d 274, 291, 139 Nev. Adv. Op. 21 (holding that ultimately the judge should be disqualified if "a reasonable person, knowing all the facts, would harbor reasonable doubts about the [judge's] impartiality"). *Id., citing Ybarra v. State*, 127 Nev. 47, 51, 247 P.3d 269, 272 (2011).

In this case, Woodman has demonstrated that he is biased against the Board in the handling of the disciplinary proceeding of McCleve because he continues to apply his interpretation of the law and uses his power as the hearing officer to seek to have Board cases dismissed without being heard on the merits of the complaint. The Board as of today has filed two petitions for writ of mandamus against Mr. Woodman challenging his interpretation of the Board's statutes and he is currently the Respondent in those proceedings pending in the Second Judicial Court.

The second writ petition was filed on May 31, 2024, which was precipitated by his desire to dismiss the case against McCleve prior to hearing the case on the merits because the Board did not comply with his decision that is currently being challenged and pending in court. Without the actual authority to grant dismissal[2], he indicated on the record of the McCleve hearing that he would wrap this hearing and send his recommendations to the Board that this case does not go any further. He

[2] Notably, Woodman has no authority as a hearing officer to dismiss a case on the grounds requested here (i.e. failure to provide confidential non discoverable information). A request for a motion to dismiss is permitted by NRS 622A, if the complaint filed to initiate disciplinary proceedings fails to state facts which, if true, would form a sufficient basis for discipline. Any findings and recommendations of the hearing officer are only final if approved by the regulatory body which may approve, modify, reject, remand, order trial de novo, or take any other action it deems appropriate. For this reason, IC counsel requested that the hearing on the merits go forward, and Woodman could provide his opinion on the legal issue of confidential discovery in his recommendations after hearing all the evidence.

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used time on the record to excoriate the Board for its unfairness while never citing any legal provisions in support of his harsh critique.

The disagreement Woodman has with the Board and its counsel regarding the interpretation of the legal provisions has escalated to the point where Woodman cannot hide his biased. Notwithstanding that Woodman's interpretation of the Board's statutory provision has been pending in the Second Judicial District Court since April 17, 2024, he issued the same decision in yet a second matter on May 29, 2024, then determined that a matter should be dismissed prior to hearing any evidence. He rejected a request to continue the McCleve hearing pending the determination on the pending writ proceedings in the Chacon matter which further demonstrates that his decision making is unreasoned and unbiased as waiting for court input is appropriate in the case where a writ has been filed challenging his statutory interpretation.

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Woodman did not take the time on the record during the McCleve hearing to delineate the legal principles on which his decisions were based. Instead, he laid out his grievances toward the Board (specifically that it is outrageous, unconscionable, and unfair). Any reasonable person witnessing his verbal abuse and personal attacks of the Board at the McCleve hearing would harbor reasonable doubts about his impartiality[3].

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[3] The Board will supplement this request to complete the record pending receipt of the final transcript of the May 30, 2024, hearing in the matter of the IC's formal complaint against DAVID KAYLE McCLEVE, PA-C.

IV. CONCLUSION

Woodman's feelings and opinions are conclusory - he just does not feel that the Board is fair. His tone, forum, and timing of comments at the McCleve hearing raise questions of his impartiality in considering the disciplinary hearings of the IC. Accordingly, the IC requests that Woodman recuse himself from the instant matter.

DATED this 3rd day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Deonne E. Contine

Deonne E. Contine
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Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 4th day of June, 2024, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO RECUSE HEARING OFFICER CHARLES WOODMAN, ESQ. PURSUANT TO NRS 622A.360(2)(b)** via hand delivery to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Daehnke, Esq. & Amanda Rosenthal, Esq.

CHARLES WOODMAN, ESQ.

Further, the document mentioned above was also emailed on June 3, 2024 by Deonne Contine, General Counsel to:

CHARLES WOODMAN, ESQ.
PATRICIA DAEHNKE, ESQ.
AMANDA ROSENTHAL, ESQ.

DATED this 4th day of June, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

FILED

JUL 15 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Charges and Complaint Against

ERIC JOSEPH PIPPI, PA-C,

Respondent.

Case No. 22-48045-1

Hearing Date: July 26 - 27, 2022 @ 8:30 a.m.

ORDER DENYING MOTION TO COMPEL

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
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On June 7, 2022, Respondent filed a Motion to Compel (the "Motion") by which he seeks documents that were the subject of a prior "Deposition Subpoena and Subpoena Duces Tecum" (the "Subpoena"). The Subpoena was quashed on the basis set forth in the Order Quashing "Deposition Subpoena and Subpoena Duces Tecum" provided herewith as **Exhibit 1** and incorporated herein by reference (the "Subpoena Order"). By and through the Motion, Respondent argues that, based upon "[b]asic notions of due process and fair play," he is entitled to the production of documents pertaining to the Nevada State Board of Medical Examiners' (the "Board") "decision to discipline Respondent." Motion, p. 1, lines 9-11. Respondent premises this statement upon an allegation of selective enforcement, indicating that Respondent is entitled to

know "whether the Board engaged in arbitrary and selective prosecution." Motion, p. 2, lines 23-25.

The Investigative Committee of the Nevada State Board of Medical Examiners (the "IC") has opposed the Motion, arguing that the Moton is duplicative of the Subpoena, which was already quashed, and that the discovery Respondent is seeking is not permitted in the context of the administrative hearing and its statutory and administrative structure, which themselves ensure due process.

In reply, Respondent argues that case law relied upon by the IC, namely Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), is inapplicable to pending proceedings (versus an investigation into possible proceedings), and that deprivation of the discovery requested will be prejudicial to Respondent and, therefore, contrary to his due process rights.

The majority of the legal analysis relevant to the Motion was previously addressed in the Subpoena Order, which has been incorporated herein by reference. Based upon the analysis therein, which covers the statutory and administrative basis for denying the Motion, it remains that production of the requested documentation cannot be compelled.[1] To the extent additional arguments are made in the Motion with respect to NRS 630.336(5), case law, due process, and selective enforcement, they are addressed as follows.

NRS 630.336(4) provides, in relevant part, "a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint[,] and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential." The following section of that statute, NRS 630.336(5), provides that "[t]he formal complaint or other document filed by the Board to initiate

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[1] A portion of this argument as made by Respondent in the Motion and addressed in the Subpoena Order relies upon NAC 630.470(4), which Respondent advocates "provides that pre-hearing depositions of witnesses and parties may not be taken and no formal discovery conducted, *unless the Hearing Officer allows it.*" Motion, p. 3, lines 26-28 (original emphasis). However, NAC 630.470(4) actually provides, "[p]rehearing depositions of witnesses and parties may not be taken and no formal discovery of evidence, except as otherwise provided in NAC 630.465, will be allowed." NAC 630.465 provides only for the exchange of a list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness, as well as for the production of all evidence, except rebuttal evidence. As such, a hearing officer does not have discretion to allow pre-hearing depositions and formal discovery as Respondent advocates.

disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records."[2] In support of his argument, Respondent relies upon the latter language in subsection 5 that references as public "documents and information considered by the Board when determining whether to impose discipline are public records."

When considering the two provisions, subsection 4 and subsection 5, they establish that investigative documents are not public save and except for if they are relied upon by the Board when determining whether to impose discipline.[3] To that end, what is submitted to the Board in its determination to impose discipline are the documents that consist of the record before the hearing officer and the hearing officer's synopsis of the testimony taken, which includes a recommendation on the veracity of witnesses. NAC 630.470. As such, any documents outside of the evidentiary hearing record and the submission of from the hearing officer, which is likewise based upon the evidentiary hearing record, remain confidential pursuant to subsection 4 and are not discoverable. Thus, reliance upon NRS 630.336(5) is unavailing to compel the production of such documentation.

In consideration of Sarfo v. State Bd. of Medical Examiners, 134 Nev. 709, 429 P.3d 650 (2018), Respondent is correct that Sarfo addressed the confidentiality of an investigative file with respect to the investigative phase and prior to the filing of a formal complaint. Sarfo nonetheless made it clear that the confidentiality provisions apply to a responding licensee and such confidentiality provisions, by their terms, continue past the investigatory phase. Therefore, the

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[2] A complaint as contemplated by NRS 630.307 and as referenced in subsection 4 is the grievance submitted to the Board that is reviewed and investigated as a preface to what may result in a formal complaint lodged pursuant to NRS 630.399. A complaint lodged pursuant to NRS 630.339 is specifically referenced in the statutory scheme as a "formal complaint" as reflected in subsection 5.

[3] If "disciplinary action" and the "imposition of discipline" were similarly defined; for example, if the "imposition of discipline" could encompass instigating disciplinary action, the limitations of NRS 630.336(4) would be rendered meaningless, which would be contrary to rules of statutory interpretation. Further, "imposition of discipline" is referenced in NRS 630.352, which indicates that, at the conclusion of a hearing on the formal complaint, the Board shall vote to "impose discipline" or, alternatively, dismiss the charges if the Board determines that no violation has occurred. Thus, the terms are exclusive and while the disciplinary hearing is a disciplinary action, the imposition of discipline is the step considered after the conclusion of the hearing if the charges stemming from the formal complaint are substantiated.

question that remains is whether a responding licensee remains subject to such confidentiality after a formal complaint is filed based upon considerations of due process.

"Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008). To effectuate this, "[a]dministrative bodies must follow their established procedural guidelines and give notice to the defending party of 'the issues on which decision will turn and . . . the factual material on which the agency relies for decision so that he may rebut it." Id.

To facilitate notice of formal allegations brought against a respondent in a matter deemed sufficient to allow a responding party to defend, NRS 630.339 establishes that the formal complaint must: 1) include a written statement setting forth the charges alleged and setting forth in concise and plain language each act or omission of the respondent upon which the charges are based; 2) be prepared with sufficient clarity to ensure that the respondent is able to prepare a defense; and 3) specify any applicable law or regulation that the respondent is alleged to have violated. In this respect, the Nevada Supreme Court has recognized that so long as these standards are met, the minimum standard of due process with regard to notice are met. Dutchess Bus. Servs., Inc., 124 Nev. at 711, 191 P.3d at 1166 (2008) (the filing and service of accusations against a licensee that sets forth in writing the charges alleged and the acts or omission with which the respondent is charged such that the respondent may prepare a defense comports with due process).

In the formal complaint against Respondent, the IC alleges specific charges, those being Disciplinary Action by Another State Medical Board and Failure to Report Disciplinary Action. The basis of each charge is stated with sufficient clarity in that the circumstances underlying each of the charges is articulated, and each charge identifies the applicable law or regulation alleged to have been violate; in fact, the alleged violations have been thoroughly briefed by the parties by ... and through Respondent's Motion to Dismiss filed concurrently with the Motion. As such, pursuant to recognized standards of due process applicable to the instant proceeding,

Respondent's due process rights have been met and Respondent may not rely upon the same to overcome the applicable confidentiality provisions.

With respect to Respondent's allegation of selective enforcement, a *prima facia* showing must be made to support such a claim as was indicated in the Subpoena Order in the context of Respondent's discovery request. *See, e.g.,* People v. Tuck, 139 Cal. Rptr. 3d 407, 418 n. 4 (2012) (recognizing that an alleging party must make the necessary *prima facie* showing to justify discovery).

To expand upon this point, to support a claim of selective enforcement, a respondent bears the heavy burden of establishing, at least *prima facie*: 1) that, while others similarly situated have not generally been proceeded against because of conduct of the type forming the basis of the charge against respondent, respondent has been singled out for prosecution; and 2) that the government's discriminatory selection of respondent for prosecution has been invidious or in bad faith, i.e., based upon such impermissible considerations as race, religion, or the desire to prevent respondent's exercise of constitutional rights. *See* State v. Flynt, 407 N.E.2d 15, 17 (OH 1980), writ dismissed, 451 U.S. 619 (1981) (as cited in a medical board case: Brownlee v. State Med. Bd., 2013 WL 6021182, 2013-Ohio-4989).

Nevada articulates this standard in McDonald v. State, 477 P.3d 373 (Nev. App. 2020), which provides:

> To prevail on a selective prosecution claim the claimant must demonstrate that the prosecutorial policy had a discriminatory effect and it was motivated by a discriminatory purpose. United States v. Armstrong, 517 U.S. 456, 465 (1996). "A selective-enforcement claim requires essentially the same showing." United States v. Griffith, 928 F.3d 855, 866 (10th Cir. 2019). To establish a discriminatory effect[,] ... the claimant must show that similarly situated individuals ... were not prosecuted." United States v. Armstrong, 517 U.S. 456, 465 (1996). To show discriminatory purpose, a claimant must establish "that the decision-maker ... selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." Wayte, 470 U.S. at 610 (internal quotation marks omitted). "This standard is a 'demanding one.' " Griffith, 928 F.3d at 866. . . . Unless suspect classes are involved in the selective enforcement, the Equal Protection Clause is violated only if there is no rational basis to justify the selective enforcement. *See* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487-488 (1955).

