IN THE SUPREME COURT OF THE STATE OF NEVADA

DAVID GARVEY, M.D., an individual.

Petitioner,

vs.

THE FOURTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA ex rel. THE COUNTY OF ELKO, AND THE HONORABLE KRISTIN N. HILL,

Respondent,

and

DIANE SCHWARTZ, individually and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased,

Real Party In Interest.

Supreme Court No.

District Court No. : CV-C-17-439

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LEWIS BRISBOIS BISGAARD & SMITH LLP
KEITH A. WEAVER
Nevada Bar No. 10271
ALISSA N. BESTICK
Nevada Bar No. 14979C
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Tel. 702.893.3383
Fax 702.893.3789
Attorneys for Petitioner

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MPSJ
KEITH A. WEAVER
Nevada Bar No. 10271
E-Mail: Keith.Weaver@lewisbrisbois.com
ALISSA BESTICK
Nevada Bar No. 14979C
E-Mail: Alissa.Bestick@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789
Attorneys for Defendant David Garvey, M.D.

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

DIANE SCHWARTZ, individually and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased;

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; BARRY BARTLETT, an individual (Formerly Identified as BARRY RN); CRUM, STEFANKO, & JONES LTD, dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

CASE NO. CV-C-17-439
Dept. No.: 1

DEFENDANT DAVID GARVEY, M.D.'S MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES

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Defendant, DAVID GARVEY, M.D., by and through his counsel of record, LEWIS BRISBOIS BISGAARD & SMITH LLP, move this court pursuant to NRCP 56 for an order applying the "trauma cap" codified at NRS 41.503 to statutorily limit his civil damages to $50,000 as a matter of law.

This motion is made and based on the pleadings and papers on file herein, the attached memorandum of points and authorities, the declarations of Keith A. Weaver and David Barcay, M.D., and any oral argument permitted at the time of hearing on this matter.

DATED this 21st day of July, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick

KEITH A. WEAVER
Nevada Bar No. 10271
ALISSA BESTICK
Nevada Bar No. 14979C
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Tel. 702.893.3383
Attorneys for Defendant David Garvey, M.D.

DECLARATION OF KEITH A. WEAVER

I, Keith A. Weaver, declare as follows:

1. I am an attorney duly admitted to practice in all of the courts of the State of Nevada and I am a partner with Lewis Brisbois Bisgaard & Smith LLP, attorneys of record for Defendant David Garvey, M.D. herein. The facts set forth herein are of my own personal knowledge, and if sworn I could and would competently testify thereto.

2. Attached as **Exhibit A** are true and correct copies of relevant excerpts from the emergency medical services technicians who transported Mr. Schwartz to the hospital.

3. Attached as **Exhibit B** are true and correct copies of relevant excerpts of Northeastern Nevada Regional Hospital records for Mr. Schwartz.

4. Attached as **Exhibit C** are true and correct copies of relevant excerpts of the deposition transcript for David Garvey, M.D., taken on June 25, 2019.

5. Attached as **Exhibit D** are true and correct copies of relevant excerpts of the deposition transcript for Donna Kevitt, R.N., taken on March 4, 2019.

6. Attached as **Exhibit E** is a true and correct copy of the Utah trauma hospital regional map.

7. Attached as **Exhibit F** are true and correct copies of relevant excerpts of the deposition transcript for Susan Olson, R.N., taken on March 4, 2019.

8. Attached as **Exhibit G** is a true and correct copy of the Department of Health and Human Services Nevada Division of Public and Behavioral Health Licensee Search Results identifying Northeaster Nevada Hospital as a rural hospital.

9. Attached as **Exhibit H** are true and correct copies of relevant excerpts of the deposition transcript for Barry Amos Ray Bartlett, taken on December 20, 2019.

10. Attached as **Exhibit I** is a true and correct copy of the Second Amended Complaint filed in this case on February 12, 2018.

11. Attached as **Exhibit J** is a true and correct copy of relevant excerpts of the Journal of the Senate of the State of Nevada, 2002 Eighteenth Special Session, First and Second Day.

12. Attached as **Exhibit K** is a true and correct copy of the original complaint plaintiff filed in this action.

13. Attached as **Exhibit L** is a true and correct copy of the amended complaint plaintiff filed in this action.

14. Attached as **Exhibit M** is a true and correct copy of the court's order dated October 16, 2019 denying plaintiff leave to file a third amended complaint.

15. Attached as **Exhibit N** is a true and correct copy of relevant excerpts of the Elko County Coroner Records in this case.

16. Attached as **Exhibit O** is a true and correct copy of the relevant excerpts of the deposition testimony of Diane Schwartz taken on January 23, 2019.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct and that this declaration was executed on July 20, 2020, at Las Vegas, Nevada.

/s/ Keith Weaver
Keith A. Weaver

DECLARATION OF DAVID BARCAY, M.D., FACEP, FAAEM, FCCP, FACP

I, David Barcay, M.D., FACEP, FAAEM, FCCP, FACP, declare that if called as a witness I can and would competently testify to the following of which I have personal knowledge:

QUALIFICATIONS

1. I am a physician licensed to practice medicine in the State of California, and have been so since August of 1977. I obtained my medical degree in 1976 from the UCLA School of Medicine. I have been Board certified continuously in Emergency Medicine since 1992, and in Internal Medicine since 1979, and in critical care medicine since 2012. I have been the Attending Physician in the Emergency Department at Cedars-Sinai Medical Center continuously since 1988 I and have been practicing medicine in the State of California since August of 1977. I have evaluated and treated numerous patients who have presented with multi-trauma conditions similar to which Douglas Schwartz exhibited throughout his presentation to Northeastern Nevada Regional Hospital on June 22-23, 2016. Please refer to my Curriculum Vitae attached hereto as Exhibit "A", for further information about my background, training, experience and credentials.

2. As a consequence of my education, training and experience, I have continuously worked with, trained, supervised, and observed medical staff in the performance of their clinical responsibilities, caring for patients such as Mr. Schwartz under the same or similar circumstances. As a result, I am familiar with and qualified to testify on the applicable standard of care both now and in 2016 for emergency care physicians in Nevada, including whether David J. Garvey, M.D. complied with applicable standards of care rendering treatment to Mr. Schwartz. I am qualified to render an opinion as to whether or not any act or omission to act on the part of Dr. Garvey was a substantial actor in causing or contributing to Mr. Schwartz's death. In forming my opinions, I have reviewed and relied upon the medical records and medical imaging studies of Mr. Schwartz from Northeaster Nevada Regional Hospital.

Review of Materials

3. I was asked to review the medical records, imaging studies and the autopsy report in this matter on behalf of David Garvey, M.D. (hereinafter "Dr. Garvey") and give an assessment as to whether the care and treatment to and upon Mr. Schwartz by Dr. Garvey met the standard of

care. In that regard, I received and reviewed ambulance and medical records, and imaging studies relating to Mr. Schwartz's care and treatment by Dr. Garvey at the Emergency Department of Northeastern Nevada Regional Hospital on June 22-23, 2019. I also reviewed autopsy records and the depositions of Dr. Garvey and flight paramedic Barry Bartlett. The following is from my own personal knowledge gained from my review of these records, and I am fully familiar with the facts of the case.

FACTS

4. Mr. Schwartz is a 58 year old man who was reportedly hit by a motor vehicle after exiting a restaurant. (Elko County Coroner Records ("EKCR") at SDT-ECC-000010.)

5. Prior to EMS transport, Mr. Schwartz was placed in full C-spine precautions with C-collar backboard, and oxygen at 4 lpm was administered. Mr. Schwartz experienced pain in the right side and diminished breathing, following a brief loss of consciousness. (EMS Records ("EMS") at 0004; Northeaster Nevada Regional Hospital Records "("NNRH") at 000003-4.)

6. Dr. Garvey's first contact with Mr. Schwartz took place on June 22, 2016, where he presented in the Emergency Department at Northeastern Nevada Regional Hospital, with diminished breathing, and a chief complaint of pain on his right side. (NNRH at NEN000003, 8.)

7. Dr. Garvey performed a physical examination, ordered trauma blood lab work, and CT scans of Mr. Schwartz's head, chest, spine and abdomen. (NNRH at NEN 000003-4, 13-14, 17.)

8. Dr. Garvey reviewed the scans and diagnosed Mr. Schwartz with multiple right rib fractures with flail segment, right pulmonary contusions, closed head injury with loss of consciousness, right pneumothorax, hemoperitoneum, possible subdural hematoma, and possible kidney contusion. (NRNH at 000009-10, 18; Deposition of David Garvey, M.D. ("Garvey Depo") at 87,101.)

