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

APPENDIX OF EXHIBITS TO PETITION FOR WRIT OF MANDAMUS – VOLUME 9 OF 13

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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 TO STRIKE THE DECLARATION OF SHIRLEY BLAZICH, ESQ.

DEFENDANT DAVID GARVEY, M.D., by and through his counsel of record, LEWIS BRISBOIS BISGAARD & SMITH, LLP, hereby files this Motion to Strike the Declaration of Shirley Blazich, Esq. in support of his Motion for Partial Summary Judgment to Statutorily Limit Damages.

/ / /

Defendant's pleading is based upon the pleadings on file, the memorandum contained herein, and any oral argument permitted on the motion.

DATED this 26th day of August, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick
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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

In Plaintiff's Opposition to Defendant David Garvey, M.D.'s Motion for Partial Summary Judgment, Plaintiff submitted the Declaration of Plaintiff's counsel, Shirley Blazich, Esq. Ms. Blazich's declaration should be stricken pursuant to NRCP 56(h).

First, in her declaration, Ms. Blazich declared that Plaintiff's Motion to Amend the Complaint to add a claim for punitive damages was denied without prejudice. *See* Declaration of Shirley Blazich, Esq. at ¶ 5. As this Court is aware, Plaintiff's Motion to Amend the Complaint to add a claim for punitive damages was denied **with prejudice**. *See* Order Denying Plaintiff's Motion to Amend, attached hereto as **Exhibit A**. In its six-page order, this court denied Plaintiff's Motion to Amend her Complaint with prejudice, finding plaintiff had "no explanation" for the delay in seeking leave to amend, and given the "utmost seriousness" of her allegations, concluded that "Plaintiff's counsel could have paid more attention to this case than she apparently has." **Exhibit A** at pp. 5-6.

In addition, Ms. Blazich declares that additional discovery must be done in order for Plaintiff to intelligently respond to Dr. Garvey's Motion for Partial Summary Judgment pursuant to NRCP 56(d). *See* Declaration of Shirley Blazich at ¶ 7. However, she fails to specify the reasons why she cannot present facts essential to justify her opposition because she fails to explain what facts would be established through the additional discovery she claims is needed.

II. ARGUMENT

In an apparent attempt to forestall this Court from ruling on Dr. Garvey's Motion, Ms. Blazich declares that additional discovery must be done in order for Plaintiff to intelligently respond to Dr. Garvey's Motion. NRCP 56(d) provides a mechanism for nonmovants when facts "essential to justify its opposition" are unavailable to the nonmovant. Under those circumstances, the Court may: (1) defer considering the motion or deny it; (2) allow time to obtain affidavits or declarations or to take discovery; or (3)

issue any other appropriate order. *See* NRCP 56(d). However, NRCP 56(c)(4) provides that a declaration used to oppose a motion for summary judgment must **set forth facts** that would be admissible in evidence. *See* NRCP 56(c)(4)(emphasis added).

NRCP 56(f)[1] requires that the party opposing a motion for summary judgment and seeking a denial or continuance of the motion in order to conduct further discovery provide an affidavit **giving the reasons why** the party cannot present "facts essential to justify the party's opposition." (Emphasis added). When possible, the court construes statutes so that no part of the statute is without effect. *See Paramount Ins. v. Rayson & Smitley*, 86 Nev. 644, 649, 472 P.2d 530, 533 (1970); *see also Webb v. Clark County School Dist.*, 125 Nev. 611, 618, 218 P.3d 1239, 1244 (2009) (indicating that the rules of statutory interpretation apply to Nevada's Rules of Civil Procedure). The Nevada Supreme Court has also recognized that a substantial compliance standard generally applies to statutory requirements, and the complete failure to meet a specific requirement of a statute will result in a lack of substantial compliance. *Las Vegas Convention & Visitors Auth. v. Miller*, 124 Nev. 669, 682-84, 191 P.3d 1138, 1146-48 (2008).

Here, Plaintiff's counsel provided a declaration, requesting a continuance pursuant to what is now NRCP 56(d). However, her declaration was not substantially compliant with NRCP 56(c), because she failed to provide the reasons why she cannot present facts essential to her opposition, because she did not explain what facts would be established by the discovery she claims is needed, which is required. *Choy v. Ameristar Casinos, Inc.*, 127 Nev. 870, 872, 265 P.3d 698, 700 (2011).