In sum, "[s]elective enforcement is an equal protection term that applies when a law is selectively enforced based on an unjustifiably discriminatory classification such as race, religion, or some other arbitrary characteristic," nothing of which Respondent has alleged. Low Cost Pharmacy, Inc. v. Arizona State Bd. of Pharmacy, No. 1 CA-CV 07-0547, 2008 WL 2154793, at *9 (Ariz. Ct. App. May 20, 2008) (*citing* State v. Patton, 665 P.2d 587, 590 n. 6 (Ariz. App.1983) and Oyler v. Boyles, 368 U.S. 448, 456 (1962). It also remains that selective enforcement does not encompass mere selectivity of enforcement given that such selectivity has to be unconstitutionally discriminatory to be deemed to be a Constitutional violation. *See* State v. Howard, 337 S.E.2d 598, 601 (N.C. App. 1985) (*citing* People v. Utica Daw's Drug Co., 16 A.D.2d 12, 225 N.Y.S.2d 128, 4 A.L.R.3d 393 (1962)); *see also* People v. Toomey, 157 Cal. App. 3d 1, 12–13, 203 Cal. Rptr. 642 (Ct. App. 1984) ("'an equal protection violation does not arise whenever officials 'prosecute one and not [another] for the same act;' instead, the equal protection guarantee simply prohibits prosecuting officials from purposefully and intentionally singling out individuals for disparate treatment on an invidiously discriminatory basis.' 'Prosecutorial discretion permits the choice among possible defendants which to prosecute, whether to prosecute, and in what order to prosecute.'") (citations omitted).

Even further, as recognized in Williams v. State, 393 So. 2d 492, 494 (Ala. Crim. App. 1981), "the mere showing of selective enforcement of a statute, without more, is not constitutionally impermissible." Id. (*citing* Oyler v. Boles, 368 U.S. 448 (1962) for the proposition that the conscious exercise of some selectivity in enforcement is not in itself a constitutional violation; and, even though statistics might imply a policy of selective enforcement, it remains that the selection must be deliberately based upon an unjustifiable standard such as race, religion, or other arbitrary classification). The fact that some people escape prosecution under a statute is not a denial of equal protection unless selective enforcement of the statute is intentional or purposeful given that the determination to prosecute is within a prosecuting authority's discretion. *See* May v. People, 636 P.2d 672, 681–82 (Colo. 1981) (*citing* Yick Wo v. Hopkins, 118 U.S. 356 (1886); People v. District Court, 632 P.2d 1022 (Colo. 1981)).

Here, Respondent has made a blanket assertion that any and all information related to the Board's prosecution of such claims as those brought against Respondent should have to be produced "to ensure that the Board is not abusing its discretion by unfairly and selectively disciplining healthcare providers." Motion, p. 8, lines 4-9. Such an assertion does not address the relevant standards of selective enforcement, nor a mandated showing of unlawful discrimination, and is, therefore, insufficient to mandate the relief requested. As such, Respondent's Motion to Compel is DENIED.

DATED this 15th day of July 2022.

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 DENYING MOTION TO COMPEL addressed as follows:

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

Eric Joseph Pippi, PA-C
c/o Keith A. Weaver, Esq. and
Xiao Wen Jin, Esq.
6385 S. Rainbow Blvd, Ste 600
Las Vegas, NV 89118

DATED this 15th day of July, 2022.

Signature

Meg Byrd
Print

Legal Assistant
Title

Exhibit R

CONTRACT SUMMARY

(This form must accompany all contracts submitted to the Board of Examiners (BOE) for review and approval)

I. DESCRIPTION OF CONTRACT

1. Contract Number: **24012**

Amendment Number: **1**

Legal Entity Name: Law Offices of Charles B. Woodman

Agency Name: **BDC LICENSING BOARDS & COMMISSIONS**

Contractor Name: **Law Offices of Charles B. Woodman**

Agency Code: **BDC**

Address: **548 W. Plumb Lane, Suite B**

Appropriation Unit: **B015 - All Categories**

Is budget authority available?: **Yes**

City/State/Zip **Reno, NV 89509**

If "No" please explain: Not Applicable

Contact/Phone: Charles B. Woodman 775-786-9800

Vendor No.:

NV Business ID: NV20101166753

To what State Fiscal Year(s) will the contract be charged? **2021-2023**

What is the source of funds that will be used to pay the contractor? Indicate the percentage of each funding source if the contractor will be paid by multiple funding sources.

General Funds	0.00 %	**X**	Fees	**100.00 %**	**Licensure**
Federal Funds	0.00 %		Bonds	0.00 %	
Highway Funds	0.00 %		Other funding	0.00 %	

2. Contract start date:

a. Effective upon Board of Examiner's approval? **No** or b. other effective date **04/29/2021**

Anticipated BOE meeting date 08/2022

Retroactive? **No**

If "Yes", please explain

Not Applicable

3. Previously Approved Termination Date: **12/31/2022**

Contract term: **1 year and 336 days**

4. Type of contract: **Contract**

Contract description: **Woodman**

5. Purpose of contract:

This is the first amendment to the original contract which provides hearing officer services. This amendment extends the termination date from December 31, 2022 to March 31, 2023 and increases the maximum amount from $12,000 to $47,000 due to the continued need for these services.

6. CONTRACT AMENDMENT

		Trans $	Info Accum $	Action Accum $	Agenda
1.	The max amount of the original contract:	$12,000.00	$12,000.00	$12,000.00	Yes - Info
2.	Amount of current amendment (#1):	$35,000.00	$35,000.00	$47,000.00	Yes - Info
3.	New maximum contract amount:	$47,000.00			
	and/or the termination date of the original contract has changed to:	03/31/2023			

II. JUSTIFICATION

7. What conditions require that this work be done?

NRS 630.106 and NAC 630.470 authorize the Board to hire and utilize hearing officers to hold hearings regarding complaints filed pursuant to NRS 630.311. The purpose of this contract is to add a hearing officer to the Board's list of available hearing officers.

8. Explain why State employees in your agency or other State agencies are not able to do this work:

Hearing officers need to be independent from the Board staff in order to ensure due process for the respondents in the hearing.

9. Were quotes or proposals solicited? No

   Was the solicitation (RFP) done by the Purchasing Division? No

   a. List the names of vendors that were solicited to submit proposals (include at least three):

Not Applicable

   b. Soliciation Waiver: **Professional Service (As defined in NAC 333.150)**

   c. Why was this contractor chosen in preference to other?

   d. Last bid date: Anticipated re-bid date:

10. a. Does the contract contain any IT components? No

    b. Is the contract part of an IT investment project over $50,000? No

III. OTHER INFORMATION

11. Is there an Indirect Cost Rate or Percentage Paid to the Contractor?

    No If "Yes", please provide the Indirect Cost Rate or Percentage Paid to the Contractor

Not Applicable

12. a. Is the contractor a current employee of the State of Nevada or will the contracted services be performed by a current employee of the State of Nevada?

    No

    b. Was the contractor formerly employed by the State of Nevada within the last 24 months or will the contracted services be performed by someone formerly employed by the State of Nevada within the last 24 months?

    No

    c. Is the contractor employed by any of Nevada's political subdivisions or by any other government?

    No If "Yes", please explain

Not Applicable

13. Has the contractor ever been engaged under contract by any State agency?

    No If "Yes", specify when and for which agency and indicate if the quality of service provided to the identified agency has been verified as satisfactory:

Not Applicable

14. Is the contractor currently involved in litigation with the State of Nevada?

    No If "Yes", please provide details of the litigation and facts supporting approval of the contract:

Not Applicable

15. The contractor is not registered with the Nevada Secretary of State's Office because the legal entity is a:

    Sole Proprietor

16. a. Is the Contractor Name the same as the legal Entity Name?

    Yes

17. a. Does the contractor have a current Nevada State Business License (SBL)?

    Yes

18. Not Applicable

19. Agency Field Contract Monitor:

20. Contract Status:

    Contract Approvals:

Approval Level	User	Signature Date
Budget Account Approval	5522	07/18/2022 17:17:55 PM
Division Approval	5522	07/18/2022 17:17:59 PM
Department Approval	5522	07/18/2022 17:18:04 PM

Contract Manager Approval	5522	07/18/2022 17:18:07 PM
Budget Analyst Approval	hfield	07/20/2022 15:39:08 PM

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

FILED
SEP 11 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

ORDER SCHEDULING STATUS CONFERENCE

NOTICE IS HEREBY GIVEN that a status conference will be conducted for the above-referenced matter on **Thursday, September 12, 2024, at 1:30 p.m.**, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time, 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 shall be prepared to discuss the case status.

DATED this 11th day of September 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 SCHEDULING STATUS CONFERENCE addressed as follows:

Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

DATED this 11th day of September, 2024.

Meg Byrd
Signature

Meg Byrd
Print

Legal Assistant
Title

UNITED STATES POSTAL SERVICE

September 16, 2024

Dear Meg Byrd:

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Item Details

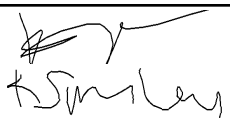
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Status Date / Time:	September 16, 2024, 12:51 pm
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Recipient Signature

Signature of Recipient:



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Washington, D.C. 20260-0004

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

FILED
SEP 12 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

ORDER CONTINUING STATUS CONFERENCE

NOTICE IS HEREBY GIVEN that a status conference set for September 12, 2024 is continued to **Thursday, September 19, 2024, at 11:00 a.m.**, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time, 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 shall be prepared to discuss the case status as well as agreed upon dates to continue the evidentiary hearing.

DATED this 12th day of September 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 CONTINUING STATUS CONFERENCE addressed as follows:

Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

9171 9690 0935 0243 8185 75

DATED this 12th day of September 2024.

Signature

Meg Byrd
Print

Legal Assistant
Title

UNITED STATES POSTAL SERVICE

October 7, 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 0243 8185 75**.

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Status Date / Time:	September 19, 2024, 3:22 pm
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Shipment Details

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Recipient Signature

Signature of Recipient:



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475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

FILED
SEP 20 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

SECOND ORDER CONTINUING STATUS CONFERENCE

A status conference for this matter was set for September 12, 2024, and was continued to September 19, 2024, to allow the parties and the hearing officer time to better grasp where this matter left off with the prior hearing officer, to facilitate a review of the June 4, 2024 hearing transcript, and to determine the impact, if any, of pending writs in other matters. With that now having been undertaken, there are two avenues for the case to proceed, which the parties are to consider and confer about: 1) the undersigned will consider the matter on the record as established to date and issue and order regarding whether and how the matter should proceed; or 2) the undersigned will consider the parties' positions on a stay pending adjudication of the writ(s), which are pending in the Second Judicial District Court and address the question of whether the Investigative Files compiled for matters such as this are discoverable. The parties shall be prepared to address the forgoing options at a status conference to be held on **Thursday,**

September 26, 2024 at 10:00 a.m. that will be held via a conference call. Unless directed otherwise prior to the scheduled date and time, 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 shall be prepared to discuss the case status as well as agreed upon dates to continue the evidentiary hearing should a stay not be agreed upon.

DATED this 19th day of September 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 SECOND ORDER CONTINUING STATUS CONFERENCE addressed as follows:

Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

DATED this 20th day of September 2024.

Signature

Meg Byrd
Print

Legal Assistant
Title

UNITED STATES POSTAL SERVICE

October 7, 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 0243 8187 28**.

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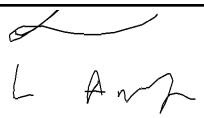
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Postal Product:	First-Class Mail®
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	Return Receipt Electronic

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Recipient Signature

Signature of Recipient:



Address of Recipient:

2110 E FLAMINGO RD STE
212, LAS VEGAS, NV 89119

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United States Postal Service®
475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

FILED
NOV 01 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

ORDER FOR MATTER TO PROCEED TO CONTINUED HEARING

A status conference for this matter was held on September 26, 2024, whereby the parties conferred with the undersigned hearing officer regarding their respective preferences for how this matter should proceed pending adjudication of a writ(s) pending before the Second Judicial District Court. The pending writ(s) has been filed by the Investigative Committee of the Nevada Board of Medical Examiners (the "IC"), which seeks a ruling establishing that its investigative files are confidential and, therefore, not discoverable. The parties were not in agreement with respect to whether this matter should proceed, which was the IC's preference, or whether it should be stayed pending a ruling on the writ(s), which was Respondent's preference.

Since the late September status conference, the Second Judicial District Court has ruled on the issue in case number CV24-00838, NEVADA STATE BOARD OF MEDICAL EXAMINERS, PETITIONER, VS. CHARLES WOODMAN, AS HEARING OFFICER OF THE

NEVADA STATE BOARD OF MEDICAL EXAMINERS, RESPONDENT, SAMUEL RODOLFO CHACON, M.D. INTERVENOR. A true and correct copy of the Order Granting Petition for Writ of Mandamus, filed October 7, 2024, is provided herewith as **Exhibit 1,** and establishes that only those portions of an investigative file that the IC intends to use at a formal hearing are discoverable, and that the investigative file remaining confidential is consistent with legislative intent and does not violate due process. With that, there is no outstanding issue of which undersigned is aware preventing this case from proceeding.

Where the case left off was in the midst of the evidentiary hearing. The June 4, 2024 transcript of the proceeding indicates that the IC had presented the testimony of its investigator, which was not fully presented, having been subject to cross-examination but cut short by timing and argument regarding the parties' respective positions about disclosure of the entirety of the IC investigative file. By and through the IC's investigator, Exhibits 1 (p. 80); 2 (pp. 83-85); 3 (pp. 88-89); and 4 (p. 92) were admitted and will remain admitted for purposes of a future hearing.

As happened with the IC investigator, testimony from IC witness Dr. Nicholas Spoerke was also cut short on cross-examination, with the hearing being suspended altogether by the hearing officer. By and through Dr. Spoerke's testimony, Exhibit 5 was admitted (p. 154) and will remain admitted for purposes of a future hearing.

Given the state of the record, undersigned being newly appointed, and neither witness' testimony having been completed, it is best to commence the hearing from the start, although undersigned would encourage the parties to discuss whether or not presenting further testimony from an investigator on behalf of the IC is necessary.[1] The parties shall confer about possible dates to recommence the hearing and, within ten (10) days of the date of this order, shall provide the undersigned hearing officer, via email, with three dates and times that both parties are available for a status conference. Once a date and time for a status conference is chosen by undersigned, an order will issue formally scheduling it.