9. The autopsy results for Mr. Schwartz revealed he actually had a bilateral flail chest due to right side rib fractures that included ribs 2 through 7 and fractures of the left ribs 2 through 4. (ECCR at SDT-ECC-000095.)

10. Mr. Schwartz's oxygenation was 83% on room air and at 91%-92% on a nasal cannula delivering 4 lpm. Dr. Garvey placed Mr. Schwartz on a Venturi mask, delivering 40% oxygen. (NNRH at NEN000009; Garvey Depo. at 110-111, 131.)

11. Dr. Garvey administered a 4mg dose of Zofran at 10:33 and another 4mg dose at 11:19 p.m. for nausea. This was in addition to the 4mg dose he received during EMS transport. (EKCR at ECA 0004; NNRH at NEN000006; Garvey Depo at 107.)

12. Dr. Garvey determined that the multi-trauma injuries Mr. Schwartz sustained required that he be transferred to a trauma center.

13. Dr. Garvey developed a plan of action that included a simultaneous thoracostomy and intubation prior to transport via air ambulance. Dr. Garvey requested a highly skilled flight paramedic to perform rapid sequence intubation on Mr. Schwartz while Dr. Garvey performed the thoracostomy. (Garvey Depo. at 136-137; Deposition of Barry Bartlett at 14-15, 35, 73.)

14. Dr. Garvey discussed the severity of the injuries and the plan of action with Mr. Schwartz and his wife, disclosing the need for intubation and the risk of not intubating. (Garvey Depo. at 117-118.)

OPINIONS

15. Based on my education, training and experience, and on my review of the medical records and other materials referenced above, I have developed the following opinions.

16. Based on the standard of care for triage in the field, Mr. Schwartz sustained a bilateral flail chest injury, which is a life-threatening injury that complicates both pulmonary and cardiac function. It poses a significant risk of death—a high risk of respiratory failure—due to inadequate ventilation from both the paradoxical movement of the chest wall with breathing, as well as splinting, and inadequate tidal volumes due to pain. For this reason, Mr. Schwartz needed a thoracostomy and intubation in order to maintain pulmonary function and patient airway, and he needed both on an emergent basis. Bilateral flail chest injuries resulting from a traumatic impact require intubation; there is no reasonable medical alternative.

17. Mr. Schwartz had a bilateral flail chest, pulmonary contusions, a traumatic pneumothorax, and inadequate oxygenationas a result of being struck by a drunk driver. None of

those injuries could be treated on a nonemergent basis because Mr. Schwartz could not be stabilized until conservative management by a trauma surgeon ruled out impending respiratory failure, the need for mechanical respiration, and the need for surgical rib fracture fixation.

18. Mr. Schwartz had clinical indications for intubation, including risk of aspiration, low oxygenation, and anticipation of a deteriorating course that leads to respiratory failure.

19. Mr. Schwartz's medical condition could deteriorate precipitously, and therefore, transport via air ambulance was superior to ground transportation, because it is much faster. In addition, intubation was clearly indicated for transport via air ambulance since Mr. Schwartz would have even lower oxygen saturation, due to the low atmospheric pressure at a high altitude. Mr. Schwartz's pneumothorax required a thoracostomy on an emergent basis for the additional reason that a pneumothorax expands during flight and runs a high risk of becoming a tension pneumothorax that can lead to cardiac arrest.

20. Nurse anesthetists generally assist with providing general anesthesia to fasted patients in the operating room and have little experience performing rapid sequence intubation in trauma settings. Rapid sequence intubation is routinely used in emergency medicine and is the safest method of quickly intubating a patient with gastric contents where the risk of aspiration is increased, even though the general risk of aspiration is low.

21. It was entirely appropriate to have a highly qualified flight paramedic perform rapid sequence intubation while Dr. Garvey performed the thoracotomy. Flight paramedics routinely intubate patients in trauma settings using rapid sequence intubation.

22. Since Mr. Schwartz needed a thoracostomy and intubation on an emergent basis, the disclosure Dr. Garvey provided to Mr. Schwartz and his wife, advising them of the serious nature of his injuries and the risks of not intubating, is what a reasonable emergency physician would disclose under the circumstances.

23. Given the above, Dr. Garvey's emergency care and treatment of Mr. Schwartz during his June 23, 2016 visit was within the standard of care because Dr. Garvey implemented a plan of action that included (1) a thoracostomy, (2) rapid sequence intubation, with a highly experienced paramedic and (3) transport via air ambulance to a trauma center.

24. Furthermore, nothing that Dr. Garvey did or failed to do caused or contributed to Mr. Schwartz's injuries. Multiple attempts to intubate are within the standard of care. While conventional wisdom says to make three attempts at intubation before creating a surgical airway, this rule is not ironclad. An attempt at intubation occurs when an attempt is made to pass an ET tube into the trachea, not merely when laryngoscope blades are used to see the larynx. Here, paramedic Bartlett made two intubation attemps and Dr. Garvey made three before CPR was started and a King airway was used to ventilate Mr. Schwartz. Thereafter, no more than three intubation attempts were made before Dr. Garvey attempted a surgical airway. After a King airway was established, and Mr. Schwartz's pulse was restored, it was within the standard of care to make a few more attempts at mechanical intubation before creating a surgical airway. In this case, there were no more than three more attempts. In this particular case, creating a surgical airway following Dr. Garvey's initial intubation attempts would have resulted in a failed airway, since emesis was blocking every tube, not just the ET tube.

25. Accordingly, based upon my education, training and experience on my review of the medical records and other materials referred to above, it is my opinion that, to a reasonable degree of medical probability, the care and treatment rendered to Mr. Schwartz was within the applicable standard of care.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on July 17, 2020, at Los Angeles, California.

David Barcay, M.D., FACEP, FAAEM, FCCP, FACP

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This partial summary judgment motion seeks an order limiting civil damages under NRS 41.503, Nevada's "Trauma Cap" statute. This statute imposes, by legislative decree, a limitation of $50,000 on a physician's liability in a trauma setting when care or treatment is rendered in good faith. In this case, Douglas Schwartz sustained life threatening injuries, was admitted to the hospital where he was treated by defendant Dr. David Garvey, and succumbed to cardiac arrest during attempts to intubate him prior to transfer to a trauma center.

The trauma cap applies here—for two reasons. *First*, Plaintiff Diane Schwartz did not allege that Dr. Garvey rendered treatment in bad faith, and this court has refused to allow further amendment. Having failed to plead an exception to the statute, Plaintiff may not now claim bad faith is a disputed material fact. This motion can be granted based on this procedural deficiency in the pleading without even reaching the merits. *Second*, even if this Court does reach the merits, both the evidence and the expert medical opinion in the relevant field demonstrate the trauma cap applies because Dr. Garvey was acting in good faith.

Mr. Schwartz was admitted to the emergency room of a rural hospital with multi-trauma life, threatening injuries. He was in an unstable condition due to a bilateral flail chest injury, in addition to a traumatic pneumothorax and lung contusions, placing him at a high risk of respiratory failure. He required a thoracostomy[1] and intubation on an emergent basis before air transport to a trauma center, and Dr. Garvey disclosed what a reasonable physician would disclose under the circumstances. Further, Dr. Garvey's decision to ask a highly skilled, veteran paramedic to perform rapid-sequence intubation on Mr. Schwartz while Dr. Garvey simultaneously performed a thoracotomy so Mr. Schwartz could be swiftly

[1] Placement of a chest tube.

transferred to a trauma center—was an appropriate judgment call.

For all of these reasons, the trauma cap applies as a matter of law and this motion should be granted in its entirety.

II. SUMMARY OF FACTS

On June 22, 2016, the decedent, Douglas Schwartz, was struck by a drunk driver as he was crossing the street.[2] (*See,* Elko County Ambulance Record ("EMS Record"), **Exhibit "A"** at 0004.) Mr. Schwartz was thrown over the driver's car and landed 10 feet away, suffering a brief loss of consciousness. (*Ibid.*) Paramedics responded to the scene, placed him in full C-spine precautions, and transported him to Northeastern Nevada Regional Hospital ("Hospital"), where he was admitted as an ESI Level 2 patient at 8:51 p.m.[3] (*Ibid; See* Northeastern Nevada Hospital Records ("Hospital Records"), **Exhibit B** at NEN000010, 18.) Plaintiff consented to "any hospital services that are appropriate for my care and as ordered by my physician(s)" on her husband's behalf. (*Id* at NEN000030-32.) When he arrived in the emergency department, Mr. Schwartz was wearing a nasal cannula, delivering oxygen at 4 liters per minute ("lpm"). (*See* EMS Records, **Exhibit A** at 0004; Hospital Records, **Exhibit B** at NEN00003, NEN000008; Deposition of David Garvey, M.D. ("Garvey Depo."), **Exhibit C** at 82:22-83:12; Deposition of Donna Kevitt, R.N. ("Kevitt Depo."), **Exhibit D** at 23:4-24:19.)