For instance, instead of explaining why further discovery is needed and what she expects to obtain from the discovery, Ms. Blazich simply makes the blanket statement in her declaration that the following additional discovery is needed:

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[1] *See* Drafter's Note: Rule 56(d) modernizes the text of former NRCP 56(f) consistent with FRCP 56(d). The changes are stylistic and do not affect *Choy v. Ameristar Casinos, Inc.,*127 Nev. 870, 265 P.3d 698 (2011), which requires an affidavit to justify a request for a continuance of the summary judgment proceeding to conduct further discovery.

- The deposition of Nancy Abrahms of NNRH;
- The deposition of Ronnie Lyons of Reach Air (since Plaintiff's opposition was filed, this deposition has been completed);
- The deposition of the NRCP 30(b)(6) witness for NNRH;
- The deposition of the NRCP 30(b)(6) witness for Ruby Crest;
- The deposition of Dr. Stefanko;
- The deposition of Dr. Jones;
- Initial and rebuttal expert disclosures; and
- The depositions of all expert witnesses.

Plaintiff has previously noticed the deposition of the NRCP 30(b)(6) witness for NNRH and the NRCP 30(b)(6) witness for Ruby Crest. The topics referenced in both deposition notices have nothing to do with the traumatic injury suffered by Mr. Schwartz when he was struck by a drunk driver while walking across the street. *See* Plaintiff's Notice of Taking the Deposition of Defendants Crum, Stefanko & Jones, Ltd. dba Ruby Crest Emergency Medicine's NRCP 30(b)(6) Witness, attached hereto as **Exhibit B**; *see also* Plaintiff's Notice of Taking the Deposition of NNRH's NRCP 30(b)(6) Witness, attached hereto as **Exhibit C**. Further, Plaintiff has failed to set forth what facts she expects to establish through the depositions of experts, Dr. Stefanko, Dr. Jones or Nancy Abrahms. Accordingly, Ms. Blazich's declaration does not comply with the requirements of NRCP 56(c)(4) and should be stricken.

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III. CONCLUSION

Based on the foregoing, the declaration of Shirley Blazich, Esq. should be stricken in its entirety.

DATED this 26th day of August, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick
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AFFIRMATION

PURSUANT TO NRS 239B.030

The undersigned does hereby affirm that the preceding document does not contain the social security number of any person.

DATED this 24th day of August, 2020.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick

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CERTIFICATE OF SERVICE

I hereby certify that on this the 26th day of August 2020, a true and correct copy of **DEFENDANT DAVID GARVEY, M.D.'S MOTION TO STRIKE THE DECLARATION OF** was sent via electronic mail to the following:

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EXHIBIT A

CASE NO. CV-C-17-439

DEPT. NO. 1

FILED

2018 OCT 15 P 2:22

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

V.

DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., 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 MEDICAL SERVICES, L.L.C., DOES 1 through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

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ORDER DENYING PLAINTIFF'S MOTION TO DISMISS

This matter came before the Court on Plaintiff's Motion to Amend Complaint filed September 4, 2018. The proposed Third Amended Complaint is attached to the motion. On September 20, 2018, Defendant Garvey filed Defendant David Garvey M.D.'s Opposition to Plaintiff's Motion for Leave to Amend Complaint. On September 24, 2018, Defendant PHC filed Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Opposition to Plaintiff's Motion for Leave to Amend Complaint and Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Joinder to Defendant David Garvey, M.D.'s