At the status conference, the continued hearing will be scheduled to possible dates agreed upon ahead of time by the parties; the parties shall address whether they have reached consensus about an IC

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[1] If the parties agree that further presentation of testimony or evidence by the IC investigator is not necessary, undersigned will consider and rely upon the June 4, 2024, transcribed testimony already provided.

investigator providing additional testimony; and the parties shall address any other issues that may be relevant to proceeding to hearing.

DATED this 1st day of November 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 FOR MATTER TO PROCEED TO CONTINUED HEARING addressed as follows:

Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

9171 9690 0935 0255 7002 64

DATED this 1st day of November 2024.

MB

Signature

Meg Byrd

Print

Legal Assistant

Title

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EXHIBIT 1

EXHIBIT 1

FILED
Electronically
CV24-00838
2024-10-07 12:04:12 PM
Alicia L. Lerud
Clerk of the Court
Transaction # 10606977

Code: 3370

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF WASHOE

NEVADA STATE BOARD OF MEDICAL EXAMINERS,

Petitioner,

vs.

CHARLES WOODMAN, As Hearing Officer of the Nevada State Board of Medical Examiners,

Respondent.

SAMUEL RODOLFO CHACON, M.D.,

Intervenor.

Case No.: CV24-00838

Dept. No.: 9

ORDER GRANTING PETITION FOR WRIT OF MANDAMUS

The Court is in receipt of Petitioner NEVADA STATE BOARD OF MEDICAL EXAMINERS (hereafter "the Board") *Petition for Writ of Mandamus* filed April 17, 2024; Intervenor SAMUEL RODOLFO CHACON, M.D.'s (hereafter "Dr. Chacon") *Opposition to Petition For Writ of Mandamus* filed July 24, 2024[1]; and the Board's *Reply in Support of its Petition for Writ of Mandamus* filed August 2, 2024.

Upon review of the pleadings, the record, and evidence and argument presented, this Court finds good cause appearing to GRANT the Board's *Petition for Writ of Mandamus.*

[1] On July 9, 2024, this Court granted Dr. Chacon's *Motion to Intervene.* This *Motion* was subjected to additional legal briefing which therefor extended the appliable time in which the parties could litigate via motion practice the original *Petition for Writ of Mandamus.*

PROCEDURAL HISTORY AND FACTUAL BACKGROUND

On April 17, 2024, the Board filed its *Petition for Writ of Mandamus* against RESPONDENT CHARLES WOODMAN (hereafter "Respondent"), seeking a writ ordering the Respondent to rescind a Summary Prehearing Order filed April 11, 2024. The Summary Prehearing Order compelled the disclosure of the Board's Investigative Committee's (hereafter "IC") confidential investigative file. The writ requested by the Board is to prevent an alleged violation by the Investigative Committee regarding statutory provisions that allegedly establish that an investigative file is confidential and not discoverable, except under extremely narrow circumstances.

The underlying Administrative Case against Dr. Chacon was initiated by the Board upon the filing of an Order for Summary Suspension by the IC pursuant to NRS 630.326 on September 5, 2023. *See Pet.* Exhibit 1. Later, a four (4) count Formal Complaint was filed concurrently with the Order for Summary Suspension on September 5, 2023, alleging violations by Dr. Chacon of the Medical Practice Act ("MPA") related to his care and treatment of a patient. *See Pet.* Exhibit 2.

A Show Cause Hearing pursuant to NRS 630.326(2) then began on October 12, 2023, and was continued on December 18, 2023. The primary reason for the hearing was to determine if there was a reasonable basis to maintain the suspension pending the outcome of a formal hearing on the Formal Complaint. The summary suspension hearing was concluded on December 18, 2023, after Dr. Chacon called an expert witness supportive of his defenses and testified on his own behalf. On January 19, 2024, the Hearing Officer issued his *Finding Of Fact, Conclusions Of Law, And Recommendation To The Board On Continuation Of The Summary Suspension Of Dr. Chacon's License To Practice Medicine In Nevada Pending Hearing Of The Complaint On File* ("January 19, 2024, Recommendation"). *Oppo.* Ex. F.

On March 27, 2024, the IC filed its First Amended Complaint in the Administrative Case alleging eight (8) total counts for violations of the MPA. *See Pet.* Exhibit 6. On April 3, 2024, attorneys for Dr. Chacon requested that Respondent review their request to produce the IC's investigative file in an email to the Respondent and Counsel for the IC. Counsel for the IC renewed a previous objection to the request for the release of the investigative file, stating that such a file is confidential pursuant to NRS 630.336(4) and NRS 622A.330(2).

On April 10, 2024, a prehearing conference was conducted pursuant to NAC 630.465(1) in preparation for the formal hearing addressing the First Amended Complaint in the Administrative Case, set to begin on May 13, 2024, at 9:00 a.m. Pursuant to NAC 630.465(3) the prehearing conference is the last day to exchange documents and witness lists. Additionally, a prehearing conference statement identifies witnesses, their qualifications, and a summary of their testimony, as well as a list of the documents that may be introduced at the hearing, and any documents or witnesses not provided to each party by the time of the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown or required for rebuttal evidence. *See* NAC 630.465(3).

It is alleged that within Dr. Chacon's prehearing conference statement, "Exhibit 24" is listed as the IC's investigative file to be provided by the IC in allegedly direct conflict with governing statutes. It is further alleged the Respondent unlawfully issued a "Summary Prehearing Order" in the Administrative Case in the late afternoon of April 11, 2024, which ordered the IC to produce any information not yet produced as requested by Dr. Chacon's counsel by no later than Wednesday, April 17, 2024. It is alleged that such an order is in contradiction of NRS 622A.330(2), and NRS 630.336(4). The instant *Petition* followed.

LEGAL AUTHORITY

Pursuant to NRS 34.160, "a writ of mandamus may be issued to compel the performance of an act of a person." Such a writ is available from a district court to "compel the performance of an act which the law especially enjoins as a duty resulting from an office." NRS 34.160; *Int'l Game Tech., Inv. v. Second Judicial Dist. Court*, 124 Nev. 193, 197 (2008); *Salaiscooper v. Eighth Judicial Dist. Court*, 117 Nev. 892 (2001). However, the issuance of a writ of mandamus to compel the action of an officer must be for a duty resulting from the office and the action itself must be required by law. *State ex rel. McGuire v. Waterman,* 5 Nev. 323 (1869). The writ of mandamus should never be granted in anticipation of an omission of duty; it should only issue after actual default of the duty. *Piper v. Gracey,* 11 Nev. 223 (1876). Furthermore, "[w]rit relief is an extraordinary remedy that is only available if a petitioner does not have a plain, speedy and adequate remedy in the ordinary course of law." *In re William J. Raggio Fam. Tr.*, 136 Nev. 172, 175, 460 P.3d 969, 972 (2020); *see also* NRS 34.170. Thus, the party requesting a writ must show that it is entitled by law to the relief it seeks. *State v. Daughtery,* 48 Nev. 299 (1924).

DISCUSSION

In the instant case, the Board seeks for this Court to issue a Writ of Mandamus compelling Respondent to rescind his Summary Prehearing Conference Order in the Administrative Case, which required the Investigative Committee ("IC") to produce its investigative file.[2] Dr. Chacon asserted within his *Opposition* that the plain language of NRS 630.336(5) is unambiguous entitling him to the investigative file, and that the initiation of the disciplinary action precluded confidentiality. Additionally, Dr. Chacon alleges that confidentiality of the investigative file is not absolute, and that Due Process is satisfied through production of investigative files. However, the Court finds that such arguments by Dr. Chacon are belied by the plain language of the applicable statute, and Nevada Jurisprudence.

I: The Investigative Files Are Confidential

As this matter involves an issue of statutory interpretation, this Court must first turn to the statute in question and the language therein. It is recognized that the goal of statutory interpretation "is to give effect to the Legislature's intent." *Doolin v. Dep't of Corr.,* 134 Nev. 809, 811 (Nev. App. 2018). To ascertain legislative intent, a Court must begin with the text of the statute to determine its plain meaning and apply any "clear and unambiguous" language "as written." *Locker v. State*, 138 Nev. Adv. Op. 62, 516 P.3d 149, 152 (2022). In so doing, the Court needs to "avoid statutory interpretation that renders language meaningless or superfluous." *Id.*

For these reasons, "when a statute 'is clear on its face, a court cannot go beyond the statute in determining legislative intent." *State v. Lucero*, 127 Nev. 92, 95, 249 P.3d 1226, 1228 (2011) (internal citations omitted). Moreover, "Where the language of a statute is plain and unambiguous, and its meaning clear and unmistakable, there is no room for construction, and the courts are not

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[2] As a matter of law, this Court finds that the requested relief is properly considered by this Court. The Respondent is engaging in a statutorily granted function, and therefore, the exercise of power to order the investigative committee in the underlying matter to release its investigative file in alleged violation of NRS 630.336(4) and NRS 622A.330(2) leaves the Board and the investigative committee without an adequate remedy under those chapters to review the Respondent's decision prior to the order requiring disclosure of confidential information. *See In re William J. Raggio Fam. Tr.*, 136 Nev. 172, 175 (2020); *see also State v. Dist. Ct. (Armstrong),* 127 Nev. 927, 931-32 (2011) (finding a manifest abuse of discretion in the context of a writ of a mandamus occurs where there is a clearly erroneous interpretation or application of the law).

permitted to search for its meaning beyond the statute itself." *Erwin v. State*, 111 Nev. 1535, 1538–39, (1995) (*citing Charlie Brown Constr. Co. v. Boulder City*, 106 Nev. 497, 503 (1990)).

Likewise, in *Dutchess Business Services Inc. v. Nevada State Board of Pharmacy*, the Supreme Court of Nevada recognized that "[w]hen the language of a statute is plain and unambiguous, and its meaning is clear and unmistakable, there is no room for construction, and the courts are not permitted to search for its meaning beyond the statute itself," but instead will "[n]onetheless *defer to an agency's interpretation of its governing statutes or regulations if the interpretation is within the language of the statute*." 124 Nev. 701, 709 (2008) (emphasis added). In analyzing NRS 630.336 (the statute at issue), the Nevada Supreme Court has held that the plain language of NRS 630.336 is unambiguous and that the Board's interpretation of NRS 630.336 was entitled to deference by a reviewing court. *Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 714-15 (2018).

It is important to note that the Nevada Supreme Court has recognized that when "the words of the statute have a definite and ordinary meaning," a court will not look beyond the plain language of the statute, "unless it is clear that this meaning was not intended." *Harris Assocs. v. Clark Cnty. Sch. Dist.*, 119 Nev. 638, 641–42 (2003) (internal citations omitted) (emphasis added). Critically, the Nevada Supreme Court has provided some guidance to district courts, holding that "When construing an ambiguous statutory provision, this court determines the meaning of the words used in a statute by 'examining the context and the spirit of the law or the causes which induced the Legislature to enact it [and] the entire subject matter and policy may be involved as an interpretive aid.' " *Leven v. Frey*, 123 Nev. 399, 405 (2007) (internal citations omitted).

Correspondingly, the Supreme Court has held a district court must "strive to the extent possible to interpret a statute in a matter that avoids 'unreasonable or absurd result[s]...'" *Platte River Ins. Co. v. Jackson*, 137 Nev. 773, 778 (2021) (*citing Great Basin Water Network*, 126 Nev. at 196, 234 P.3d at 918); *see also Allstate Ins. Co. v. Fackett*, 125 Nev. 132, 138, (2009); *Young v. Nev. Gaming Control Bd.*, 136 Nev. 584, 588 (2020) (equating an absurd result with one not intended by the Legislature). If the "literal, plain meaning interpretation" leads to an unreasonable or absurd result, this court may look to other sources for the statute's meaning. *Newell v. State*, 131 Nev. 974,

977 (2015). In its analysis of an ambiguous statutory provision, a reviewing Court is bound to ensure that the statute is interpreted in accordance "with what reason and public policy would indicate the legislature intended." *Id.*

As previously recognized, the statue in question is NRS 630.336. The primary issue within this matter, is the alleged distinction between subsection NRS 630.336(4) relied on by the Board, and subsection NRS 630.336(5) relied on by Dr. Chacon. The plain language of NRS 630.336(4) and (5) is as follows:

> 4. Except as otherwise provided in subsection 5 and NRS 239.0115, a complaint filed with the Board pursuant to NRS 630.307, all documents and other information filed with the complaint and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are confidential.
>
> 5. The formal complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose discipline are public records.

NRS 239.0115, as referenced in NRS 630.336(4), creates an exception to the strict confidentiality in NRS 630.366(4) when it allows a person to ask the District Court for permission to obtain the otherwise confidential investigative file after thirty (30) years have passed since the initiation of the investigation.

In addition to the plain language of NRS 239.0115, the legislative history demonstrates that the confidentiality imposed by NRS 630.336(4) was a paramount concern, and that any exception to the confidentiality imposed therein was to be extremely limited. Of import, when the bill enacting NRS 239.0115 was heard, the Nevada State Archivist noting the confidentiality of an investigative file, testified:

> We are looking at a record being closed forever and no one seeing it or it being opened too soon. We do not want individual rights of privacy compromised or third-party concerns, particularly correction or state mental institute records. This could mean psychiatrists, doctors, snitches or people, other than the media, seeing the record and bringing personal vendettas against people if they get the information too soon. . . . With this statute, we tried to include a period that addresses both rights and access to public information for researchers and others without compromising rights of individuals in any acceptable level of privacy. If records were available at ten years, it could raise issues of individuals being compromised with information in these records.