Dr. David Garvey, the Hospital's attending emergency physician, ordered trauma lab tests and CT scans of Mr. Schwartz's head, chest, spine and abdomen. (*See* Hospital Records, **Exhibit B** at NEN000006; Garvey Depo., **Exhibit C** at 82:16-21.) Because Mr. Schwartz sustained significant trauma, Dr. Garvey also started a second IV and crossed

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[2] The driver pled guilty to a felony charge of failing to stop at scene of a crash involving personal injury or death. (Elko County Coroner Records, Exh. L at SDT-ECC-000003.)

[3] "ESI" is the Emergency Severity Index, a triage tool for emergency department care developed by the Agency for Healthcare Research and Quality, one of twelve agencies within the United States Department of Health and Human Services. ESI 2 means the patient is at a high risk of deterioration or has signs of a time-critical problem. *See* https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf, accessed on June 25, 2020.

checked for appropriate blood supply before switching him over to the Hospital's oxygen source. (*See,* Garvey Depo., **Exhibit C** at 84:3-15.) Dr. Garvey found emergent issues on every CT scan, including pulmonary contusions, rib fractures (#4-#7) with flail segment, a traumatic pneumothorax, two pedicle fractures, possible kidney contusion, possible subdural hematoma with loss of consciousness, and hemoperitoneum[4] of unknown origin. (*See,* Hospital Records, **Exhibit B** at NEN000020, 50-58; Garvey Depo., **Exhibit C** at 87:10-89:2; 92:6-21; 97:5-104:1; 105:1-4.) The results alarmed him. (*See,* Garvey Depo., **Exhibit C** at 100:1-3.) The flail segment, one of the "deadly dozen" life threatening injuries, meant Mr. Schwartz's condition was not longer serious, but critical, a Level 1 trauma. (*Id.* at 97:5-9; 114:17-21.) Dr. Garvey testified:

> Q. And what are the symptoms that are associated with flail chest?
> A. Well, the main problem with the failed—a flail chest usually is the underlying pulmonary contusion where the lung itself is bruised and filling with blood. ⁋ But you also have an area of the chest that when the patient breathes, there's paradoxical movements. So when you do an inspiration, the rest of the chest goes out and the flail segment goes in, so ventilation isn't adequate.
>
> Q. And was Mr. Schwartz—did Mr. Schwartz have any of those symptoms?
>
> A. Yes, he did.
>
> Q. And did you document that somewhere?
>
> A. It is documented in the—the reports, especially in the radiology findings. His oxygen saturations are documented, and they started diminishing. He required to be placed on a Venti-mask as opposed to a four-liter nasal cannula.
>
> Q. And when you're talking about the---the breathing pattern, did you document that anywhere in the medical record?
>
> A. No. Well, it's not obvious.

(*See* Garvey Depo., **Exhibit C** at 98:2-23.)

Based on these emergent findings and compromised respiration, Dr. Garvey made

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[4] Hemoperitoneum is the accumulation of blood in the space between the inner lining of the abdominal wall and the internal abdominal organs.

the decision to transfer Mr. Schwartz to a trauma hospital and arranged for early transport via air ambulance[5] to the University of Utah ("UofU"), a Level 1 trauma center. (*See* Hospital Records, **Exhibit B** at NEN000005; Garvey Depo., **Exhibit C** at 92:17-93:8; 100:17-24; 113:6-7; Utah Department of Health Trauma Map,[6] **Exhibit E**.) The Hospital is a rural hospital[7], not a trauma center[8], and lacks a pulmonary surgeon, a trauma surgeon, and an anesthesiologist. (*See* Garvey Depo., **Exhibit C** at 95:17-19; 96:4-5; 126:18-127:10; 133:23-24; Deposition of Susan Olson, R.N. ("Olson Depo."), attached as **Exhibit F** at 72:22-73:3; Department of Health and Human Services Nevada Division of Public and Behavioral Health Licensee Search Results ("License"), **Exhibit G**.) Nearly all transfers out of the Hospital are emergent. (*See,* Garvey Depo., **Exhibit C** at 114:11-13; Kevitt Depo., **Exhibit D** at 29:25-30:5.) Mr. Schwartz would be under the care of a trauma surgeon from the University of Utah (UofU) for several days and would need to be evaluated for bleeding in his abdomen. (*Id.* at 95:10-16; 103:12-19.) Mr. Schwartz also required a chest tube. (*Id.* at 93:23-94:15.) After learning about the extent of Mr. Schwartz's injuries, the attending emergency physician at UofU also requested placement of a chest tube and requested possible intubation. (*See,* Hospital Record, **Exhibit B** at NEN000005; Garvey Depo., **Exhibit C** at 111:22-113:9.) On room air, Mr. Schwartz's O2 saturation was very low, at 83%; when placed on a nasal cannula with 4 liters per minute, it rose to only 91%. By 11:37 p.m., Mr. Schwartz was placed on a 40% Venti-mask, which delivers oxygen at higher levels.[9] (*See*

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[5] NRS 450B.030 defines "air ambulance" as an "aircraft especially designed, constructed, modified or equipped to be used for the transportation of injured or sick persons" and does not include a commercial aircraft carrying passengers on regularly scheduled flights.

[6] https://www.utahtrauma.org/registryMembers/documents/regionmap.pdf, accessed on June 25, 2020.

[7] A "rural hospital" has 85 or fewer beds and is the sole provider of health care located within a city whose population is less than 25,000. NRS 449.0177.

[8] A hospital in the state of Nevada may not operate as a trauma center without approval from the State Board of Health. NRS 450B.060; 450B.236; 450B237.

[9] Nurse Kevitt observed Mr. Schwartz was not stable on room air and had compromised breathing sounds. (Kevitt Depo, **Exhibit D** at 78:23-79:6; 94:7-96:19.) She clarified that upon arrival she noted on the medical records that he was breathing without difficulty, but she was only observing him from across the room. (*Id.* at 37:11-38:12.)

Hospital Records, **Exhibit B** at NEN000004, NEN00009-10; Garvey Depo., **Exhibit C** at 84:16-85:13; 107:12-15; 109:22-111:2; 132:13-133:2.)

Mr. Schwartz became nauseous and received two doses of Zofran, one at 9:02 p.m. and another at 11:18 p.m. (*See* Hospital Records, **Exhibit B** at NEN000006; Garvey Depo., **Exhibit C** at 107:16-17; Kevitt Depo., Exhibit . D at 68:5-18.) After the second dose was administered, Dr. Garvey concluded that Mr. Schwartz, who remained in a C-collar on a backboard, could vomit at any time, and that his airway was unstable. (*See* Garvey Depo., **Exhibit C** at 107:18-20; 108:4-7.) Dr. Garvey also concluded that "there was a much greater risk of aspiration if Mr. Schwartz remained on a backboard in an airplane trying to transport him two hours to the trauma center." (*See* Garvey Depo., **Exhibit C** at 119:7-10; 120:6-10; 126:9-10.) Because of the risk of aspiration in flight, the safer course of action would be to intubate Mr. Schwartz pre-flight rather than risk intubation in a cramped aircraft without the resources of a hospital, which would have been disastrous. (*See,* Garvey Depo., **Exhibit C** at 130:22-133:3.) Dr. Garvey made the decision to intubate Mr. Schwartz and was familiar with the need for pre-flight intubation, having transferred hundreds of patients out of the Hospital.[10] (*Id.* at 63:17-64:8; 113:4-16 [That's my decision. I'm the transferring physician"].)