Opposition to Plaintiff's Motion for Leave to Amend Complaint. On that same date, Defendant REACH Air filed REACH Air Medical Services, LLC's Memorandum in Opposition to Plaintiff's Motion for Leave to Amend Complaint. On September 28, 2018, Defendants Crum, Stefanko, & Jones Ltd filed Defendant, Crum, Stefanko, & Jones Ltd, d/b/a Ruby Crest Emergency Medicine's Joinder to Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Opposition to Plaintiff's Motion for Leave to Amend Complaint. On October 1, 2018, Defendant Garvey filed Defendant David Garvey, M.D.'s Joinder to Defendant REACH Air Medical Services, LLC's Memorandum in Opposition to Plaintiff's Motion for Leave to Amend Complaint. On October 2, 2018, Plaintiff filed Plaintiff's Reply to David Garvey, M.D.'s Opposition to Plaintiff's Motion for Leave to Amend Complaint; Plaintiff's Reply to Defendant PHC-ELKO Inc.. dba Northeastern Nevada Regional Hospital's Opposition to Plaintiff's Motion for Leave to Amend Complaint; and, Plaintiff's Reply to REACH Air Medical Services, LLC's Opposition to Plaintiff's Motion for Leave to Amend Complaint.

On October 4, 2018, Plaintiff filed a Request for Review. On October 5, 2018, Defendant PHC filed a Request for Submission of Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Joinder to Defendant David Garvey, M.D.'s Opposition to Plaintiff's Motion for Leave to Amend Complaint.

A hearing on this matter was held on June 5, 2019. None of the parties was present. Plaintiff was represented by Jennifer Morales, Esq. Defendant Garvey was represented by Alissa Bestick, Esq. Defendant PHC was represented by Zachary Thompson, Esq. Defendant REACH Air was represented by Austin Westergard, Esq. Defendants Crum, et.al. were represented by Gerald Tan, Esq. The Court, having considered the documents filed by the parties and the oral arguments, finds and orders as follows.

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Plaintiff seeks leave of the Court to file her Third Amended Complaint. All Defendants have opposed the amendment for several reasons. In Adamson v. Bowker, 85 Nev. 115, 121, 450 P.2d 796, ___ (1969), the Nevada Supreme Court quoted with approval Foman v. Davis, 371 U.S. 178, 182, 83 S. Ct. 227, 230, 9 L. Ed. 2d, 222, 226 (1962), wherein it was stated:

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason—such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendment previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.—the leave sought should, as the rules require, be "freely given."

In the case at hand, the Complaint was filed June 22, 2017. The original Complaint included a claim for punitive damages in the Fifth Claim for Relief (Loss of Consortium). On July 20, 2017, Defendant PHC filed its Motion for Partial Dismissal of Plaintiff's Complaint. PHC sought dismissal of the first claim for relief and the punitive damages portion of the Fifth Claim for Relief. On August 3, 2017, Defendant Garvey filed a Motion to Dismiss Plaintiff's prayer for punitive damages. On August 28, 2017, Defendant REACH Air filed its Answer to Complaint as well as its Joinder in David Garvey, M.D.'s Motion to Dismiss Plaintiff's Request for Punitive Damages. On September 1, 2017, Defendant Garvey filed his Request for Submission of his Motion to Dismiss.

According to Defendant REACH Air, in its opposition to the motion to amend, on October 17, 2017, Plaintiff amended her complaint, omitting any claim for punitive damages. The court docket does not show an Amended Complaint filed on October 17, 2017. An Amended Complaint is loose in the court file with a notation, written in red ink, "REC'D 10/20/17." It does not have a certificate of service attached. The Amended Complaint was actually filed on February 5, 2018, but it, also, does not include a certificate of service, so the Court cannot tell when, or if, it was served on the parties. The Amended Complaint does not contain any claim for punitive damages and does not request punitive damages in the prayer.

Moreover, at page 13 of the Amended Complaint, under the Fifth Claim for Relief, the heading states, "Plaintiff Eli Colburn's Claim Against All Defendants." Eli Colburn is not a party to this action.

In any event, on October 12, 2017, Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Answer to Amended Complaint was filed. On November 13, 2017, REACH Air filed its Answer to Amended Complaint. On February 2, 2018, a Stipulation and Order to Amend the Amended Complaint was filed. On February 12, 2018, Plaintiff filed her Second Amended Complaint. It does not include a claim or prayer for punitive damages or a certificate of service. However, on April 23, 2018, Defendant David Garvey M.D.'s Answer to Plaintiff's Second Amended Complaint was filed. On May 25, 2018, an Order Setting Hearing on Pending Motions was filed. A hearing was scheduled for one-half day on September 6, 2018, on Defendant PHC's motion for partial dismissal; Defendant Garvey's motion to dismiss the request for punitive damages; and Defendant REACH Air's motion to dismiss the request for punitive damages. On June 21, 2018, Defendant, Crum, Stefanko, & Jones Ltd dba Ruby Crest Emergency Medicine's Answer to Plaintiff's Second Amended Complaint was filed.