Minutes of the Senate Committee on Government Affairs, (February 26, 2007, Page 27) (emphasis added).

Such explicit rational by the legislature distinctly demonstrates that the legislature contemplated the tension between patient confidentiality and the access to public information. Ultimately, the legislature struck a balance between the two competing forces within NRS 239.0115 by instituting its 30-year time limitation.

Additionally, the Nevada Supreme Court has also addressed the tension between patient confidentiality and the right to access to public information; ultimately holding that patient privacy was vital and that it would defer to the Board's reasonable interpretation of the plain language of NRS 630.336(4). *See Sarfo*, 134 Nev. at 714. The Court also reasoned that such deference to the Board's interpretation of NRS 630.336(4) was supported by the fact that disclosing the investigative file may make patients hesitant to report malpractice without the protection of confidentiality, which cut against public policy. *See Sarfo*, 134 Nev. at 714.

As such, the plain language of NRS 630.336(4) unambiguously ensures that all documents and other information filed with the complaint and all documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action are to be confidential. The plain language of the statute is likewise supported by the statutory history of the statute and its corresponding sections, as well as Nevada jurisprudence. As such, this Court finds that the investigative file in question is presumed to be confidential unless one of the very narrow exceptions applies such as those enumerated in NRS 630.336(5) as the 30-year window has not yet passed as required by NRS 239.0115.

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Significantly, NRS 630.336(5) addresses the information from the investigative file that is introduced as evidence at the hearing in the contested case and holds that such information is not confidential if such information is used within a formal complaint hearing. The Board conceded that pursuant to NRS 630.336(5), when investigative materials are introduced as evidence in a formal complaint proceeding, they become part of the public record (and are no longer confidential) as they will be considered by the adjudicating members of the Board when determining whether a statutory violation has occurred and if discipline should be imposed pursuant to NRS 630.352. (emphasis added). However, the Board countered by emphasizing that such an exception did not apply in this matter as the proceedings have not reached the "formal" stage as alleged by Dr. Chacon. The Court finds such an assertion by the Board to be supported by Nevada law.

As an initial matter, NRS 630.352(1) establishes the procedure by which the Board must deliberate and consider any findings of fact and conclusions of law following the hearing to adjudicate disciplinary cases and render discipline in accordance with NRS 630.352(4), which outlines the actions the Board can take against a licensee. Additionally, the Board concedes that the record of the formal complaint is reviewed and discussed in a public meeting under Nevada's Open Meeting Law. *See* NRS 622.320(2) (Board decisions related to disciplinary action are subject to the provision of NRS 241.020); *see also* NRS 630.336(2) (formal hearings on any charges heard by the Board, records of formal hearings, and orders or decisions of the case are public).

The Board also recognized that the documents and information considered by the Board when determining whether to impose discipline include those documents from the investigative file admitted at the hearing on a formal complaint, and that such are not confidential due to such actions being public. However, the Board asserted that the information reviewed by the adjudicating Board members does not include any of the IC's investigative file, and that such information is not used in prosecuting the violations of NRS 630 because they are not part of the record of the formal complaint as required by the plain language of 630.336(5).

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Indeed, the legislature contemplated such a distinction in 2011 when it amended 630.336(5) to include the word "formal" within the statute. During the 2011 Legislative session, the Board sought to amend NRS 630.336(5) to clarify the confidentiality distinction between a complaint filed by a person pursuant to NRS 630.307 and a complaint filed pursuant to NRS 630.399. Board Executive Director Cooper noted in his testimony that, "the investigative complaint is a confidential report that starts an investigation...[and that] this information needs to remain confidential to prevent unscrupulous and nefarious competitors from loading up complaints on their competitors." Minutes of the Senate Committee on Commerce, Labor and Energy, (February 23, 2011, Page 29). The word "formal" in NRS 630.336(5) was added to clarify that the formal complaint and other documents related thereto are public records while the investigative file, which includes the complaint filed pursuant to NRS 630.307, remains confidential unless the Board intends to introduce certain documents in the investigative file into evidence during a hearing on a formal complaint. The clarification is consistent with NRS 630.339 which allows for filing of a formal complaint to prosecute a violation of the MPA.

As such, based on the confidentiality distinction between the complaint filed by a person to initiate an investigation and the formal complaint filed to initiate disciplinary action by the adjudicating members of the Board, a licensee is entitled only to the documents from the investigative file that the prosecutor intends to use at the hearing after a formal complaint is filed and the licensee makes a request for such documents under NRS 622A.330(1) and as otherwise required by NAC 630.465.

In this case, Dr. Chacon's license to practice medicine was suspended pursuant to NRS 630.326 which requires a show-cause hearing to determine if the licensee will remain suspended pending the conclusion of a formal complaint against the licensee which must be filed no later than thirty (30) days following the issuance of the suspension. See NRS 630.326(2) (The Board shall hold a hearing not later than 60 days after the date on which the order is issued to determine whether a reasonable basis exists to continue the suspension of the license pending the conclusion of a hearing to consider a formal complaint against the licensee).

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The statutory authority by which the IC suspended Chacon's license to practice medicine is clearly different from the formal discipline contemplated in NRS 630.336(5). NRS 630.352(4)(d) allows the Board to suspend a license, but only following a formal hearing and the adjudication by the Board that the licensee has violated the medical practice act. Moreover, NRS 630.352(1) precludes any member of the IC, who participated in any determination instituting a formal complaint, from adjudicating the formal complaint and imposing discipline. The record related to the summary suspension is part of the record which will be reviewed by the Board's adjudicating members following the prosecution of the formal complaint related to the summary suspension.

Due to these reasons, the Court finds that to read NRS630.336(5) to eliminate the confidentiality of the investigative file delineated in NRS 630.336(4) when such information contained within the investigative file is not being used in a formal prosecuting action is not the legislatures' intent. Moreover, to grant Dr. Chacon's discovery request in this case would potentially open the door to theoretically allow any person to request, and be entitled to, a complete copy of the investigative file pursuant to NRS 239.0107. Such a result is legally absurd, as it would allow extremely private healthcare-related information to be widely accessed with almost little to no oversight, an outcome that the legislature was attempting to avoid.

As such, this Court finds that the plain language of NRS 630.336(4) mandates that the IC's investigative file is confidential. The Court also finds that Dr. Chacon is not able to access the investigative file as there has not been a formal proceeding against him as required by NRS 630.336(5) to potentially negate the presumption of confidentiality. Such a finding is consistent not only with the plain language of the applicable statute, but also supported by the Board's interpretation of the statue and the applicable legislative history. *See Sarfo v. Bd. of Med. Examiners*, 134 Nev. 709, 714-15 (2018). Therefore, this Court hereby GRANTS the Board's *Petition for Writ of Mandamus.*

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II: Due Process Does Not Require Disclosure of the Investigative File

The Board conceded that Dr. Chacon is entitled to due process in a "Formal Board Disciplinary Proceedings." *Reply*, pg. 9:11 (*citing Dutchess Bus. Servs., Inc. v. Nevada State Bd. of Pharmacy*, 124 Nev. 701, 711 (2008) ("Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply.")). Additionally, the Nevada Supreme Court has explained that in an administrative proceeding, "it is the opportunity to prepare a defense that defines due process." *Id.* at 712 (*citing Nevada State Apprenticeship Council v. Joint Apprenticeship & Training Comm.*, 94 Nev. 763, 765 (1978)). Thus, a process that ensures that a licensee is noticed of the charges against him and the factual bases underlying them, and where the administrative body follows its established procedural guidelines, provides the required due process. *See id.* at 711-12.

Accordingly, the Court finds that the Board has complied with all established procedural guidelines and that Dr. Chacon was provided due process. *See id.* First, the charges against Dr. Chacon are factually alleged in accordance with NRS 630.339(1) in the First Amended Complaint served on March 27, 2024. Additionally, a Prehearing Conference on this matter was held on April 10, 2024. Prior to the conference, the IC filed its Prehearing Conference Statement on April 5, 2024, and Chacon filed his Prehearing Conference Statement on April 10, 2024, and all documents were exchanged in accordance with NAC 630.465. As such, Chacon has received adequate due process protections to defend the IC's charges for violations of NRS Chapter 630. *Id.* at 712.[3]

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[3] Additionally, unfettered pre-hearing discovery is disfavored by the Nevada Supreme Court. *See Resnick v. Nevada Gaming Commission*, 104 Nev. 60 (1988). Within *Resnick*, the Supreme Court held that a petitioner who was seeking the entire investigative file by the State Gaming Control Board regarding his license suspension was not entitled to the investigative report, but instead was afforded due process as he had the right to call, examine, cross-examine, and impeach witnesses during the applicable hearing. Importantly the Supreme Court noted that "[i]f the legislature intended an applicant to have access to the Board's report or to otherwise be entitled to conduct discovery, it could have so specified. Therefore, Resnick's argument, that NRS 463.313 should be interpreted to allow pre-hearing discovery, was without merit." *Id.* at 65. Much like the statute being analyzed within *Resnick*, NRS 630.336 does not entitle Dr. Chacon to unfettered discovery, as such discovery was not specified within NRS 630.336. To the contrary, NRS 630.336 holds that the investigative file is confidential unless relied upon within a formal proceeding. However, such a proceeding has not yet happened within this matter as set forth in detail above. Moreover, Dr. Chacon is entitled to o call, examine, cross-examine, and impeach witnesses during his disciplinary hearing. *See* NRS 622A.380. Finally, a speculative deprivation of due process claim is not ripe for consideration in a prehearing motion. *Resnick*, at 66 *(citing Doe v. Bryan*, 102 Nev. 523, 525 (1986) (Nevada has a long history of requiring an actual justifiable controversy as a predicate to judicial relief... [and] litigated matters must present an existing controversy, not merely the prospect of a future problem.)).

CONCLUSION

Due to the above analysis and findings, IT IS HEREBY ORDERED that the Board's *Petition for Writ of Mandamus* is hereby GRANTED.

IT IS FURTHER ORDERED that Respondent is to rescind his Summary Prehearing Conference Order in the Administrative Case requiring the Investigative Committee to produce its entire investigative file, as such an Order cut against Nevada Law.

IT IS SO ORDERED.

DATED this 7th day of October 2024.

DISTRICT JUDGE

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of the Second Judicial District Court of the State of Nevada, County of Washoe, and I electronically filed the foregoing with the Clerk of the Court electronic filing system, which will send notice of electronic filing to the following:

CHARLES WOODMAN, ESQ. for CHARLES B. WOODMAN
ERIC STRYKER, ESQ. for SAMUEL CHACON, MD
IAN CUMINGS, ESQ. for NEVADA STATE BOARD OF MEDICAL EXAMINERS

DATED this 7th day of October 2024.

Judicial Assistant

UNITED STATES POSTAL SERVICE

November 18, 2024

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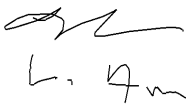
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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

Status Hearing: **November 25, 2024 @ 2:00 p.m**

FILED

NOV 15 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

ORDER SCHEDULING STATUS CONFERENCE

NOTICE IS HEREBY GIVEN that a status conference will be conducted for the above-referenced matter on **Monday, November 25, 2024, at 2:00 p.m.**, and will be held via a conference call. Unless directed otherwise prior to the scheduled date and time, 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 shall be prepared to discuss the case status.

DATED this 15th day of November 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 SCHEDULING STATUS CONFERENCE addressed as follows:

Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

9171 9690 0935 0255 7005 61

DATED this 15th day of November 2024.

Signature

Meg Byrd
Print

Legal Assistant
Title

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

Hearing: **April 3-4, 2025, commencing each day @ 8:30 a.m.**

FILED

NOV 26 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Vomall

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

ORDER SCHEDULING CONTINUED EVIDENTIARY HEARING

NOTICE IS HEREBY GIVEN that the hearing previously commenced for this matter on June 4, 2024, is continued to **April 3, 2025 through April 4, 2025**, starting each day at 8:30 a.m. The parties, their counsel, 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, and the IC will make accommodations for witnesses not appearing in person to appear remotely.

As addressed during the November 25, 2024 status conference with the parties, neither party intends to recall IC Investigator Monica Gustafson despite her testimony having been cut short on cross-examination. As previously ordered, Exhibit 1 (June 4, 2024 Hearing Transcript ["HT"] p. 80); Exhibit 2 (HT pp. 83-85); Exhibit 3 (HT pp. 88-89); and Exhibit 4 (HT p. 92), which were admitted by and through the IC Investigator, will remain admitted for purposes of the continued hearing.

IC witness Dr. Nicolas Spoerke also commenced testifying but, similar to the IC Investigator, his testimony was cut short on cross-examination. While direct testimony was presented, as indicated in a prior order, given the state of the record and undersigned being newly appointed, Dr. Spoerke's testimony shall begin a new; however, Respondent may cite to and question Dr. Spoerke regarding his June 4, 2024 testimony as preserved by the June 24, 2024 Hearing Transcript for purposes of impeachment or for any other appropriate purpose.

Prior to the hearing, the parties are expected to confer about exhibits and stipulate to admission as they may agree, as well as to confer about facts and stipulate to any facts that need not be proven up through formal presentation of evidence.

Following the formal 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 hearings 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 decisions. *See* NAC 630.470.

Should the parties deem a status conference necessary prior to the continued evidentiary hearing, 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.

Both parties shall keep the undersigned hearing officer apprised of each issue that has been resolved by negotiation or stipulation or of any other change in the status of this case.

DATED this 25th day of November 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 SCHEDULING CONTINUED EVIDENTIARY HEARING addressed as follows:

Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

9171 9690 0935 0255 7007 21

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq. and
Amanda E. Rosenthal, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

DATED this 26th day of November 2024.