Due to the nature of his injuries, intubation was needed on an emergent basis and there was no alternative to intubation before Mr. Schwartz could be air transported, where his oxygenation would decrease due to the altitude. (*Id.* at 120:14-121:18; Barcay Decl. ¶¶ 16-19.) In addition, Mr. Schwartz's pneumothorax required a thoracostomy on an emergent basis for the additional reason that a pneumothorax expands during flight and runs a high risk of becoming a tension pneumothorax that can lead to cardiac arrest. (Barcay Decl., ¶19.) Dr. Garvey discussed the severity of the injuries and the necessity for the chest tube

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[10] Although Dr. Garvey was formerly the Medical Director for Reach Air, the flight company that was supposed to transport Mr. Schwartz, he received no compensation based on the number of transports from the Hospital; The flight company responding to a request for transport would depend on patient preference or on who could offer the quickest transport. Dr. Garvey did not create the policies or protocols for the Reach Air crew, and he was unaware if the Hospital had a contractual relationship with Reach Air. (Garvey Depo., **Exhibit C** at 37:3-12; 45:13-17; 51:3-10.)

placement and intubation with both Mr. Schwartz and Plaintiff. He stated that the risk of intubation was outweighed by the risk of not intubating. They expressed no disagreement, and Plaintiff consented to her husband's transfer to UofU to receive immediate access to trauma specialists, equipment and monitoring.[11] (*See* Hospital Records, **Exhibit B**. at NEN000040; Garvey Depo., **Exhibit C** at 117:2-119:13.) Reach Air flight paramedic, Barry Bartlett, was present for this discussion. (*See* Deposition of Barry Bartlett ("Bartlett Depo."), **Exhibit H** at 51:6-52:24.) Due to the fact Mr. Schwartz had recently eaten, Dr. Garvey's plan was to proceed with rapid-sequence intubation, a procedure which reduces the risk of aspiration, although the risk of aspiration with this procedure is low. (*See*, Garvey Depo., **Exhibit C** at 136:12-22; Barcay Decl. at ¶20.) When the decision has been made to secure the airway of an emergency patient, Dr. Garvey always assumes the patient has a full stomach.

Dr. Garvey asked Bartlett, a 33-year veteran paramedic with over 1,500 intubations in the field, to assist because he knew Bartlett was competent.[12] (*See* Garvey Depo., **Exhibit C** at 148:11-15; Bartlett Depo., **Exhibit H** at 14:25-15:3; 35:5-7.) Bartlett has never lost a patient, had experience intubating patients who had just eaten, and was aware that Mr. Schwartz had recently eaten. (*Id.* at 38:20-25; 39:16-23.) The plan was to have Bartlett intubate Mr. Schwartz while Dr. Garvey simultaneously placed the chest tube.[13] (*See*, Garvey Depo., **Exhibit C** at 127:19-23; Bartlett Depo., **Exhibit H** at 78:21-24.)

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[11] It is not the custom and practice of the Hospital or Dr. Garvey to obtain written consent to undergo intubation. (*See* Garvey Depo., **Exhibit C** at 128:9-13; Kevitt Depo., **Exhibit D** at 87:2-15; Olson Depo., **Exhibit F** at 59:5-8.)

[12] It can be inferred Bartlett actually has much more experience, since he stopped keeping a record of the number of intubations he had performed after logging 1,500 intubations, *fifteen years earlier*. (*See* Bartlett Depo., **Exhibit H** at 35:10-19.)

[13] Dr. Garvey would never have a nurse anesthetist intubate a patient in the emergency room, since nurse anesthetists intubate patients in a fasted state under general anesthesia, in the operating theater, and have little to no experience performing a rapid sequence intubation, which is routinely performed by flight paramedics. (*See* Garvey Depo., **Exhibit C** at 129:3-130:5; Kevitt Depo., **Exhibit D** at 62: 10-24; 99:9-100:4; Olson Depo., **Exhibit F** at 27:15-28:22; Bartlett Depo., **Exhibit H** at 35:5-7; 42:19-20; 57:2-3; 70:14-16; 71:15-16.)

Mr. Schwartz was preoxygenated and Ketamine and Rocuronium were administered. (*See*, Hospital Records, **Exhibit B** at NEN000033.) There were nine team members in the room, including Dr. Garvey, nurses Donna Kevitt, Sue Olson, and Cyndy Fuo, an ER technician, a respiratory therapist, an EMS technician, flight paramedic Bartlett, and Dr. Garvey. (*Id.* at NEN000033-35.) After sedation, Dr. Garvey prepared for the thoracostomy and Bartlett used a computerized fiberoptic laryngoscope to begin intubation. At 12:20 a.m., Bartlett stated he was having difficulty visualizing the glottic opening, due to anterior vocal cords, a situation Bartlett had encountered many times. (*See*, Bartlett Depo., **Exhibit H** at 63:15-20; 66:3-6; 72:7-23; 73:8-11.) He reoxygenated Mr. Schwartz and attempted intubation at 12:23 a.m., at which time Mr. Schwartz vomited, and aggressive suctioning of the airway was undertaken. (*Id.* at 76:2-24; 84:17-21.) Bartlett initiated a second intubation attempt, but Mr. Schwartz vomited again and the tube filled with emesis. (*Id.* at 78: 2-15.) At this point, Dr. Garvey had not yet placed the chest tube, and Mr. Schwartz was logrolled[14] multiple times, and his airway was suctioned repeatedly, using several suction machines. (*See,* Hospital Records, **Exhibit B** at NEN00003; Garvey Depo., **Exhibit C** at 152:2-6; Kevitt Depo., **Exhibit D** at 52:19-55:2.) Dr. Garvey attempted three intubations, applying cricoid pressure control regurgitation and make the trachea more visible, but he also had difficulty visualizing the airway. (*See*, Garvey Depo., **Exhibit C** at 78:25-79:2; 23-25; 82:13-15; 86:10-19; 91:23-24; 93:6.) CPR was started and his pulse was restored with a King airway, but his airway once again filled with emesis. (*See*, Garvey Depo., **Exhibit C** at 153:20-25; Bartlett Depo., **Exhibit H** at 96:7-18; 97:17, 21-25;) Thereafter, Dr. Garvey performed a cricothyrotomy, but this intervention was also thwarted when emesis filled the tubes, preventing any effort to oxygenate Mr. Schwartz. (S*ee*, Garvey Depo., **Exhibit C** at 154:4-19; Bartlett Depo., **Exhibit H** at 104:24-106:3.) Mr. Schwartz went into cardiac arrest and was pronounced dead at 1:33 p.m. (*See*, Hospital

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[14]Logrolling involves multiple people turning the patient completely face down in an effort to clear the airway. (*See*, Bartlett Depo., **Exhibit H** at 79:18-21; 88:7-13.)

Records, **Exhibit B** at NEN000035.) Dr. Garvey was in the room the entire time. (*See,* Kevitt Depo., **Exhibit D** at 98:8-12; Olson Depo., **Exhibit F** at 41:20-42:15.)

III. CONCISE STATEMENT OF UNDISPUTED FACTS

The following material facts are undisputed or conclusively established by the evidence submitted with this motion[15]:

1. After being struck by a drunk driver, Douglas Schwartz received care and treatment by Dr. David Garvey in the emergency department of Northeastern Nevada Regional Hospital, a rural hospital lacking a pulmonary surgeon, a trauma surgeon, and an anesthesiologist. (EMS Record, **Exhibit A** at 0004; Hospital Records, **Exhibit B** at NEN000006, 10, 18.)

2. As a result of the accident, and based on the standard of care for triage in the field, Mr. Schwartz sustained multiple traumatic injuries, including a bilateral flail chest, lung contusions, traumatic pneumothorax, pedicle fractures, hemoperitoneum, of unknown origin, possible kidney contusion, subdural hematomas, and loss of consciousness. (Hospital Records, **Exhibit B** at NEN000020, 50-58; Garvey Depo., **Exhibit C** at 87:10-89:2; Coroner Records, Exhibit . L, at SDT-ECC-000095.)

3. A bilateral flail chest is a life-threatening injury that complicates both pulmonary and cardiac function, and poses a significant risk of death—a high risk of respiratory failuredue to inadequate ventilation from both the paradoxical movement of the chest wall with breathing, as well as splinting, and inadequate tidal volumes due to pain. (Coroner Records, **Exhibit L** at SDT-ECC-000095; Barcay Decl., ¶16.)