On June 28, 2018, the Joint Case Conference Report was filed. All parties participated except Defendants Crum, et.al. The report was signed by the attorneys for the participating parties. The only mention of punitive damages is included in a recitation of Defendant REACH Air's Affirmative Defenses Twenty-Ninth through Thirty-Sixth.

The hearing on the various motions to dismiss went forward on September 6, 2018, with counsel appearing for all parties except Defendants Crum, et.al. At that hearing, counsel informed the Court that they would not be arguing the motions to dismiss the punitive damages request because punitive damages had been omitted from the Amended Complaint and Second Amended Complaint. Additionally, Plaintiff had filed her Motion to Amend Complaint two days before the hearing. Plaintiff's counsel told the Court that punitive damages had been unintentionally omitted by her office from the Amended Complaint and Second Amended

Complaint.

On September 10, 2018, Plaintiff filed her Errata to Plaintiff's Complaint, Amended Complaint and Second Amended Complaint. Exhibit 1 to the Errata is the *curriculum vitae* of Kenneth Scissors, M.D., the doctor who had authored the affidavit attached to the three complaints. At the September 6 hearing, the Court had informed Plaintiff's counsel that, although Dr. Scissors had referenced the *curriculum vitae* as an exhibit to his affidavit, it was not in fact attached. The Court, therefore, was unable to discern, on the basis of the affidavit, whether Dr. Scissors practiced in a field "substantially similar" to that involved in this case.

Concerning the motion presently before the Court, Plaintiff's proposed Third Amended Complaint contains the punitive damages request in the Fifth Claim for Relief that was in the original Complaint but omitted from the next two complaints. It also contains, for the first time, punitive damages allegations in the first four claims for relief.

In Defendant Garvey's opposition to the motion to amend, his counsel asserts that he sent an email to Plaintiff's counsel on April 10, 2018, five months before Plaintiff filed her Motion to Amend Complaint, stating that Defendant Garvey would be filing an answer to Plaintiff's Amended Complaint, given that the Amended Complaint no longer sought punitive damages. An email is attached to the opposition supporting this allegation. Plaintiff's counsel did not dispute this. In its opposition, PHC-ELKO states that Plaintiff delayed seeking leave to amend for seven months. At the September 6 hearing, Plaintiff's counsel had no explanation for the delay. She blamed her paralegal for removing the punitive damages language. The delay is too great, whether it was five months or seven months. Additionally, Plaintiff filed two amended complaints, both times omitting any allegations or prayer for punitive damages. In the meantime, several defendants filed answers, triggering the early case conference which occurred on May 9, 2018, and was attended by counsel for all parties except Defendants Crum et.al. The Joint Case Conference Report was filed on June 28, 2018, signed by counsel for all parties except Defendants Crum, et.al. Discovery then began. At the September 6, 2018, hearing, the three

appearing defendants did not argue their motions to dismiss because Plaintiff had filed her Motion to Amend Complaint two days before the hearing.

Although several defendants have alleged that they have been prejudiced by the delay, it is not necessary that this Court find any prejudice. The existence of prejudice is but one example cited by the Foman and Adamson courts of reasons for which a trial court may deny a motion to amend. Two of the other examples in those cases are "undue delay," and "repeated failure to cure deficiencies by amendment previously allowed . . . ." Id. Plaintiff delayed seeking leave to amend, after which she was or should have been aware of the problem, for at least five months, and for possibly as many as seven months. Plaintiff amended two times after her original complaint, both times excluding the issue of punitive damages. The amendment now sought by Plaintiff not only includes punitive damages as sought in the original complaint, it now adds the issue of punitive damages, where none existed before, to four claims for relief. Finally, the proposed Third Amended Complaint does not even contain a prayer for punitive damages. This is simply too much. The allegations made by Plaintiff are of the utmost seriousness. She alleges that the actions of these defendants led to the death of her husband. Surely, Plaintiff's counsel could have paid more attention to this case than she apparently has.