Meg Byrd
Signature

Meg Byrd
Print

Legal Assistant
Title

UNITED STATES POSTAL SERVICE

December 5, 2024

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BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

FILED

JAN 13 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

NOTICE OF CHANGE OF FIRM

PLEASE TAKE NOTICE that Patricia Egan Daehnke and Amanda E. Rosenthal, counsel for Respondent Annabel Elizabeth Barber, M.D., have changed firms from COLLINSON, DAEHNKE, INLOW & GRECO to **DRR LAW GROUP**. Email addresses are now as follows:

Patricia Egan Daehnke: pdaehnke@drrlawgroup.com

Amanda E. Rosenthal: arosenthal@drrlawgroup.com

The firm address and telephone/facsimile numbers remain unchanged.

Dated: January 13, 2025

DRR LAW GROUP

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

DRR LAW GROUP
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

CERTIFICATE OF SERVICE

I hereby certify that on this 13th day of January, 2025, a true and correct copy of **NOTICE OF CHANGE OF FIRM** was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Patricia Halstead, Esq. 615 S. Arlington Avenue Reno, NV 89509 phalstead@halsteadlawoffices.com

By */s/ Lacey Ambro*
An employee of DRR LAW GROUP

DRR LAW GROUP
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED

MAR 2 6 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

RESPONDENT ANNABEL ELIZABETH BARBER, M.D.'S SUPPLEMENTAL PREHEARING CONFERENCE STATEMENT

COMES NOW, Respondent Annabel Elizabeth Barber, M.D. by and through his counsel of record, and hereby submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Notice and Order Rescheduling Pre-Hearing and Hearing filed on February 29, 2024.

List of Witnesses

Respondent Dr. Barber lists the following witnesses whom she may call at the hearing on the charges in the Complaint against her filed herein.

A. Annabel Elizabeth Barber, M.D.

Dr. Barber is expected to testify regarding the care and treatment provided to Patient A as well as the facts and circumstances surrounding the allegations in the Complaint. Dr. Barber's qualifications are set forth in her Curriculum Vitae.

B. Arnold Baskies, M.D.

Dr. Baskies is a board-certified general surgeon and is expected to testify regarding the care and treatment provided to Patient A, as well as standard of care and causation and the allegations in the Complaint. Dr. Baskies' qualifications are set forth in his Curriculum Vitae.

///

///

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2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL (702) 979-2132 | FAX (702) 979-2133

C. Maxwell Vest, M.D.

Dr. Vest was the assistant surgeon during Patient A's February 22, 2019 surgery. Dr. Vest is expected to testify regarding the care and treatment provided to Patient A as well as the facts and circumstances surrounding the allegations in the Complaint.

D. All witnesses identified by the Investigative Committee of the Nevada State Board of Medical Examiners in its prehearing conference statement and any amendments, revisions or supplements thereto.

Dr. Barber reserves the right to amend and supplement this list as necessary as this case progresses.

List of Exhibits

Respondent Dr. Barber lists the following exhibits she may introduce at the hearing on the charges and complaint against her. **New items appear in bold font.**

1. Nevada State Board of Medical Examiners inquiry letter dated October 28, 2019, bates Barber 000001-000002.

2. Dr. Barber's response to the Nevada State Board of Medical Examiners inquiry letter dated November 15, 2019, bates Barber 000003.

3. Patient A's medical records from UNLV Medicine, previously provided to the Nevada State Board of Medical Examiners with Dr. Barber's response to the inquiry letter, bates Barber 000004-000046.

4. Patient A's January 15, 2019 CT Abdomen Pelvis Without Contrast from Desert Radiology, bates Barber 000047.

5. Patient A's Las Vegas Surgery Center medical records, bates Barber 000048-000096.

6. Complaint filed on November 17, 2023, bates Barber 000097-000101.

7. Dr. Barber's Answer to Complaint filed on December 12, 2023, bates Barber 000102-000109.

8. Annabel Barber, M.D.'s Curriculum Vitae, bates Barber 000110-000129.

9. Arnold Baskies, M.D.'s Curriculum Vitae, bates Barber 000130-000144.

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2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

10. Maxwell Vest, M.D.'s qualification information from the Nevada State Board of Medical Examiners, bates Barber 000145-000148.

11. Complaint filed in case 22-11660-1 on September 20, 2022, bates Barber 000149-000153.

12. Order of dismissal without prejudice, filed on November 16, 2023, bates Barber 000154.

13. Patient A's January 15, 2019 CT Abdomen Pelvis Without Contrast films from Desert Radiology, ~~to be requested through the Board and produced upon receipt.~~

14. Correspondence, certificate of custodian of records, radiology report and Patient A's January 15, 2019 CT Abdomen Pelvis Without Contrast films from Desert Radiology, in response to Subpoena Duces Tecum, bates labeled Barber 000155-000158, available for download at the following OneDrive link: https://collinsonlaw-my.sharepoint.com/:f:/g/personal/lacey_ambro_cdiglaw_com/EoClvmPiQYxIpHDAuCwXAnUB2eRBS-W23xsremZnqoBAHA?e=USYifK

Respondent Dr. Barber reserves the right to use any exhibits relied upon or identified by the Investigative Committee of the Nevada State Board of Medical Examiners and further reserves the right to amend and supplement this list to include any additional documents as required.

Dated: December 13, 2024

COLLINSON, DAEHNKE, INLOW & GRECO

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

COLLINSON, DAEHNKE, INLOW & GRECO
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL (702) 979-2132 | FAX (702) 979-2133

CERTIFICATE OF SERVICE

I hereby certify that on this 13th day of December, 2024, a true and correct copy of **RESPONDENT ANNABEL ELIZABETH BARBER, M.D.'S SUPPLEMENTAL PREHEARING CONFERENCE STATEMENT** was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Patricia Halstead, Esq. 615 S. Arlington Avenue Reno, NV 89509 phalstead@halsteadlawoffices.com

By */s/ Lacey Ambro*
An employee of COLLINSON, DAEHNKE, INLOW & GRECO

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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 the Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.,** **Respondent.**	**Case No.: 23-11660-1**

FILED
SEP 15 2025
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby requests reconsideration of the findings and recommendations of the Hearing Officer pursuant to NRS 622A.390(1)(b).

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

On November 17, 2023, the IC filed a Complaint charging Respondent with: Count I, a violation of NRS 630.301(4), Malpractice (Malpractice Count); and Count II, a violation of NRS 630.3062(1)(a), Failure to Maintain Timely, Legible, Accurate, and Complete Medical Records (Records Count).

The formal hearing of the Complaint was initially conducted on June 4, 2024, and was held before a different hearing officer. Appointment of a new hearing officer took place, and a new hearing date was scheduled of April 3, 2025, and April 4, 2025. The formal hearing was held on April 3 and 4 and then continued again to April 10, 2025, since the hearing had not concluded in time on April 4, 2025. The hearing was held at the Nevada State Board of Medical Examiners' Reno office, with counsel for the Investigative Committee of the Board Donald K. White, and Respondent's counsel Patricia Egan Daehnke, Esq. appearing in person on behalf of the Respondent. The final day of the hearing, April 10, 2025, was held remotely by and through

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

internet-based audio-visual communications (Zoom) by consent of the parties. The Hearing Officer issued a Synopsis of Record (Synopsis) pursuant to NAC 630.470(8) and the Synopsis was filed August 29, 2025. In pertinent part, the Hearing Officer submits that the burden had not been met as to Count I alleged in the Complaint. Synopsis at 14:11–12. Respectfully, the IC asserts error in the Synopsis with respect to the malpractice count and further asserts that this error constitutes grounds for the Hearing Officer to reverse her findings with respect to the malpractice count in the Synopsis. *See* NRS 622A.390(5)(b).

Accordingly, the IC requests the Hearing Officer reconsider her assessment and recommendation in the Synopsis with respect to Count I and to issue an amended Synopsis.

II. LEGAL ARGUMENT

NRS 622A.390(1)(b) provides in part that 1. [a]fter the close of the hearing, a party may file only the following motions: (b) [a] motion requesting reconsideration of the findings and recommendations of the hearing panel or officer or the final decision of the regulatory body. NRS 622A.390(5)(b) provides in part that [e]rror in the hearing or in the findings and recommendations or the decision that would be grounds for reversal of the findings and recommendations or the decision. Therefore, this motion is timely and made pursuant to NRS 622A.390.

NRS 233B.121(2)(c) and (d) require that the IC's notice prior to a hearing provide Respondent with a reference to the statutes and regulations involved and provide "[a] short and plain statement of the matters asserted." In the instant matter, Respondent was on notice that the IC alleged both the Malpractice Count and the Records Count. Further, NRS 233B.121(9) and NRS 233B.125 require that the Board's findings of facts and decisions be based on a preponderance of the evidence. The IC respectfully asserts that Respondent was on notice that the IC asserted that she had violated NRS 630.301(4) and that this violation was proven at the hearing by a preponderance of evidence.

NRS 233B.0375 defines preponderance of the evidence as evidence that enables a trier of fact to determine that the existence of the contested fact is more probable than the nonexistence of the contested fact. Regardless of whether the IC provided any unsolicited supporting

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documentation, the IC met this burden and proved its case by a preponderance of the evidence. The Hearing Officer states that "the IC relied solely upon Dr. Spoerke's opinion that, with all her experience, Respondent should have stopped proceeding laparoscopically before the midline entry and done an open surgery. Respondent's experience, however, is, in some weeks, ten laparoscopic hernia repairs, versus Dr. Spoerke having done five to ten laparoscopic hernia repairs in his career." Synopsis at 12:18-22. What this statement by the Hearing Officer omits is that Dr. Nicholas Spoerke has done hundreds of laparoscopic surgeries for other ailments in the abdomen.

Tr. 142:6–143:10. His experience in doing laparoscopic surgeries was well documented and to which he testified under oath. On the other hand, the Hearing Officer rather took Respondent's word for it during her testimony, "that she can frequently perform a successful laparoscopic hernia repair surgery despite a person having had a lot of prior abdominal surgery in that she can often times locate an entry point with less scarring where it is safe to proceed." Synopsis at 12:23-25. Respondent's statement was uncorroborated and self-serving.

The Hearing Officer points out that the IC's peer reviewer, Dr. Spoerke, did not provide any literature to corroborate his opinion that this was malpractice. Put simply, there is nothing that requires the IC's peer reviewer to provide literature to back up his opinion. His testimony alone, if convincing, can meet the required burden of proof which is a preponderance of the evidence. The IC's peer reviewer testified that he has read thousands of pages in all kinds of areas, he undisputedly has vast experience in both open and laparoscopic surgeries, and he testified how it was predictable that there was no visualization of Patient A's left inguinal hernia due to his medical history of multiple abdominal surgeries that cause scarring, starting when he was born with an omphalocele. It was not necessary to present literature, nor was the IC asked to present any literature to support the peer reviewer's opinion.

Dr. Spoerke's veracity as a witness, not whether he read and could recite other literature, should be the focus of the Hearing Officer per NAC 630.470(8). No one, not the Respondent, not her expert, and not her counsel, had asked to see any literature before or during the hearing.

NAC 630.470(8) provides in part that the hearing officer or panel of members of the Board

conducting a hearing shall:

(a) Submit to the Board a synopsis of the testimony taken at the hearing; and

(b) Make a recommendation to the Board on the veracity of witnesses if there is conflicting evidence or the credibility of witnesses is a determining factor.

Nowhere in the Synopsis has the Hearing Officer made a recommendation to the Board on the veracity of witnesses, particularly Dr. Spoerke, when, clearly, there was conflicting evidence, and the credibility of witnesses was a determining factor. Again, all the Hearing Officer put forth as the reason that the IC did not prove by a preponderance of the evidence that Respondent committed malpractice was because the IC and Dr. Spoerke did not provide medical literature. Despite quoting and referring to Dr. Spoerke in the Synopsis, the Hearing Officer does not comment on his veracity as a witness.

The Hearing Officer also spends some time contemplating whether the bowel perforation was a known complication and/or whether Respondent should be found responsible for malpractice because of the bowel perforation. The IC did not charge Respondent with malpractice as a result of the bowel perforation. The malpractice charge in the Complaint points to the Respondent's incorrect decision to continue laparoscopic surgery after failed attempts and instead pivoting to an open surgery. Therefore, it is confusing that the Hearing Officer spent so much time contemplating Patient A's bowel perforation in the Synopsis. See Synopsis 13-14.

In the Synopsis, the Hearing Officer made little mention of Respondent's expert, Dr. Arnold Baskies[1]. On cross-examination, Dr. Baskies said "it depends" twenty-four (24) times in his responses to IC counsel's direct questions. However, the Hearing Officer also made no mention of Dr. Baskies' veracity or effectiveness as a witness.

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[1] Dr. Baskies is not and never has been licensed in the State of Nevada. Tr. 261:16–19. When asked, Dr. Baskies was unable to provide the definition of malpractice and the requirements for documentation of medical records in Nevada. Tr. 208:25–210:17.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

III. CONCLUSION

For the foregoing reasons, the IC respectfully requests the Hearing Officer reconsider her recommendations and synopsis for this matter with respect to Count I as contained in the IC's formal complaint and issue an amended Synopsis.