4. A patient with a bilateral flail chest, pulmonary contusions, a traumatic pneumothorax, and inadequate oxygenation cannot be treated on a nonemergent basis because he cannot be stabilized until conservative management by a trauma surgeon rules out impending respiratory failure, the need for mechanical respiration, and the need for

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[15] Undisputed Facts will be referred to as "UMF."

surgical rib fracture fixation. (Hospital Records, **Exhibit B** at NEN000005, 20, 50-58; Garvey Depo., **Exhibit C** at 87:10-89:2; 92:6-93:8; 95:17-19; 96:4-5; 97:5-104:1; 98:2-23; 100:17-24; 105:104; 113:6-7; 114:17-21; 133:24-25; Trauma Map, **Exhibit E**; Olson Depo., **Exhibit F** at 72:22-73:3; Hospital Health License, **Exhibit G**; Barcay Decl. ¶17.)

5. Clinical indications for intubation include risk of aspiration, low oxygenation, and anticipation of a deteriorating course that will lead to respiratory failure, all of which were present here. (Barcay Decl., ¶18.)

6. A bilateral flail chest, traumatic pneumothorax and lung contusions create a high risk of respiratory failure, and require both emergent intubation and thoracotomy, especially for a patient transported via air ambulance at a high altitude, where oxygenation will be even further reduced due to the lower atmospheric pressure. (Garvey Depo., **Exhibit C** at 117:2-119:13; Barcay Decl., ¶¶16, 20.)

7. Mr. Schwartz's pneumothorax required a thoracostomy on an emergent basis for the additional reason that a pneumothorax expands during flight and runs a high risk of becoming a tension pneumothorax that can lead to cardiac arrest.

8. Bilateral flail chest injuries resulting from a traumatic impact by a drunk driver require intubation, and there is no reasonable medical alternative to intubation. (Barcay Decl., ¶16.)

9. Since a patient's medical condition can deteriorate precipitously, transport via air ambulance is superior to ground transportation because it is much faster. (Garvey Depo., **Exhibit C** at 126:18-127:10; Barcay Decl., ¶19.)

10. Nurse anesthetists generally do not perform rapid sequence intubation because they provide general anesthesia to fasted patients in the operating theater and they do not perform rapid sequence intubation at the Hospital in trauma settings. (Garvey Depo., **Exhibit C** at 129:3-130:5; Kevitt Depo., **Exhibit D** at 99:9-100:4; Olson Depo., **Exhibit F** at 27:15-28:22; Barcay Decl., ¶20.)

11. Barry Bartlett is a veteran flight paramedic with over thirty years experience, having performed intubations on patients who had recently eaten, and on patients with

difficult airways, with over 1,500 intubations in the field. (Bartlett Depo, **Exhibit H** at 14:24-15:21; 35:5-19; 73:8-11.)

12. It is entirely appropriate to have a highly qualified flight paramedic perform rapid sequence intubation while Dr. Garvey performed a thoracostomy, since flight paramedics routinely intubate patients in trauma settings using rapid sequence intubation. (Barcay Decl., ¶21.)

13. Rapid sequence intubation is routinely used in emergency medicine and is the safest method of quickly intubating a patient with gastric contents where the risk of aspiration is increased, even though the risk of aspiration is low. Barcay Decl., ¶20.)

14. If Mr. Schwartz was going to aspirate, he was going to aspirate without regard to who intubated him. (*See,* Garvey Depo., **Exhibit C** at 153:20-25; 154:4-19; Bartlett Depo., **Exhibit H** at 76:2-24; 84:17-21; 78:2-15.)

15.Multiple intubation attempts before surgical airway attempt is within the standard of care, and an earlier surgical airway would not have changed the outcome. (Barcay Decl., ¶ 24.)

16.Because Mr. Schwartz needed a thoracostomy and intubation on an emergent basis, the disclosure give to Mr. Schwartz and his wife was what a reasonable emergency physician would do under the circumstances. (Barcay Decl., ¶22.)

17. Plaintiff pled ordinary negligence in her operative pleading ("Complaint"), supported by an affidavit from Dr. Scissors, claiming only that the standard of care was breached. (Complaint, **Exhibit I** at ¶¶ 25-29, 41-44, 75-76, 79, 81-82; and pp. 18-21.)

IV. ARGUMENT IN SUPPORT OF SUMMARY JUDGMENT

A. Early Resolution of "Limitation of Liability" Issues Via Summary Judgment is Sound Public Policy.

Before this court even reaches the question of professional negligence, it should first determine if the civil damage cap applies. Early resolution of a damage cap is a matter of sound public policy. The Nevada Supreme Court has observed that district courts "must" consider whether speedy resolution of damage limitation issues promotes economy in

litigation or "might lead to meaningful pretrial settlement . . . ." *County of Clark ex rel. University Med. Ctr. v. Upchurch by & Through Upchurch*, 114 Nev. 749, 961 P.2d 754 (1998) ("*Upchurch*"); see also *Brice v. Second Judicial Dist.*, 2011 Nev. Unpub. LEXIS 1196 *3 [Supreme Court ordered district court to clarify how the trauma cap would apply while the case was in its "early stages".]

This question can be resolved pre-trial. Summary judgment is not a disfavored procedure, but an integral part of Nevada rules designed to secure the just, speedy and inexpensive determination of an action lacking genuine issues of material fact. NRCP 56(c); *Wood v. Safeway*, 121 Nev. 724, 730, 121 P.3d 1026, 1030 (2005) (*Wood*) citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 106 S. Ct. 2548, 91 L.Ed.2d 265 (1986). "The substantive law controls which factual disputes are material and will preclude summary judgment; other factual disputes are irrelevant." *Id.* at 731. Once a moving defendant establishes his or her initial burden of showing there is no dispute as to any issue of material fact, the burden shifts to the plaintiff to establish a dispute of material fact actually exists. *Cuzze v. Univ. & Cmty. Coll. Sys. of Nev.*, 123 Nev. 598, 602, 172 P.3d 131, 134 (2007). A plaintiff may not rest upon general allegations and conclusions, but must set forth specific facts that transcend the pleadings with admissible evidence. *Wood*, 121 Nev. at 731-32, 121 P.3d at 1031 [the non-moving party may not build a case on "the gossamer threads of whimsy, speculation, and conjecture"].

Partial summary judgment is indeed appropriate here to resolve the question whether the state's trauma cap statute limits civil damages to $50,000.

B. Nevada's Trauma Cap Statute.

The Nevada Legislature convened for a special session to enact NRS 41.503, the "trauma cap" statute, in response to closure of UMC Trauma Center in 2002 after multiple trauma surgeons resigned in response to skyrocketing malpractice insurance costs. In doing so, the Legislature intended to "create an environment where [ ] doctors can continue to treat the most critically injured trauma patients." [*See*, Excerpt from Journal of the Senate of the State of Nevada, Eighteenth Special Session, July 29, 2002, **Exhibit J**, at 2.) The

liability limitations of NRS 41.503 provides, in relevant part:

> 1. Except as otherwise provided in subsection 2 and NRS 41.504, 41.505 and 41.506:
>
> a. A hospital which has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to NRS 450B.237 and which is a nonprofit organization;
>
> b. A hospital other than a hospital described in paragraph (a);
> ***
> d. **A physician or dentist under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a) or (b)**, whether or not the care or assistance was rendered gratuitously or for a fee; [ ]
> ***
> **That in good faith renders care or assistance necessitated by a traumatic injury demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, may not be held liable for more than $50,000 in civil damages**, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance **if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct**.

The cap does not apply once a patient is "stabilized" or if treatment is unrelated to the original traumatic injury:

> 2. The limitation on liability provided pursuant to this section does not apply to any act or omission in rendering care or assistance:
>
> a. Which occurs **after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient**, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation on liability provided by subsection 1 applies to any act or omission in rendering care or assistance which occurs before the stabilization of the patient following surgery; or
>
> b. Unrelated to the original traumatic injury

The statute defines "reckless, willful or wanton conduct" and "traumatic injury" as follows:

> 4. For the purpose of this section:
>
> (a) "Reckless, willful or wanton conduct," as it applies to a person whom subsection 1 applies, shall be deemed to be that conduct which the person knew or should have known at the time the person rendered the care or assistance would be likely to result in injury so as to affect the life or health of another person, taking into consideration to the extent applicable:
>
> 1. The extent or serious nature of the prevailing circumstances;

2. The lack of time or ability to obtain appropriate consultation;

3. The lack of prior medical relationship with the patient;

4. The inability to obtain an appropriate medical history of the patient; and

5. The time constraints imposed by coexisting emergencies.

(b) "Traumatic injury" means any acute injury which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities.

NRS 41.503 (emphasis added).

C. This Court Should Grant Summary Judgment Based on the Absence of Facts in the Complaint Raising a Disputed Material Fact.