Plaintiff asks that any denial of her Motion to Amend be without prejudice so that she can seek to amend at a later date. A denial without prejudice will not cure the problems caused by Plaintiff's undue delay and previous failures to correct the deficiencies.

Therefore, IT IS HEREBY ORDERED that Plaintiff's Motion to Amend Complaint is **DENIED** with prejudice.

SO ORDERED this 15 day of October, 2019.

NANCY PORTER
DISTRICT JUDGE - DEPARTMENT 1

CERTIFICATE OF MAILING

Pursuant to NRCP 5(b), I hereby certify that I am an employee of the Fourth Judicial District Court, Department 1, and that on this 16th day of October, 2019, I deposited for mailing in the U.S. mail at Elko, Nevada, postage prepaid, a true file-stamped copy of the foregoing **ORDER DENYING PLAINTIFF'S MOTION TO AMEND COMPLAINT** addressed to:

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EXHIBIT B

CASE NO.: CV-C-17-439

DEPT. NO.: I

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; 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.

PLAINTIFF'S NOTICE OF TAKING THE VIDEOTAPED DEPOSITION OF DEFENDANTS CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY MEDICINE'S N.R.C.P. 30(b)(6) WITNESSES

TO: DEFENDANTS CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY MEDICINE; and

TO: ROBERT C. MCBRIDE, ESQ., and CHELSEA R. HUETH, ESQ., of CARROLL, KELLY, TROTTER, FRANZEN, McBRIDE & PEABODY; and

TO: ALL PARTIES AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE that on the **4th day of June, 2020, at 9:00 a.m. (PST)** Plaintiff, by and through her counsel of record, CLAGGETT & SYKES LAW FIRM, will take the deposition of **DEFENDANTS CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY**

MEDICINE'S N.R.C.P. 30(b)(6) WITNESS(ES) upon oral examination, before a Notary Public or other officer authorized by law to administer oaths. The videotaped deposition shall commence at Claggett & Sykes Law Firm, 4101 Meadows Lane, Suite 100, Las Vegas, Nevada 89107.

Pursuant to N.R.C.P. 30(b)(6) the Defendant shall designate one or more officers, directors, or managing agents, or other persons who consent to testify on your behalf, and you may set forth, for each person designated, the matters on which the person will testify. **The person(s) so designated shall testify as to matters known or reasonably available to the organization, and a diligent inquiry and reasonable investigation must be made into to each topic by the organization and/or the person(s) designated to speak on behalf of the organization. The minimum topics the witness shall be knowledgeable of are set forth in Exhibit "A."**

YOU ARE REQUIRED to bring with you any and all documents and/or documentary and/or tangible records, and/or papers in your possession which in any way relate to the topics set forth in Exhibit A. **These documents must be produced to our office five (5) calendar days before the deposition.** This request includes not only reports and/or statements of witnesses, but also includes all documentary papers in your possession regarding the above-captioned litigation including all correspondence (regardless of who it is to or from), photographs, notes, tapes, and any and all other documentation regarding the above-referenced litigation regardless of the date and/or apparent relevance of the same to you, including, but not limited to the specific information listed in **Exhibit "A."**

FOR FAILURE TO ATTEND you will be deemed guilty of contempt of Court and liable to pay all losses and damages sustained thereby to the parties aggrieved.

You are invited to attend and cross-examine.

DATED this 15th day of April, 2020.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich, Esq.

_____

Sean K. Claggett, Esq.
Nevada Bar No. 008407
Jennifer Morales, Esq.
Nevada Bar No. 008829

Shirley Blazich, Esq.
Nevada Bar No. 008378
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107
(702) 655-2346 – Telephone
Attorneys for Plaintiff

EXHIBIT "A"

1. Ruby Crest's contractual agreements with Northeastern Nevada Regional Hospital in effect on June 22, 2016.

2. Dr. Garvey's independent contractor agreement with Ruby Crest.

3. Supervision of independent contractor physicians such as Dr. Garvey.

4. Dr. Garvey's, hiring, orientation, licensure, duties and responsibilities, continuing education, and on the job training at Ruby Crest.