DATED this 15th day of September, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE,
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: dwhite@medboard.nv.gov
Attorney for the Investigative Committee

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

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 15th day of September, 2025, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION** via USPS Certified Mail to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Egan Daehnke, Esq. & Amanda Rosenthal, Esq.
DRR Law Group
2110 E. Flamingo Rd., Suite 212
Las Vegas, NV 89119
Attorney for Respondent

Tracking No. 9171 9690 0935 0255 6846 70

With courtesy copy by email to:

Patricia Egan Daehnke, Esq., at [pdaehnke@drrlawgroup.com]
Amanda Rosenthal, Esq. at [arosenthal@drrlawgroup.com]
Donald K. White, Esq. at [dwhite@medboard.nv.gov]
Patricia Halstead, Esq. at [phalstead@halsteadlawoffices.com]

DATED this 15th day of September, 2025.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

UNITED STATES POSTAL SERVICE

October 3, 2025

Dear Meg Byrd:

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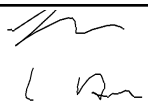
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Washington, D.C. 20260-0004

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

*****

In the Matter of Charges and Complaint Against: **ANNABEL ELIZABETH BARBER, M.D.** **Respondent.**	**Case No. 23-11660-1**

FILED
SEP 23 2025
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION AND COUNTERMOTION FOR PRODUCTION OF THE CORRESPONDENCE TO THE INVESTIGATIVE COMMITTEE PROVIDING THE FINDINGS AND RECOMMENDATIONS

Respondent Annabel Elizabeth Barber, M.D., by and through her attorneys of record, hereby files her Opposition to the Investigative Committee of the Nevada State Board of Medical Examiners' Motion for Reconsideration filed on September 15, 2025.

Dated: September 22, 2025 **DRR LAW GORUP**

By */s/ Patricia Egan Daehnke*

Patricia Egan Daehnke
Nevada Bar No. 4976
Amanda E. Rosenthal
Nevada Bar No. 10748
2110 E. Flamingo Road, Suite 212
Las Vegas, NV 89119
Attorneys for Respondent,
Annabel Elizabeth Barber, M.D.

DRR LAW GROUP
2110 E. Flamingo Road, Suite 212
LAS VEGAS, NEVADA 89119
TEL. (702) 979-2132 | FAX (702) 979-2133

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Almost six years after the Nevada State Board of Medical Examiners initiated their investigation in this matter[1], where two separate Complaints were filed with one being dismissed, three different Hearing Officers were involved, and after the Investigative Committee filing two motions to recuse the second Hearing Officer and the Hearing was ultimately suspended by the Hearing Officer, Hearing Officer Patricia Halstead issued her Findings and Recommendations in this matter.[2] At issue in the Motion for Reconsideration is Hearing Officer Halstead's recommendation which stated that she "cannot recommend a finding that the midline entry to try to perform the surgery was malpractice," as alleged in Count I of the Complaint.

The Investigative Committee seeks reconsideration of this recommendation as the Investigative Committee alleges some vague "error in the hearing or in the findings and recommendations or the decision that would be grounds for reversal of the findings and recommendations or the decision." The Investigative Committee's arguments appear to be that 1) the Hearing Officer's evaluation of the credibility of Investigative Committee's expert witness Nicholas Spoerke, M.D. was in error; 2) the Investigative Committee was not required to provide any literature to corroborate Dr. Spoerke's opinion despite the fact that Paragraph 15 of the Complaint alleged that a midline incision in this case was "contraindicated by medical literature"; 3) the Hearing Officer's contemplation of whether a bowel perforation was a known complication; and 4) the Hearing Officer's little mention of Respondent's expert Dr. Baskies. The Hearing Officer's Findings and Recommendations were well-reasoned, and there is no basis for finding error in decision that would be grounds for reversal. The Investigative Committee's Motion for Reconsideration should be denied in totality.

///

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[1] The initial correspondence from the Nevada State Board of Medical Examiners initiating their investigation in this matter is dated October 28, 2019.

[2] The Findings and Recommendations were signed by Hearing Officer Halstead on August 25, 2025, but were not filed until August 29, 2025.

II. PROCEDURAL HISTORY

On October 28, 2019, the Nevada State Board of Medical Examiners opened their investigation in this matter. See Exhibit A. Approximately three years later, on September 20, 2022, the Investigative Committee filed their first Complaint regarding Patient A in Case No. 22-11660-1. Exhibit B. Case 22-11660-1 was assigned to Hearing Officer Nancy Moss Ghusn.

Just prior to the scheduled Hearing in Case No. 22-11660-1, Respondent Dr. Barber discovered a conflict of interest, as a member of the Investigative Committee had treated Patient A. Dr. Barber obtained permission from Hearing Officer Ghusn to file a Motion to Dismiss. Exhibit C (Medical records attached to the Motion have been removed.) Ultimately, Hearing Officer Ghusn granted Respondent's Motion to Dismiss and requested Respondent to draft the Order. Exhibit D (Medical records attached to the Motion within have been removed.) Respondent drafted the Order granting the Motion to Dismiss, but counsel for the Investigative Committee continually delayed providing any edits to the Order, despite saying such would be provided. Exhibit D (Medical records attached to the Motion within have been removed.) Instead of providing edits to the draft Order, on November 16, 2023, the Investigative Committee filed their Order for Dismissal Without Prejudice. Exhibit E.

One day later, on November 17, 2023, the Investigative Committee filed their Complaint in this matter, Case 23-11660-1. Exhibit F. Despite knowing that Respondent was represented by counsel, the Investigative Committee served Dr. Barber at her home. The Complaint alleges the following counts:

- Count I: Malpractice; and
- Count II: Failure to Maintain Accurate Medical Records.

Case 23-11660-1 was assigned to Hearing Officer Charles Woodman. On June 3, 2024, Respondent filed her Request for Production of Public Records and/or Production of the Investigative File. Exhibit G. Therein, Respondent requested production of the Investigative File in this matter, including Nicholas Spoerke, M.D.'s opinions and matters considered by him. *Id.* On June 4, 2024, the Investigative Committee filed their Opposition to Respondent's Motion. Exhibit H. Hearing Officer Woodman ultimately denied Respondent's Motion at the Hearing on June 4, 2024.

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On June 4, 2024, the Investigative Committee filed a Motion to Recuse Hearing Officer Woodman. Exhibit I. However, the matter proceeded to Hearing on June 4, 2024. Ex J. Ultimately, Hearing Officer Woodman denied the Motion to Recuse. Hearing Officer Woodman overruled certain objections to questions posed to witnesses Monica Gustafson and Nicholas Spoerke, M.D. regarding medical literature referenced in the Complaint. However, these witnesses were instructed not to answer due to the Investigative Committee's objections to the production of materials contained within the "Investigative File." Hearing Officer Woodman ultimately suspended the Hearing in this matter. *Id.*

One June 14, 2024, the Investigative Committee filed a second Motion to Recuse. Exhibit K. Respondent filed an Opposition to the second Motion to Recuse. Exhibit L. Ultimately, Hearing Officer Woodman never ruled on the Motion. Instead, on August 20, 2024, the Board sent correspondence stating that this matter had been reassigned to Hearing Officer Patricia Halstead. Exhibit M.

The Hearing in this matter was ultimately re-set for April 3-4, 2025, and continued on April 10, 2024. Exhibits N, O, P, and Q. Hearing Officer Halstead determined that the Investigative Committee's expert Dr. Spoerke's testimony would begin again anew, but that his prior testimony on June 4, 2024 could be used for impeachment or any other appropriate purpose. Exhibit N. Dr. Spoerke, Dr. Barber, and Dr. Barber's expert witness Dr. Baskies testified at the Hearing on these dates.

On August 5, 2025, Hearing Officer Halstead requested a conference call to clarify information Respondent want included in the record regarding Complaint 22-11660-1. Exhibit R. As a result, on August 5, 2025, Respondent provided information to Hearing Officer Halstead for supplementation of the record and formally requested supplementation of the record in this matter. *See* Exhibit D (Medical records attached to the Motion within have been removed.)

On August 8, 2025, the Board sent correspondence to Dr. Barber indicating that this matter would be adjudicated on September 12, 2025. Exhibit S. However, no Findings and Recommendations had yet been issued.

On August 25, 2025, Hearing Officer Halstead issued her Findings and Recommendations. Exhibit T. Despite the fact that her Findings and Recommendations were

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signed on Monday August 25, 2025, the Findings and Recommendations were not filed by the Nevada State Board of Medical Examiners until Friday August 29, 2025, four days later. It is unclear to Respondent why the Hearing Officer's findings were not immediately filed and provided to Respondent. It is also unclear why Respondent was not copied on the correspondence wherein the Findings and Recommendations were provided.

On September 2, 2025, Respondent provided her Notice of Attendance, informing the Board that she would be attending the Board meeting on September 12, 2025 to participate in the adjudication of this matter as provided in the Board's August 8, 2025 correspondence. Exhibit U. At that time, Respondent was informed that the matter had been taken off the September agenda "since we did not receive the decision in time to keep the matter on the agenda and the State's network outage and issues were also a factor in shifting this matter to December." *Id.* Respondent Dr. Barber was never notified of the change in the Hearing, nor is it clear to Respondent Dr. Barber why the matter could not proceed on September 12, 2025.

III. LEGAL STANDARD

The Investigative Committee has the burden of proof in this matter. NRS 622A.370(1). The standard of proof for this matter is a preponderance of the evidence. *Id.*; NRS 630.346(2). "Preponderance of the evidence" means evidence that enables a trier of fact to determine that the existence of the contested fact is more probable than the nonexistence of the contested fact. NRS 633B.0375.

The hearing officer is not bound by strict rules of procedure or rules of evidence, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123. NRS 622A.370(2). Similarly, NRS 630.346 provides that the hearing officer is "not bound by formal rules of evidence, except that evidence must be taken and considered in the hearing pursuant to NRS 233B.123." In *Nassiri v. Chiropractic Physicians' Board of Nevada*, the Nevada Supreme Court explained:

> Although administrative proceedings typically need not strictly follow the rules of evidence, *see* NRS 233B.123(1) (allowing the admittance of evidence during administrative proceedings "except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs"), the fact-finder is charged with making a decision based only on evidence of a type and amount that will ensure a fair and impartial hearing. *See* NRS 233B.125; *State, Dep't of Motor Vehicles & Pub.*

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Safety v. Evans, 114 Nev. 41, 44–45, 952 P.2d 958, 961 (1998); *Steamboat Canal Co. v. Garson*, 43 Nev. 298, 308–09, 185 P. 801, 804 (1919).

Nassiri v. Chiropractic Physicians' Bd. of Nev., 327 P.3d 487, 130 Nev. Adv. Op. 27 (Nev. 2014).

"Evidence may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs." NRS 233B.123. Pursuant to NRS 233B.123(4), "each party **may call and examine witnesses**, introduce exhibits, cross-examine opposing witnesses **on any matter relevant to the issues** . . . ." (Emphasis added). Although the Nevada rules of evidence may not technically apply in administrative hearing, the hearing officer may follow those rules at their discretion. Pursuant to NRS 48.015, relevant evidence is evidence "having any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence," that is, evidence that is probative of some disputed issue in the case. NRS 48.015.

NRS 622A.390(1)(b) provides that after the close of the hearing, a party may file a "motion requesting reconsideration of the findings and recommendations of the hearing panel or officer or the final decision of the regulatory body." A motion for reconsideration may only be based on one of the following grounds: 1) newly discovered or available evidence; 2) error in the hearing or in the findings and recommendations or the decision that would be grounds for reversal of the findings and recommendations or the decision; or 3) the need in the public interest for further consideration of the issues or evidence, or both.

IV. THE INVESTIGATIVE COMMITTEE'S MOTION IS UNTIMELY

A) The Motion for Reconsideration is Untimely

The Investigative Committee's Motion for Reconsideration is untimely and must be denied. NRS 622A.390(2)(a) provides that a motion for reconsideration must be filed with the hearing officer "not later than 15 days after the date of service of the findings and recommendations of the hearing panel or officer."

In this case, the Hearing Officer signed her Findings and Recommendations on August 25, 2025. *See* Exhibit T. However, the Findings and Recommendations were not filed until

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August 29, 2025, four days later. It is unclear why there was a four day delay in filing the Findings and Recommendations.

NRCP 6(a) provides the method for computing any time period specified in any statute that does not specify a method of computing time. NRCP 6(a)(1) states that when the period is stated in days: A) exclude the day of the event that triggers the period; B) count every day, including intermediate Saturdays, Sundays, and legal holidays, and C) include the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.

The Findings and Recommendations were filestamped on August 29, 2025. Pursuant to NRCP 6(a)(1), this would make the deadline to file the Motion for Reconsideration Saturday, September 13, 2025. However, since this is a Saturday, the deadline would move to Monday, September 15, 2025. The Motion for Reconsideration was filed on September 15, 2025.

However, the Motion for Reconsideration is untimely considering that the Findings and Recommendations were issued on August 25, 2025. Using this date, a Motion for Reconsideration was due on Tuesday, September 9, 2025. The Motion for Reconsideration was not filed until Monday, September 15, 2025, and was untimely. As the Motion was untimely, the Hearing Officer should deny it.

B) Countermotion for Production of Documentation Regarding when the Findings and Recommendations were Provided to the Investigative Committee

Pursuant to NRS 622A.390(1)(3), after the close of the hearing, a party may file, with leave of the hearing officer, "any other motion requesting appropriate action or relief after the close of the hearing." In this case, Respondent requests authority to file this Countermotion requesting that the Investigative Committee be ordered to produce the correspondence from the Hearing Officer to the Investigative Committee or the Nevada State Board of Medical Examiners providing the Findings and Recommendations, so it can be determined whether the Investigative Committee inappropriately delayed filing the Findings and Recommendations or

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notifying Respondent of the Findings and Recommendations to obtain an advantage by allowing them additional time to prepare their Motion for Reconsideration. If this was done, it would be gamesmanship and Respondent would move, and does hereby move, for immediate dismissal of the charges in this matter. "Although proceedings before administrative agencies may be subject to more relaxed procedural and evidentiary rules, due process guarantees of fundamental fairness still apply." *Dutchess Bus. Servs., Inc.*, 124 Nev. 701, 711, 191 P.3d 1159, 1166 (2008).