A motion for summary judgment is framed by substantive law. If a factual issue is not alleged in the pleadings, it cannot become a material fact for purposes of summary judgment simply by raising it in the opposition. Summary judgment cannot be based upon unpled claims that do not give a defendant fair notice of what the plaintiff's claim is and the ground upon which it rests. *Young v. Mercury Cas. Co.* 2016 U.S. Dist. LEXIS 100227 *13. Thus, a plaintiff may not raise an unpled issue for the first time in opposition to a summary judgment. *Hasan v. E. Wash. State Univ.*, 485 Fed. Appx. 168 170-171 (9th Cir. 2012.). This motion seeks an order limiting damages to a maximum of $50,000 based on NRS 41.503. An exception to the statute is conduct that is either gross negligence or reckless, willful and wanton. Those allegations are missing from the Complaint, since Plaintiff only alleged ordinary negligence. (*See,* Complaint, **Exhibit I**.) Further, the supporting affidavit of Dr. Scissors only asserts breached the standard of care based on ordinary negligence. (*Ibid.* at 18-21.)

Professional negligence means "the failure of a provider of health care, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health." NRS 41A.015. However, Plaintiff's operative pleading alleges ordinary negligence based on NRS 41A.015, nothing bordering on gross negligence, or reckless, willful or wanton conduct.

Plaintiff's original complaint alleged, in conclusory fashion, punitive damages, and only as to the 4th claim of relief for loss of consortium. (*See*, Original Complaint, **Exhibit K** at ¶¶ 83-85.) Plaintiff alleged, without any supporting facts, that Dr. Garvey engaged in despicable, outrageous, contemptible and unconscionable conduct, that was willful, malicious, fraudulent and oppressive, and that was "carried on with willful and conscious disregard for the safety of" her husband "and others in the State of Nevada." (*Ibid.*)

Just four months later, however, Plaintiff filed an amended complaint removing these allegations (*See*, Amended Complaint, **Exhibit L** at 14), and then filed a second amended complaint with the same omissions. (*See*, Complaint, **Exhibit I.**) Plaintiff sought leave to file a third amended complaint inserting these recycled boilerplate allegations into, not just the fourth claim for relief, but into every cause of action. This Court denied leave, however, citing inattention and unreasonable delay. (*See*, Order, **Exhibit M**.) The ship has now sailed, and Plaintiff is stuck with her current pleading, alleging ordinary negligence *only*.

Nevada distinguishes between ordinary negligence, gross negligence, and wanton conduct. "In the civil context, 'ordinary' negligence has been described as the 'failure to exercise that degree of care in a given situation which a reasonable man under similar circumstances would exercise. Gross negligence 'is an act or omission respecting legal duty of an *aggravated character* as distinguished from a mere failure to exercise ordinary care.'" *Cornella v. Churchill Cnty.*, 132 Nev. 587, 593-594, 377 P.3d 97, 102 (2016) (emphasis added). Likewise, "gross negligence" is distinct from "reckless, willful and wanton conduct", which borders on intentional conduct. It is "beyond the routine. There must be some act of perversity, depravity or oppression," because it involves "an intention to perform an act that the actor knows, or should know, will very probably cause harm." *Davies v. Butler,* 95 Nev. 763, 771, 602 P.2d 605, 610 (1979).

Words have objective meaning, and Plaintiff must be bound by the words used in her Complaint. Plaintiff pled ordinary negligence. The words "gross negligence", or "reckless, willful, or wanton conduct" are nowhere in her operative pleading, and professional negligence, lack of informed consent, and loss of consortium claims are based

upon Dr. Garvey's purported "negligence and carelessness" that allegedly "fell below the standard of care." (*See*, Complaint, **Exhibit I** at ¶¶ 25-29, 41-44, 75-76, 79, 81-82.) Simply put, there are no allegations of an aggravated (gross negligence) or willful (perverse, depraved, oppressive) nature that would alert any defendant that these issues are raised in the pleadings. Thus, Plaintiff has failed to rebut the presumption of good faith, which applies to every physician, *Hulse v. Sheriff, Clark County,* (1972) 88 Nev. 393, 398, 498 P.2d 1317, 1320, and has thus failed to allege an exception to the trauma cap statute in order to create a triable issue.

Marshall v. Eighth Judicial Dist. Court, 108 Nev. 459, 461, 836 P.2d 47, 49 (1992) illustrates how the failure to plead bad faith precludes consideration of the issue on summary judgment. In *Marshall,* the police responded to a potentially life-threatening situation involving a mentally ill person. The trial court found that the police officers and the city were entitled to statutory immunity under NRS 433A.740, which affords immunity "unless it is shown that such officer or employee acted maliciously or in bad faith or that his negligence resulted in bodily harm to such person." *Id.* at 465, 836 P.2d at 51. Since the complaint did not allege bad faith, malice or negligence causing bodily harm, the Supreme Court held that summary judgment in favor of the city and its police officers was proper. *Id.* at 466, 836 P.2d at 52.

The same situation arises here. Under the trauma cap statute, Dr. Garvey is entitled to invoke the legislatively decreed damage cap because plaintiff failed to plead gross negligence or reckless, willful or wanton conduct. Since bad faith is not a material fact issue for purposes of the instant motion, the damage cap should apply as a matter of law under controlling authority, such as *Marshall*.

Preemptively, Dr. Garvey objects to any attempt by Plaintiff to raise the unpled issue of bad faith in opposition to this motion, and he does not expressly or implicitly consent to defense of such an issue. NRCP 15(b) allows a court to hear an issue not raised in the pleading when the issue is tried with the express or implied consent of the parties. In *Baughman & Turner v. Jory*, 102 Nev. 582, 583, 729 P.2d 488, 489 (1986), the Nevada

Supreme Court held that the failure to object to a theory of recovery raised in opposition to the summary judgment motion, which was never alleged in the complaint, constitutes implied consent to trial on that issue.

Since gross negligence, reckless, willful and wanton conduct were not pled, and there is no consent to try unpled issues, this court can grant this motion without reaching the merits.

D. Alternatively, Civil Damages Should Be Limited to $50,000 Because the Trauma Cap Statute Indisputably Applies .

Should this Court choose to address the merits, summary judgment should still be granted. The plain language of NRS 41.503 informs which facts are material for purposes of summary judgment: (1) care or assistance; (2) rendered by a doctor in a hospital; (3) to a trauma patient; (4) before the patient is stabilized; and (5) in good faith and without gross negligence, willful or wanton conduct. Here, it is undisputed Dr. Garvey rendered care or assistance to Mr. Schwartz after he sustained multiple life-threatening injuries, which could not be stabilized until he reached the trauma hospital. Care and assistance was rendered in good faith and without gross negligence, reckless, willful or wanton conduct.

1. Mr. Schwartz received treatment from Dr. Garvey for traumatic injuries at a regional hospital.

The evidence conclusively establishes Mr. Schwartz received multi-traumatic injuries, and upon his admission to the Hospital, he was treated by Dr. Garvey. UMF Nos. 1-3.

2. Mr. Schwartz could not stabilized at the regional hospital

Plaintiff may contend her husband was stabilized at the Hospital before evaluation. She alleges Mr. Schwartz arrived at the Hospital on "non-emergent" transport mode, and while at the hospital, he had a normal heart rate and rhythm, showed no signs of respiratory distress, his neurological and abdominal evaluation were normal, and his vital signs were stable up until the point of intubation. (*See*, Complaint, **Exhibit I** at ¶¶ 5, 8-11, 17.) These allegations are irrelevant, since Mr. Schwartz's injuries placed him at a

heightened risk of respiratory failure.

Material facts are driven by substantive law in a summary judgment motion. *Anderson v. Liberty Lobby, Inc.* 477 U.S. 242, 247-248 (1986). Under NRS 41.503, the trauma cap does not apply to professional negligence occurring "after the patient is stabilized and capable of receiving treatment as a nonemergency patient . . . ." NRS 41.503, subpart 2. Stabilization depends on the circumstances of each case and is to be based upon expert medical opinion. (*See*, Special Session, Day 2, **Exhibit J** at p. 3.) Stabilization occurs when a patient is capable of receiving medical treatment on a non-emergent basis. (*Id.* at 4.)

Mr. Schwartz remained in a very unstable condition before he was to be transferred to UofU. A bilateral flail chest requires emergency intubation, without which there will be respiratory failure due to inadequate ventilation from both the paradoxical movement of the chest wall with breathing as well as splinting and inadequate tidal volumes due to pain. UMF No. 3. A patient with bilateral flail chest, pulmonary contusions, and a traumatic pneumothorax cannot be stabilized until conservative management by a trauma surgeon rules out impending respiratory failure, the need for mechanical respiration, and the need for surgical rib fracture fixation. UMF No. 4.