5. Hiring/Credentialing committee minutes and notes from any meetings where Dr. Garvey's hiring, credentialing and re-credentialing were discussed.

6. Dr. Garvey's performance evaluations, including any and all disciplinary actions and/or reprimands given to him.

7. Dr. Garvey's immediate supervisor with Ruby Crest on June 22, 2016.

8. Dr. Garvey's employee/independent contractor/credentialing file with Ruby Crest.

9. Dr. Garvey's Ruby Crest work schedule and timesheets from 2015 through 2016.

10. Ruby Crest's Bylaws and Rules & Regulations, including specifically those signed by Dr. Garvey.

11. Written complaints received by Ruby Crest with regard to Dr. Garvey.

12. List of all Ruby Crest medical providers, whether on site or on call, available at NNRH on June 22, 2016.

13. Any tenders of defense or reservation of rights made by Ruby Crest, or on its behalf, to any other person, party, or entity regarding the subject incident and/or this lawsuit.

14. Ruby Crest's responses to Plaintiffs' interrogatories.

15. Ruby Crest's policies and procedures pertaining to both emergency and non-emergency patient transfers to/from contracted facilities.

16. Ruby Crest's policies and procedures pertaining to intubations, difficult intubations, difficult airways, high risk intubations, surgical airways, failed airways, and rescue devises.

17. Ruby Crest's charts, flowcharts, or airway algorithms pertaining to patient intubations, difficult intubations, high risk intubations, surgical airways, failed airways and rescue devices.

18. Ruby Crest's policies and procedures for treating pneumothorax or flail chest.

19. Ruby Crest's policies and procedures regarding written and verbal consents of patients.

20. Ruby Crest's policies and procedures pertaining to Code Blues.

21. Any written or verbal consents provided by Plaintiffs to Ruby Crest for any procedures or care provided to Douglas Schwartz by Dr. Garvey.

22. Ruby Crest's Chain of Command and Organizational Hierarchy from June, 2016 to the present.

23. Ruby Crest's billing for the services it provided in the subject incident and an explanation as to each charge included in said billing.

24. Ruby Crest's status and certification as a Patient Safety Organization from June, 2016 to the present.

25. The identity of the members of Ruby Crest's Patient Safety Committee and/or Quality Improvement Committee from June 22, 2016 - June 22, 2017.

26. Whether or not a peer-review investigation was conducted pertaining to the subject incident.

27. Whether or not the subject incident was classified as a sentinel event.

28. All minutes from Ruby Crest's Patient Safety Committee and/or Quality Improvement Committee from June 22, 2016 - June 22, 2017 which mention the subject incident.

29. Ruby Crest's Mission and Values.

30. Any and all actions taken, or investigations performed by Ruby Crest with regard to the subject incident.

Request for Production of Documents

Plaintiff also requests that CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY MEDICINE, produce any and all documents and tangible things relevant to the foregoing topics at the time of the deposition, to the extent CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY MEDICINE, has not previously produced said documents in its NRCP 16.1 disclosures or in previous responses to requests for production of documents. Plaintiff also requests that CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY MEDICINE, produce any and all documents used in preparation for the deposition, including any documents used during its investigation to prepare for said topics. **These documents must be produced to our office five (5) calendar days (May 26, 2020) before the deposition.**

CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of April, 2020, I caused a true and correct copy of the foregoing **PLAINTIFF'S NOTICE OF TAKING THE VIDEOTAPED DEPOSITION OF DEFENDANTS CRUM, STEFANKO, & JONES LTD, D/B/A RUBY CREST EMERGENCY MEDICINE'S N.R.C.P. 30(b)(6) WITNESSES,** on the following person(s) via US Mail:

VIA US MAIL Casey W. Tyler, Esq. James W. Fox, Esq. HALL PRANGE & SCHOOVELD, LLC 1160 N. Town Center Drive, Suite 200 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital*	***VIA US MAIL*** Keith A. Weaver, Esq. Danielle Woodrum, Esq. LEWIS BRISBOIS BISGAARD & SMITH, LLP 6385 S. Rainbow Blvd., Suite 600 Las Vegas, NV 89118 *Attorneys for Defendant, David Garvey, M.D.*
VIA US MAIL Todd L. Moody, Esq. HUTCHISON & STEFFEN, PLLC. 10080 West Alta Drive, Suite 200 Las Vegas, NV 89145 James T. Burton, Esq. KIRTON MCCONKIE 36 S. State Street, Suite 1900 Salt Lake City, UT 84111 *Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees*	***VIA US MAIL*** Robert C. McBride, Esq. Chelsea R. Hueth, Esq. CARROLL KELLY TROTTER FRANZEN MCBRIDE & PEABODY 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113

/s/ Jackie Abrego

_____

An Employee of CLAGGETT & SYKES LAW FIRM

EXHIBIT C

CASE NO.: CV-C-17-439

DEPT. NO.: I

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; 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.

PLAINTIFF'S SECOND AMENDED NOTICE OF TAKING THE VIDEOTAPED DEPOSITION OF DEFENDANT PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL'S N.R.C.P. 30(b)(6) WITNESSES

(Date and topics)

TO: PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL; and

TO: CASEY W. TYLER, ESQ. and TYSON J. DOBBS, ESQ., of HALL PRANGLE & SCHOONVELD, ESQ.; and

TO: ALL PARTIES AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE that on the **August 17, 2020, at 9:00 a.m. (PST)** Plaintiff, by and through her counsel of record, CLAGGETT & SYKES LAW FIRM, will take the deposition of **PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL'S N.R.C.P. 30(b)(6) WITNESS(ES)** upon oral examination, before a Notary Public or other officer authorized

by law to administer oaths. The videotaped deposition shall commence at Claggett & Sykes Law Firm, 4101 Meadows Lane, Suite 100, Las Vegas, Nevada 89107.

Pursuant to N.R.C.P. 30(b)(6) the Defendant shall designate one or more officers, directors, or managing agents, or other persons who consent to testify on your behalf, and you may set forth, for each person designated, the matters on which the person will testify. **The person(s) so designated shall testify as to matters known or reasonably available to the organization, and a diligent inquiry and reasonable investigation must be made into to each topic by the organization and/or the person(s) designated to speak on behalf of the organization. The minimum topics the witness shall be knowledgeable of are set forth in Exhibit "A."**

YOU ARE REQUIRED to bring with you any and all documents and/or documentary and/or tangible records, and/or papers in your possession which in any way relate to the topics set forth in Exhibit A. **These documents must be produced to our office five (5) calendar days before the deposition.** This request includes not only reports and/or statements of witnesses, but also includes all documentary papers in your possession regarding the above-captioned litigation including all correspondence (regardless of who it is to or from), photographs, notes, tapes, and any and all other documentation regarding the above-referenced litigation regardless of the date and/or apparent relevance of the same to you, including, but not limited to the specific information listed in **Exhibit "A."**

FOR FAILURE TO ATTEND you will be deemed guilty of contempt of Court and liable to pay all losses and damages sustained thereby to the parties aggrieved.

You are invited to attend and cross-examine.

DATED this 30th day of June, 2020.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich, Esq.

_____

Sean K. Claggett, Esq.
Nevada Bar No. 008407
Jennifer Morales, Esq.
Nevada Bar No. 008829
Shirley Blazich, Esq.
Nevada Bar No. 008378

4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107
(702) 655-2346 – Telephone
Attorneys for Plaintiff

EXHIBIT "A"

1. Education and training of NNRH medical staff, including Nancy Abraham's, Tom Evers, Susan Olson, Carmen Gonzales, Donna Kevitt, Cindy Fus, and Sylvia Wines up to and including June of 2016.
2. Any and all disciplinary actions and/or reprimands given to NNRH staff as a result of the subject incident.
3. The NNRH job description for a nurse.
4. The NNRH job description for a respiratory therapist.
5. Nancy Abrahms hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
6. Tom Evers hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
7. Susan Olson hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
8. Carmen Gonzales' hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
9. Donna Kevitt's hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
10. Cindy Fus's hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
11. Sylvia Wines' hiring, orientation, employment, licensure, job duties and responsibilities, and performance evaluations at NNRH.
12. Any tenders of defense or reservation of rights made by NNRH, or on its behalf, to any other person, party, or entity regarding the subject incident and/or this lawsuit.
13. NNRH's responses to Plaintiffs' interrogatories, **requests for production and requests for admission.**