V. RECONSIDERATION IS NOT WARRANTED

A) The Hearing Officer Correctly Determined that The Investigative Committee did not Prove a Violation of NRS 630.301(4) by a Preponderance of the Evidence

"Preponderance of the evidence" means evidence that enables a trier of fact to determine that the existence of the contested fact is more probable than the nonexistence of the contested fact. NRS 633B.0375. In this case, the Hearing Officer appropriately provided a synopsis of the testimony and her evaluation of the evidence. It is clear from her Findings and Recommendations that she did not believe the Investigative Committee presented evidence that would enable her to determine that Dr. Barber committed malpractice. She appropriately relied on evaluations of the credibility of the witnesses, such as Dr. Spoerke who has performed 4-5 laparoscopic hernia repairs, versus Dr. Barber who has performed hundreds or thousands of laparoscopic hernia repairs. Her findings regarding the malpractice claim were not in error and reconsideration is not warranted.

B) The Hearing Officer Appropriately Evaluated the Credibility of the Investigative Committee's Expert Nicholas Spoerke, M.D.

The Investigative Committee argues that the Hearing Officer insufficiently evaluated the credibility of the Investigative Committee's expert Dr. Spoerke, as compared to Respondent. Specifically, the Investigative Committee takes issue with the Hearing Officer's statement that the Investigative Committee's expert has done "five to ten laparoscopic hernia repairs in his career," as compared to Respondent's experience of ten laparoscopic hernia

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repairs per week. Exhibit T, at 12:18-22. The Investigative Committee notes that the Hearing Officer fails to mention that Dr. Spoerke has done hundreds of laparoscopic surgeries for other ailments in the abdomen." Motion at 3:6-8.

The Investigative Committee argues that Dr. Spoerke's experience in doing laparoscopic surgeries was well documented, and he testified to this under oath. Motion, at 3:9-10. However, the Investigative Committee never produced any evidence that Dr. Spoerke had performed hundreds of laparoscopic surgeries other than his own testimony. However, the Investigative Committee then characterizes Dr. Barber's testimony "that she can frequently perform a successful laparoscopic hernia repair surgery despite a person having had a lot of prior abdominal surgery in that she can often times locate an entry point with less scarring where it is safe to proceed" as "uncorroborated and self-serving. Motion, at 3, 10-14. It is unclear why Dr. Spoerke's testimony regarding his experience would be credible, while Respondent's testimony about her own experience would be "uncorroborated and self-serving."

NAC 630.470(8)(b) states that the hearing officer shall "make a recommendation to the Board on the veracity of witnesses if there is conflicting evidence or the credibility of witnesses is a determining factor." The Hearing Officer did this. Dr. Spoerke clearly testified that he had performed four or five laparoscopic hernia repairs in his career. Dr. Barber testified that she performs ten laparoscopic hernia repairs per week, amounting to hundreds or thousands of laparoscopic hernia repairs over her career. The issue in this case was not the performance of laparoscopic surgeries. The issue was the performance of a laparoscopic hernia repair. The issue was whether a midline approach was appropriate for a laparoscopic hernia repair in a patient with prior abdominal surgeries. Given the vast difference in experience on this issue, the Hearing Officer clearly, and appropriately, evaluated the credibility of the witnesses and found Dr. Spoerke's testimony on the issue lacked credibility given his lack of experience as compared to Dr. Barber. There was no error in how the Hearing Officer evaluated Dr. Spoerke's credibility.

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C) The Hearing Officer Appropriately Evaluated the Investigative Committee's Failure to Produce any Literature to Corroborate Dr. Spoerke's Opinions

Paragraph 15 of the Complaint clearly alleges that:

> Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

Exhibit F. Although NRS 233B.121(2)(c) and (d) require only a "short and plain statement of the matters asserted," it is expected that if the medical literature forms the basis for the Complaint and sets the standard of care such that the Investigative Committee argues Respondent's actions were "contraindicated by medical literature," the medical literature would be produced or referenced specifically by Dr. Spoerke at the Hearing. It never was. The Hearing Officer appropriately gave weight to this failure to identify the "medical literature" that was so clearly referenced in the Complaint, when determining the Investigative Committee had not met its burden of proof.

In the Motion, the Investigative Committee states that "No one, not the Respondent, not her expert, and not her counsel, had asked to see any literature before or during the hearing." Motion at 3:25-27. This statement is patently false. Respondent asked repeatedly for the literature, contained in the "Investigative File", which would be used by the Investigative Committee at Hearing.

On June 3, 2024, Respondent filed her Request for Production of Public Records and/or Production of the Investigative File. Exhibit G. This was a request for the medical literature as referenced in Paragraph 15 of the Complaint.

At the Hearing on June 4, 2024, Respondent's counsel asked the investigator Monica Gustafson about the literature, along with Dr. Spoerke. Dr. Barber then moved to dismiss the Complaint for failure to produce the literature. Exhibit J, at 134:2-138:7.

Dr. Barber's counsel asked investigator Monica Gustafson about the literature, and counsel for the Investigative Committee affirmatively stated that Dr. Spoerke "can" and

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"will" point to the medical literature referred to in the Complaint, as follows:

Q: So paragraph 15, the allegation against Dr. Barber is essentially that she failed to use proper medical judgment in her surgery. But then the last sentence is relevant in that it – this says that the laparoscopic approach is contra indicated by medical literature, just going to that without reading the whole paragraph. And so I would like to know what medical literature is contained in the investigative file that supported the decision to file this complaint.

HEARING OFFICER WOODMAN: And, Mr. White, do you object to that? Because that's -- it appears to me right now to be a critical part of your case?

MR. WHITE: Publication -- he lists his publications here that he -- if she wants to know that he's written anything else, here's his publications in his CV, page 135.

HEARING OFFICER WOODMAN: But are you saying that he's only relying on his own publications?

MR. WHITE: Oh no. I don't know.

MS. DAEHNKE: Okay. That wasn't my question at all. I'm not really particularly interested, at least at this point, in his publications. I didn't see any that were relevant. But what I am asking about is this is the Complaint, it mirrors the first Complaint against Dr. Barber. The second Complaint, which is what we're here for, is my understand, paragraph 15 states that the allegations against Dr. Barber for violating the Medical Practice Act is that her approach was contra indicated by medical literature, and I would like to know what medical literature is referred in the Complaint that's contained in the IC file.

HEARING OFFICER WOODMAN: And --

MR. WHITE: Well, we can ask him too.

MS. DAEHNKE: I am asking this witness.

MR. WHITE: Or I can -- okay.

HEARING OFFICER WOODMAN: And are you objecting to this witness answering that question?

MR. WHITE: Oh yes. Yeah.

HEARING OFFICER WOODMAN: So the objection's overruled. If you're making this allegation, it's only fair to point to the medical literature you're referring to.

MR. WHITE: He will. He can.

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Exhibit J, 121:17-123:12. On April 4, 2025, Dr. Barber again renewed her request for the literature relied on by Dr. Spoerke, and Hearing Officer Halstead noted the objection. Exhibit P, 108: 21-110:5.

Respondent Dr. Barber then asked Dr. Spoerke about the literature, but "preferred not to answer. His testimony was as follows:

> Q. Did you consult any literature or learned treatises when you were preparing your report?
>
> A. I prefer not to not answer.
>
> Exhibit J, at 237:2-4.

Dr. Spoerke further testified:

> Q: Did you tell me that you had any medical literature, had reviewed any medical literature as a part of your review and formulation of your expert opinion?
>
> A. Yes.
>
> Q. What medical literature did you review?
>
> A. I would prefer not answer.
>
> Q: Okay. You recognize that part of the charge against Dr. Barber is your apparent opinion that use of laparoscopic -- here, I can read it. Actually, I should probably ask you if this is your opinion. Well, how much medical literature did you review, how many articles or treatises did you review in assisting in formulating your opinion in this case?
>
> A. Same. I prefer not to answer that question. . . .
>
> MS. DAEHNKE: Are you instructing him not to answer?
>
> MR. WHITE: No. He can answer that. Literature that he consulted, yeah.
>
> THE WITNESS: I'd have to refer back to the references on my report.

Exhibit J, 237:2-240:9. Dr. Spoerke then testified that the references were in his report, and he "cannot provide them right now." Exhibit J, 242:13-15.

At the Hearing on April 3, 2024, Respondent's counsel again asked Dr. Spoerke about the literature he has reviewed. He admitted he had not reviewed any literature about

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laparoscopic hernia repairs. He testified:

Q. Did you review any medical literature from the time of your first testimony?

A. Yes.

Q. What medical literature did you review?

A. I reviewed thousands of pages of medical literature in that time period. You have to be more specific.

Q. All right. When I ask you a question like that, you don't understand -- let me ask that you consider the literature that I'm asking about to be in reference to the case, and -- Dr. Barber's case, which her license is -- her medical license is at issue here. You understand that, right?

A. Yes.

Q. All right. So when you just answered saying that you read thousands and thousands of pages, you were talking about generally in your practice; correct?

A. Yes. I have continuing medical education requirements. I had to recertify for both my surgical critical care and my general surgery boards. So, yes, I've done a lot of literary reviews since we last met. Yes. And they are in all kinds of areas: surgical nutrition, general surgery, trauma, surgical critical care, ventilator management.

Q. Did you review anything relating to laparoscopic hernia repairs?

A. No, not specifically.

Exhibit O, 104:9-105:13.

Dr. Spoerke further testified:

Q. And in any literature review that you conducted, either prior to the first hearing or today, did you come across literature that discusses that open versus laparoscopic hernia repair is something that is very contingent upon not just the patient's comorbidities but also contingent upon the skill and comfort of a surgeon?

A. Yes.

Q. And -- I mean, it's a topic that is peer reviewed and there are studies about this; correct?

A. Um-hum.

Q. And you've reviewed those?

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A. I can't say I've reviewed all of them, the things you're talking about --

Q. Of course not.

A. -- but I have read quite a bit of literature about laparoscopic versus open surgery, yes.

Q. Can you think of any that you have reviewed recently?

A. I cannot list them without going home and getting the references. I'd be happy to get those for you if needed them.

Q. No, I don't. You don't need to tell me the name, maybe the author or the journal?

A. It's all at home in a stack of papers and books. Or it's online, there's some called "Selective Readings for General Surgery." We have a number of different ACGME-approved, I guess, platforms that we use for our ongoing certification and for licensing.

Q. How many articles, whether in print or online, have you read about open versus laparoscopic hernia repair?

A. Probably 30 or 40.

Q. And -- all right. With regard to the comfort level of the surgeon and the experience and skill, how does that -- what did the article say about how that factors into the decision as to whether to go open or laparoscopic?

A. I think the biggest take-home point that I took from the discussion of surgeon comfort and the choice of procedure has to do with a TEP versus a TAPP, not whether you do it open versus laparoscopic. All of the things being equal, if a surgeon is more comfortable doing one type of operation, we tend to think that that's probably better for the patient. With the caveat that if hat operation not safe, that is not the correct operation for the patient.

Exhibit O, at 106:8-108:8.

Dr. Spoerke, and the Investigative Committee, were given numerous opportunities to provide the literature, or at least a citation to the literature, that was so critical to the case that it was referenced in Paragraph 15 of the Complaint. Despite these numerous opportunities, the literature was never referenced, or produced. The Hearing Officer gave appropriate weight to this failure when evaluating the credibility of Dr. Spoerke and the veracity of his testimony.

Additionally, Dr. Spoerke's testimony ultimately undermined the Investigative Committee's theory, as he agreed that the comfort of the surgeon in performing laparoscopic

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surgery is important, and that "if a surgeon is more comfortable doing one type of operation, we tend to think that that's probably better for the patient." Exhibit O, at 106:8-108:8. In this case, Dr. Barber testified she has performed hundreds or thousands of laparoscopic hernia surgeries, and she was very comfortable with the procedure. Therefore, Dr. Spoerke's testimony in this regard contradicts the allegation in paragraph 15 that the medical literature supports that the laparoscopic procedure would be contraindicated.

Additionally, the Hearing Officer appropriately evaluated Dr. Spoerke's testimony in light of his testimony that he had no idea of Dr. Barber's qualifications in performing laparoscopic hernia repairs, given his concession that if the surgeon is more experienced or comfortable with laparoscopic repair, it may be more appropriate. Dr. Spoerke testified:

> Q. What is your understanding now, as you sit there today, as to Dr. Barber's experience in performing laparoscopic hernia repairs?
>
> A. I have only evidence that she's ever done one, attempted in her life. That's the only record I've ever read of hers.
>
> Q. You were not provided any information about Dr. Barber's background, training, skills, experience?
>
> A. I was given a brief outline of what her training is. I was given no information as to her laparoscopic cases, number of cases, her skill level, any of those things. I was only provided with her very simple, basic CV, and that's it.
>
> Q. Okay. It was her -- you were provided Dr. Barber's CV?
>
> A. No. I was provided with very short, three-line piece of paper that told me who she was, where she went to school, et cetera. . . .
>
> Q: Doctor, I'm just trying to find out – I mean, it's not fair to ask you -- if you weren't provided the information, you can't use it to formulate your opinion; correct?
>
> A. If I wasn't given information, I could use that to formulate an opinion. It would be very strange. Normally we formulate opinions on information we're given, so I will would agree with you, yes.
>
> Q. Then let me ask again. Do you or do not agree that the experience level, the skill and training, the number of laparoscopic hernia repairs, the comfort of the physician is an important factor in judging whether or not to do an open versus laparoscopic hernia repair, just generally?