Clinical indications for intubation including risk of aspiration, low oxygenation, and anticipation of a deteriorating course leading to respiratory failure were all present. UMF No. 5. Mr. Schwartz's abdomen CT scan revealed bleeding of unknown origin and the CT scan of his head, revealed a subdural hemorrhage. The autopsy findings confirmed multifocal areas of subgaleal hemorrhage. (*See*, Garvey Depo. **Exhibit C** at 101:23-102:8; Coroner Records, **Exhibit N** at SDT-ECC-000010.). Mr. Schwartz would have underdone further testing and investigation at UofU to determine the source of abdominal bleeding and the extent of cerebral trauma.

Documentary and declaratory evidence confirms Mr. Schwartz's unstable condition. Mr. Schwartz admitted to the Hospital with an acuity level of "Emergent 2" with abnormal vital signs, due to low oxygenation. (*See*, EMS Records, **Exhibit A** at 0004; Hospital

Records, **Exhibit B** at NEN000003, 10; Garvey Depo., **Exhibit C** at 82:22-83:12; Kevitt Depo., **Exhibit D** at 24:19-23:4.) His vital signs continued to be abnormal, up until intubation. (*See*, Hospital Records, **Exhibit B** at NEN00004, 19-20.) Even on a nasal cannula and a Venti-mask, his O2 stats hovered around 91%. *Ibid.* Bartlett observed Schwartz had unstable oxygenation. (*See*, Bartlett Depo., **Exhibit H** at 58:5-23.) Air transport was ordered because Mr. Schwartz was too unstable for a ground unit and required critical care abilities of an air transport team. (*See,* Hospital Records, **Exhibit B** at NEN000046.) Dr. Garvey was transferring Mr. Schwartz to the care of *another emergency physician*, Dr. Ray, at UofU. (*See,* Garvey Depo., **Exhibit C** at 112.) Certainly, this indicates treatment to be rendered on an emergent basis.

The fact is, Mr. Schwartz's traumatic injuries had been stabilized until he could be transferred to the care of a trauma team at UofU. During this time, the treatment Mr. Schwartz received was covered by the trauma cap.

3. Dr. Garvey rendered care and assistance in good faith and was not grossly negligent, reckless, willful or wanton.

Dr. Garvey rendered care and assistance to Mr. Schwartz in good faith. Evidence of gross negligence, or reckless, willful or wanton conduct is lacking.

Even if Dr. Garvey made an error in judgment, which is not the case, this is not evidence he acted in bad faith. An error in judgment is not evidence of bad faith. "The law affords every physician a presumption that whenever he attends a patient the treatment he renders is given in good faith. Good faith means good intent and the honest exercise of the physician's best judgment as to the needs of the patient. Mere errors of judgment are not evidence of bad faith. [citation.] The term 'good faith' has been defined as an honest, lawful intent, and the opposite of fraud and bad faith." *Hulse v. Sheriff, Clark County* (1972) 88 Nev. 393, 398, 498 P.2d 1317, 1320. Thus, decisions made in the good faith but erroneous belief that a physician is exercising his best judgment to care for a patient is not evidence of bad faith.

The standard for gross negligence is set forth in Nevada Pattern Civil Jury

Instructions, No. 7.4, and is taken directly from *Hart v. Kline*, 61 Nev. 96, 116 P.2d 672 (1941) [subsequently approved in *Troop v. Young*, 75 Nev. 434, 345 P.2d 226 (1959)]. It reads: "Gross negligence is substantially and appreciably higher in magnitude and more culpable than ordinary negligence. Gross negligence is equivalent to the failure to exercise even a slight degree of care. It is materially more want of care than constitutes simple inadvertence. It is an act or omission respecting legal duty of an aggravated character, as distinguished from a mere failure to exercise ordinary care. It is very great negligence, or absence of slight diligence, or the want of even scant care."

Finally, wanton conduct is "beyond the routine. There must be some act of perversity, depravity or oppression," because it involves "an intention to perform an act that the actor knows, or should know, will very probably cause harm." *Davies v. Butler,* 95 Nev. 763, 771, 602 P.2d 605, 610 (1979).

4. Decision to Intubate and Intubation Attempts

Dr. Garvey made the decision to intubate Mr. Schwartz based on a good faith belief that intubation was not only in the best interests of his patient, but was an emergency based on CT scan results. UMF Nos. 1, 2 . Further, intubation was a medical emergency due to the bilateral flail chest injuries. UMF No. 3. It would have been negligent to put Mr. Schwartz on the plane without intubation, since it would be next to impossible to intubate Mr. Schwartz inflight, without proper staff and all of the necessary equipment, had he lost his airway on the plane. Further, Dr. Garvey chose the safest approach for a patient that needed intubation who had recently eaten—rapid sequence intubation. UMF No. 12. While aspiration does happen, the risk of aspiration is low. UMF No. 12.

Aside from flail chest injuries indicating that intubation was an emergency, Mr. Schwartz was at high risk for respiratory failure due to his other pulmonary injuries. UMF Nos. 1-4. The inability to protect a patient's airway against the risk of aspiration is one of the clinical indications for intubation. UMF No. 5. The medical records also reveal his oxygenation was low while Mr. Schwartz was on oxygen due to a lung contusion, pneumothorax, and flail chest—situations which would worsen oxygenation during transport

at a high altitude. UMF No. 8. The failure to oxygenate and the anticipation of a deteriorating course that will lead to respiratory failure are two additional clinical indications for intubation. UMF No. 5. There was also no alternative to intubation. UMF No. 7. Further, Mr. Schwartz's thoracotomy was an emergency because a pneumothorax expands during flight and runs a high risk of becoming a tension pneumothorax that can lead to cardiac arrest. UMF No. 7. It would have been negligent to place Mr. Schwartz on the plane without intubation and a thoracostomy, where he had a high risk of respiratory failure and possible cardiac arrest. Multiple intubation attempts are within the standard of care under the circumstances presented here, and an earlier surgical airway would not have changed the outcome, given massive aspiration. UMF No. 15.

5. Paramedic Performing the Rapid Sequence Intubation

Likewise, Dr. Garvey acted in good faith when he asked paramedic Bartlett to intubate Mr. Schwartz. Dr. Garvey concluded Bartlett was competent and qualified in airway management, having performed rapid-sequence intubation quite frequently. (*See,* Garvey Depo., **Exhibit C** at 129-130.) Bartlett was highly skilled at intubation in the field. UMF No. 10. It was entirely appropriate to have a highly qualified flight paramedic perform rapid sequence intubation with Dr. Garvey performed the thoracostomy, since flight paramedics routinely intubate patients in trauma settings using rapid sequence intubation. UMF No. 11. A flight paramedic is only required to have three years of field experience as a paramedic. NRS 450B.225(1)(b)(2). Bartlett had over thirty years experience and had performed over 1,500 intubations in emergent conditions. UMF No. 10. Because of the emergency situation, a simultaneous intubation would allow Dr. Garvey to place the chest tube—something only a doctor could do—while Bartlett performed the intubation, so that Mr. Schwartz did not need to be sedated twice, and could be transported to UofU sooner. (*See*, Garvey Depo., **Exhibit C** at 137:9-25.) After Bartlett's second intubation attempt failed, Dr. Garvey abandoned any attempt to insert the chest tube and began several intubation attempts as well as a cricothyrotomy. (*See*, Garvey Depo., **Exhibit C** at 154:4-25.) Under

the circumstances, Dr. Garvey was operating in good faith to do what was best for Mr. Schwartz.

Moreover, asking a highly skilled flight paramedic—with over 1,500 intubations in the field—to intubate a patient while the emergency medicine physician remained at the patient's side to perform an emergent thoracostomy, that only a physician could perform, is not gross negligence or reckless, willful or wanton conduct. In Nevada, flight paramedics routinely makes the decision when to intubate a patient, and can even perform a cricothyrotomy. (*See,* Bartlett Depo., **Exhibit H** at 36:1-3.) Dr. Garvey's decision to have a simultaneous thoracostomy/intubation in order to more quickly transfer Mr. Schwartz to the trauma center was a sound judgment call. He chose rapid sequence intubation, the safest method for quickly intubating a patient who is not in a fasted state. UMF No. 12. If aspiration was to occur, it would have occurred regardless of who performed intubation. UMF No. 13. Moreover, the hospital had no anesthesiologist, and the nurse anesthetists on call had no experience with rapid sequence intubation. UMF Nos. 1, 9. Under these circumstances, the course of conduct taken was not grossly negligent, reckless, willful or wanton.

6. Informed Consent

Dr. Garvey's disclosure to Mr. Schwartz that his serious injuries required intubation and a thoracostomy before he would be transported was made in good faith. Given the emergency need for intubation, the disclosure falls within what a reasonable emergency physician would have done under similar circumstances.

Plaintiff purportedly is concerned with the scope of disclosure. She has not alleged a total lack of consent, which constitutes a battery. *Humbolt Gen. Hosp. v. Sixth Judicial Dist.*, 132 Nev. 544, 548, 376 P.3d 167, 170 (2016) [scope of consent involves malpractice; lack of consent involves battery]. Since the scope of Dr. Garvey's consent raises a question of negligence based upon expert medical testimony, it sounds in negligence. Given the emergency nature of the injuries, Plaintiff cannot point to aggravated or deliberate conduct that would place the informed consent issue beyond the reach of ordinary negligence.

Plaintiff even admits she was unaware whether her husband consented to intubation after she left his hospital room, when Dr. Garvey was preparing Mr. Schwartz for the procedure. (*See*, Schwartz Depo., **Exhibit O** at 66:22-67:18; 129:8-19.)

Whether a physician gave informed consent is to be established by expert medical testimony. "Under the traditional view, the physician's duty to disclose is measured by a professional medical standard, which the plaintiff must establish with expert testimony. The standard is either the customary disclosure practice of physicians in the relevant 'community,' or what a reasonable physician would disclose under the circumstances. *Beattle v. Thomas*, 99 Nev. 579, 584, 668 P.2d 268, 271 (1983).

Here, since there was no reasonable alternative to intubation, and intubation was required on an emergent basis in order to secure the airway before respiration failed, Dr. Garvey disclosed what a reasonable emergency room physician would disclose under the circumstances. UMF Nos. 3, 4, 6, 7, 14, 16. Since at least one other emergency physician—board certified in critical care and internal medicine—agrees that informed consent was obtained, it is unlikely a reasonable person would conclude Dr. Garvey's disclosure constituted gross negligence or reckless, willful or wanton conduct.

On a final note, NRS 41.503, subpart 4 requires the court to consider, *to the extent applicable*, certain factors in assessing reckless, willful, or wanton. Here, the extent or serious nature of the prevailing circumstances (factor 1) and the time constraints imposed by coexisting emergencies (factor 5) establish that Mr. Schwartz sustained life-threatening, traumatic injuries that required immediate attention at a trauma center that was readily reachable by air transport. The failure to intubate before flight likely would have placed Mr. Schwartz in the precarious position of needing intubation in a cramped plane, without proper medical staff and equipment, should his condition have warranted intubation.

There are no disputed issues as to whether Dr. Garvey engaged in an inadequate consultation, or a failure to obtain Mr. Schwartz's medical history (factors 2 and 4). Dr. Garvey had no previous relationship with Mr. Schwartz (factor 3). None of these factors suggest reckless, willful or wanton conduct, since emergency medicine physicians routinely

employ rapid sequence intubation on patients who have recently eaten; it is the nature of their practice.

V. CONCLUSION

The trauma cap was designed to protect physicians, such as Dr. Garvey, who render care to trauma patients in good faith. The undisputed evidence establishes Mr. Schwartz had life threatening injuries requiring emergency intervention—a high risk of respiratory failure, low oxygenation and aspiration—requiring intubation. Dr. Garvey asked a highly skilled flight paramedic to perform rapid sequence intubation. Gross negligence, reckless, willful or wanton conduct do not arise here. Plaintiff failed to plead anything other than ordinary negligence, and should not be permitted to oppose the motion based on unpled assertions. For these reasons, Dr. David Garvey respectfully requests that damages be limited to a maximum of $50,000.

DATED this 21st day of July, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick
KEITH A. WEAVER
Nevada Bar No. 10271
ALISSA BESTICK
Nevada Bar No. 14979C
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant David Garvey, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on this the 21st day of July, 2020, a true and correct copy of **DEFENDANT DAVID GARVEY, M.D.'S MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES** was sent via electronic mail to the following:

SERVICE LIST

Sean Claggett, Esq.
Jennifer Morales, Esq.
CLAGGETT & SYKES LAW FIRM
4101 Meadows Lane, Suite 100
Las Vegas, NV 89107
Tel: 702.655.2346
Fax: 702.655.3763
Email:sclaggett@claggettlaw.com
Email:jmorales@claggettlaw.com
Attorneys for Plaintiff

Richard De Jong Esq.
Arla Clark Esq.
HALL PRANGLE & SCHOOVELD, LLC
1140 N. Town Center Drive, Suite 350
Las Vegas, NV 89144
Tel: 702.889.6400
Fax: 702.384.6025
Attorneys for Defendant, PHC-Elko, Inc. d/b/a Northeastern Nevada Regional Hospital

James T. Burton, Esq.
Matthew Ballard, Esq.
KIRTON MCCONKIE
36 S. State Street, Suite 1900
Salt Lake City UT 84111
Tel: 801.328.3600
Fax: 801.321.4893
Email: jburton@kmclaw.com
Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees

Todd L. Moody, Esq.
L. Kristopher Rath, Esq.
HUTCHISON & STEFFEN
Peccole Professional Park
10080 W. Alta Dr., Suite 200
Las Vegas, NV 89145
Tel: 702-385-2500
Fax: 702.385.2086
Email: tmoody@hutchlegal.com
Email: krath@hutchlegal.com
Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees

Robert McBride, Esq.
Chelsea R. Hueth, Esq.
Gerald L. Tan, Esq.
CARROLL, KELLY, TROTTER, FRANZEN, & MCBRIDE
8329 W. Sunset Rd., Suite 260
Las Vegas, NV 89113
Tel: 702.792.5855
Fax: 702.796.5855
Email: crhueth@cktfmlaw.com
Attorneys for Defendant Ruby Crest

By /s/ *Emma L. Gonzales*
An Employee of LEWIS BRISBOIS BISGAARD & SMITH LLP

EXHIBIT A

Incident Number: EA16-2256 **Patient Name:** Schwartz , Douglas

EMS Unit Call Sign: 939 **Patient Care Report Number:** 68ffb27070654b639ee678a

Narrative: Responded to the location above with lights and sirens for a 29-D-2-M, 58 y.o. male C/C right sided body pain after being struck by a car traveling approx 35-40 mph per bystander (car did not stop) Pt was struck by car on his right side cars drivers side fender struck pt he was then thrown up on the hood rolling along windshield up onto roof then falling to the ground. Pt does not remember is he had LOC but last thing he remembered is walking out of restaurant.

Arrived to find the pt lying on his right side in the side of the street with towels under his head and someone attempting to hold c-spine. pt is AAOx person/place/time but fuzzy about event but knows he was told he was hit by a car, skin W/P/D, positive trauma noted to right - shoulder/upper chest ribs/and knee, pupils PERL but right eye is blurry so it is pt thinks he may have lost his right contact, nose/ears /mouth all free of fluid/blood, negative pain on palp of neck/and spine area, negative JVD, trachea midline, chest = rise/fall/expansion pain to right upper ribs more towards back/scapula area there is abrasions and reddening to the area no defomity/crepitus noted, no pain to rest of ribs or chest, lungs diminished due to pt not wanting to take a deep breath, abdo soft/nontender, pelvis stable, = pulses to all extremities , left extremities not trauma noted, right shoulder pain upon movement which also increases rib pain with abrasions to shoulder and upper arm area, right knee has abrasions but not deformity noted and only slight pain on movement.

Pt was placed in full c-spine precautions with c-collar/backboard /headbeds and spider straps, placed on gurney/secured, in ambulance pt vitals obtained showing all within normal limits, O2 placed just for precaution 4L, saline lock 20g started inleft wrist area, monitor placed showing normal sinus no ectopy noted, pt then given 4mg Zofran IVP followed by 100mcg Fentanyl IVP, this did help with the pt pain and as long as we did not hit any bumps in the road pt was comfortable. Placed in room 12 upon arrival report given to RN's at bedside.

Past Medical History

Medication Allergies

Medication Allergies

No Known Drug Allergy

Medical History: CV - Primary
Hypertension

Assessment Exam