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A. Those are part of the decision, but just part.

Q. Sure. And that's also part of the literature that you read, that that's a consideration?

A. Yes.

Q. And consideration in those studies that are conducted on the subject; correct?

A. Sure.

Q. Okay. Did you ever ask Mr. White what Dr. Barber's training was?

A. I don't recall.

Q. Did you ever ask Mr. White how many laparoscopic hernia repairs Dr. Barber had done up until the time of this patient's surgery?

A. No.

Exhibit O, 115:6-117:21. Given that proceeding with Dr. Spoerke felt the standard of care was influenced by the experience of the surgeon, it would have been important for him to understand the qualifications of Dr. Barber and her experience in performing the surgery. The Hearing Officer gave appropriate weight to his lack of this understanding in evaluating Dr. Spoerke's credibility and veracity.

D) The Hearing Officer's Discussion About the Bowel Perforation as Known Complication was Appropriate

In Investigative Committee takes issue with the Hearing Officer's discussion of a bowel perforation as a known complication. However, it is clear that the Hearing Officer understood the allegations in this case and directed the testimony appropriately during the Hearing to stay focused on the issue. At the Hearing, Hearing Officer Halstead stated:

> The issue is the surgical decisions by continuing the high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has extensive surgical history and scarring in his abdomen, which is contradicted by medical literature. So the line of questioning you've gone down for the last few minutes isn't -- I know that you both discussed it, but it doesn't go to the actual allegation in the Complaint, so it's not something that's helping me.

Exhibit P, 174:11-21.

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In fact, the Hearing Officer's focus on the bowel perforation issue in the Findings and Recommendations was precisely to discuss that the Investigative Committee was focusing on the midline incision issue only because the bowel perforation is a recognized complication, which resulted in an inappropriate hindsight analysis of Dr. Barber's care and treatment, and therefore an inappropriate basis for disciplinary action. In the Findings and Recommendations, the Hearing Officer noted:

> Respondent made three entry points, which is consistent with a laparoscopic procedure whereby three entry points are utilized, so the number of times Respondent attempted entry to gain visualization was not excessive. The problem arose instead because Respondent perforated the patient's bowel in attempting the midline entry. The injury, however, was not the basis for the malpractice claim and, again, was acknowledged by each of the testifying professionals as a known complication. With that, it appeared that, to circumvent the fact that a known complication would not necessarily support a malpractice claim, the focus was instead shifted to the attempted midline entry that preceded the injury. Doing so, however, lends to a hindsight analysis that stems solely from the complication. Gros v. LAMMICO, 316 So. 3d 61, 69 (La. App. 2020) (appeal and affirmation of a defense verdict for a medical malpractice claim in relation to a bowel perforation caused during a laparoscopic hernia repair and noting, "[a] physician is not held to a standard of absolute precision; rather, his [or her] conduct and judgment are evaluated in terms of reasonableness under the circumstances existing when his professional judgment was exercised, and not on the basis of hindsight or in light of subsequent events").
>
> As Dr. Baskies testified, the patient suffered a known complication and there was no guarantee that a complication would not have also occurred with an open surgery. T2 242-243; 245; *see also* T 72 at which Dr. Spoerke acknowledges that, regardless of what procedure was used, they all carry a risk of injury to the bowel.2 Suffering from a known complication is not akin to the surgeon having committed malpractice. *See, e.g.,* Bristol v. Bunn, 189 A.D.3d 2114, 2116, 138 N.Y.S.3d 774, 777 (2020) ("Plaintiffs expert acknowledged that bowel perforation is a known complication from this type of surgery. Thus, plaintiff failed to raise a triable issue of fact with respect to the claims that defendant negligently caused the bowel perforation"). It was evident that the patient's bowel was not in a healthy state and the surgery was unfortunately not successful. This does not *per se* lend to a finding of malpractice.
>
> Respondent articulated why she chose to undertake the surgery laparoscopically and why she attempted the midline entry. Her reasoning was sound, was supported by her experience and skill, and was undertaken based upon what she deemed was best for the patient as far as recovery and healing. To fault her for a known complication and deem that malpractice is seemingly an effort to punish her for the complication, which would not be appropriate.

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> There is no doubt that the patient suffered a great deal due to the bowel perforation and that is not to be taken away or minimized by this recommendation. It remains, however, that even as conceded by Dr. Spoerke, "the laparoscopic approach is probably a better repair overall." T 40. While the surgery was not successful due to the bowel perforation, I cannot recommend a finding that the midline entry to try to perform the surgery was malpractice.

Exhibit T, pages 13-14. The Hearing Officer understood that Respondent was not charged with malpractice as a result of the bowel perforation. The Hearing Officer discussed the bowel perforation to highlight the errors in the Investigative Committee's arguments by attempting to discipline Dr. Barber for malpractice based on an inappropriate hindsight view, rather than a fair and thorough evaluation of Dr. Barber's qualifications to proceed laparoscopically with a midline entry given that her reasoning was supported by her experience and skill, and was undertaken based on what she believed was best at the time. There was no error that warrants reconsideration.

E) The Hearing Officer's Discussion of Respondent's Expert Dr. Baskies is not a Basis for Reconsideration

The Investigative Committee has the burden of proof in this matter. NRS 622A.370(1). The Investigative Committee argues that the Hearing Officer only made "little mention of Respondent's expert Dr. Baskies." Motion, at 4, lines 19-20. However, this is not error and is not reason for reconsideration. The Investigative Committee bears the burden of proof. It is clear from the Findings and Recommendations that the Hearing Officer evaluated Dr. Spoerke's testimony and determined that his testimony had not met the preponderance of the evidence standard, such that she could not determine that the existence of the alleged malpractice was more probable than the nonexistence. It is clear that the Hearing Officer determined that Dr. Spoerke's testimony did not meet the necessary threshold. Whether or not the Hearing Officer extensively evaluated Dr. Baskies' testimony is irrelevant if the Investigative Committee did not meet its burden of proof.

VI. CONCLUSION

Respondent requests that the Hearing Officer deny the Investigative Committee's Motion for Reconsideration. The Motion is untimely and must be denied on this basis alone.

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Furthermore, there is no basis for reconsideration in this case as the Hearing Officer's decision was appropriate and thoroughly reasoned.

Dated: September 22, 2025 **DRR LAW GROUP**

By */s/ Patricia Egan Daehnke*

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CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of September, 2025, a true and correct copy of **RESPONDENT'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION AND COUNTERMOTION FOR PRODUCTION OF THE CORRESPONDENCE TO THE INVESTIGATIVE COMMITTEE PROVIDING THE FINDINGS AND RECOMMENDATIONS** was served by email to the following parties:

Donald K. White, J.D. *Senior Deputy General Counsel* 9600 Gateway Drive Reno, NV 89521 dwhite@medboard.nv.gov mbyrd@medboard.nv.gov *Attorney for the Investigative Committee*	Patricia Halstead, Esq. 615 S. Arlington Avenue Reno, NV 89509 phalstead@halsteadlawoffices.com

By */s/ Lacey Ambro*
An employee of DRR LAW GROUP

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

ANNABEL ELIZABETH BARBER, M.D.,

Respondent.

Case No.: 23-11660-1

FILED
SEP 24 2025
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

TO: Donald K. White
Senior Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Annabel Elizabeth Barber, M.D.
c/o Patricia Egan Daehnke, Esq.
2110 E. Flamingo Rd., Ste 212
Las Vegas, NV 89119

ORDER DENYING THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINER'S MOTION FOR RECONSIDERATION

On August 29, 2025, Findings and Recommendations were filed in the above-referenced matter by which, for reasons stated therein, undersigned recommended against a finding that the midline entry to try to perform a laparoscopic inguinal hernia repair surgery was malpractice as was the subject of Count I of the Complaint against Respondent filed on November 17, 2023. The Investigative Committee of the Nevada State Board of Medical Examiners (the "IC") seeks reconsideration of that portion of the Findings and Recommendations by and through a Motion for Reconsideration, filed on September 15, 2025 (the "Motion").

The basis for the Motion as argued by the IC is that the IC proved Count I by a preponderance of the evidence and that, in finding otherwise, the undersigned failed to consider the extent of Dr. Spoerke's experience in relation to laparoscopic repair of "other ailments of the abdomen." Motion, p. 3, lines 7-8. In addition, the IC argues that the undersigned improperly

focused on the lack of presentation of literature in support of Dr. Spoerke's testimony. Motion, p. 3-4. The IC further took issue with undersigned not addressing the veracity of witnesses and alleges that the undersigned conflated the patient's injury with the alleged basis for the malpractice claim, which was the midline entry to attempt to continue the surgery laparoscopically as opposed to converting to an open surgery. Motion, p. 4.

Annabel Elizabeth Barber, M.D. ("Respondent") filed an Opposition on September 23, 2025, whereby she deems the Motion untimely, arguing that it was brought within fifteen days of the date that the Findings and Recommendations were filed, as opposed to the date that they were signed (a difference of four days); and, in doing so, questions the filing delay.[1] Respondent deduces credibility determination from the findings made; points out that medical literature was at issue in the charging Complaint; addresses requests for supporting literature and testimony regarding the same; and argues that the bowel perforation being a known complication was appropriately addressed to support the finding that the malpractice claim was premised upon "an inappropriate hindsight analysis of Dr. Barber's care and treatment." Opposition, p. 17, line 4.

In evaluating the IC's malpractice claim undersigned is required to consider it as it is noticed in the Complaint, paragraph 15 of which reads as follows:

> As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when she failed to use proper discretion when making surgical decisions by continuing to pursue a high-risk laparoscopic surgery through a midline incision to repair a hernia on a patient that has an extensive surgical history and surgical scarring in his abdomen which is contraindicated by medical literature.

Relevant to undersigned's Findings and Recommendations, the foregoing, by its very terms, takes issue with "proper discretion" about "surgical decisions" and specifically pleads that the decision Respondent made "is contraindicated by medical literature." Thus, *as pleaded,* the IC premised the malpractice charge on Respondent's discretionary decision to attempt a midline incision in contravention of medical literature yet failed to present *any* medical literature.

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[1] Undersigned has no first hand knowledge of the filing delay but, regardless of the reason for the lag in the filing, the Motion was filed within fifteen days of the filing date and is addressed on the merits herein.

Given how the charge was pleaded, it is erroneous for the IC to claim as a basis for reconsideration that "[i]t was not necessary to present literature, nor was the IC asked to present any literature to support the peer reviewer's opinion." Motion, p. 3, lines 23-24. If the IC did not intend to rely upon any medical literature, then it was incumbent upon the IC not to premise the malpractice claim upon Respondent's discretionary decision making being in contravention thereof and, under no circumstances, was it appropriate for undersigned to assist the IC in fulfilling its obligation to establish the charge by asking the IC to present such literature in support of its case.

With respect to Dr. Spoerke's experience, undersigned took into consideration Dr. Spoerke's testimony that he had performed other abdominal surgeries different than the surgery at issue, specifically having testified that he had performed "say a hundred" open inguinal hernia surgeries and "hundreds" of bowel repairs. T 21, 23. It remains, however, that Respondent's experience as to the specific surgery at issue, that being a laparoscopic hernia repair, was vastly greater.

As to credibility of the witnesses, no witness was deemed to be incredulous. Undersigned's Findings and Recommendations did not hinge on credibility and, therefore, no credibility determinations were addressed nor relied upon.

As pleaded, and as was considered, what was at issue was review of a discretionary decision. Bottom line is that the patient suffered a known complication that was the result of the midline entry and undersigned was clear that, given the procedure contemplated three points of entry and the midline was the third, it was not unreasonable to attempt a midline entry, particularly given Respondent's experience and history of success, in addition to the fact that scarring is unpredictable as testified to by all of the medical professionals.

It was apparent to undersigned that Respondent was charged with malpractice as a result of the injury, and the criticism thereof was couched in terms of the midline entry to be able to state a claim for malpractice that the injury itself would not support. For that reason, undersigned concluded that second guessing Respondent's actions after the fact based upon a known

complication having occurred was not an appropriate basis for a malpractice finding and that conclusion was supported by cited case law.

As a final matter, although the standard of "a preponderance of the evidence" is not as stringent of a standard as "beyond a reasonable doubt," for example, the IC cannot rest on having offered some evidence of any proportion to claim the burden of proof has been met. For the reasons stated in the Findings and Recommendations, and as further addressed herein, undersigned maintains that the IC did not meet its burden of proof to sustain the malpractice claim.

Based upon the foregoing, in moving for reconsideration the IC failed to establish an error in the Findings and Recommendations that constitutes grounds for reversal as contemplated by NRS 622A.390(5)(b). Accordingly, the Motion is DENIED.

DATED this 23rd day of September, 2025.

By: 

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 24th day of September, 2025, I served a file-stamped copy of the foregoing **ORDER DENYING THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION FOR RECONSIDERATION** via USPS Certified Mail to:

ANNABEL ELIZABETH BARBER, M.D.
c/o Patricia Egan Daehnke, Esq. & Amanda Rosenthal, Esq.
DRR Law Group
2110 E. Flamingo Rd., Suite 212
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Attorney for Respondent

Tracking No. 9589 0710 5270 2375 5546 80

With courtesy copy by email to:

Patricia Egan Daehnke, Esq., at [pdaehnke@drrlawgroup.com]
Amanda Rosenthal, Esq. at [arosenthal@drrlawgroup.com]
Donald K. White, Esq. at [dwhite@medboard.nv.gov]
Patricia Halstead, Esq. at [phalstead@halsteadlawoffices.com]

DATED this 24th day of September, 2025.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners

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