14. NNRH policies and procedures pertaining to event reporting and sentinel events, **including the documents Bates stamped as ORP000001-4 and OCC_RPT000001-5.**

15. NNRH's obligations to report sentinel events pursuant to NRS 439.835.

16. Whether the subject incident was reported as a sentinel event **to the Nevada Division of Public and Behavioral Health pursuant to NRS 439.835.**

17. NNRH's mandatory investigation of the subject incident as a sentinel event pursuant to NRS 439.837.

18. Whether the patient (or patient's family) was notified that the subject incident was a sentinel event, pursuant to the requirements of NRS 439.855.

19. NNRH policies and procedures pertaining to both emergency and non-emergency patient transfers to/from NNRH

20. NNRH policies and procedures pertaining to intubations, difficult intubations, difficult airways, high risk intubations, surgical airways, failed airways, and rescue devises.

21. NNRH charts, flowcharts, or airway algorithms pertaining to patient intubations, difficult intubations, high risk intubations, surgical airways, failed airways and rescue devises.

22. Written complaints received by NNRH with regard to Dr. Garvey.

23. The contract between Ruby Crest and NNRH.

24. The contract between NNRH and REACH, if any.

25. The Patient Transfer Agreement between NNRH and the University of Utah Hospital.

26. Dr. Garvey's credentialing file and the credentialing and re-credentialing process.

27. Credentialing committee minutes and notes from any meetings where Dr. Garvey's credentialing and re-credentialing were discussed after June 22, 2016.

28. List of all on-call medical providers available at NNRH on June 22, 2016.

29. NNRH policies and procedures pertaining to crash cart inventory, **logs of crash cart checks,** and intubation trays.

30. Whether all required intubation equipment was at the patient bedside **or contained on the crash cart** before intubation attempts commenced on Douglas Schwartz.

31. Logs of crash cart checks done in the Emergency Department from January 1, 2016 to June 30, 2016.
32. NNRH code blue policy.
33. The NNRH code sheet for Douglas Schwartz.
34. NNRH medical staff Bylaws, Rules & Regulations, including specifically those signed by Dr. Garvey.
35. NNRH's status and certification as a Patient Safety Organization from June, 2016 to the present.
36. **The date(s) when NNRH became certified/re-certified as a Patient Safety Organization.**
37. **Any documents or correspondence NNRH sent to a Patient Safety Organization as part of the certification/re-certification process demonstrating NNRH's satisfaction of the criteria to become a Patient Safety Organization.**
38. The identity of the members of NNRH's Patient Safety Committee and/or Quality Improvement Committee from June 22, 2016 - June 22, 2017.
39. Whether or not a peer- review investigation was conducted pertaining to the subject incident.
40. **Whether or not the results of any peer-review investigation of the subject incident was reported to a Patient Safety Organization, who it was reported to, the date it was reported, and the results of the investigation.**
41. All minutes from NNRH's Patient Safety Committee and/or Quality Improvement Committee from June 22, 2016 - June 22, 2017 which mention the subject incident.
42. NNRH's Chain of Command and Organizational Hierarchy from June, 2016 to the present.
43. NNRH's billing for the services it provided in the subject incident and an explanation as to each charge included in said billing.
44. NNRH policies and procedures regarding written and verbal consents of patients.
45. Any written or verbal consents provided by Plaintiffs to NNRH staff for any procedures or care provided to Douglas Schwartz.
46. NNRH's Mission and Values.

47. The audit trail for the NNRH medical records indentured by the following Bates numbers: NEN000005 - NEN000010.

48. NNRH policies and procedures for treating pneumothorax or flail chest.

Request for Production of Documents

Plaintiff also requests that PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL, produce any and all documents and tangible things relevant to the foregoing topics at the time of the deposition, to the extent PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL, has not previously produced said documents in its NRCP 16.1 disclosures or in previous responses to requests for production of documents. Plaintiff also requests that PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL, produce any and all documents used in preparation for the deposition, including any documents used during its investigation to prepare for said topics. **These documents must be produced to our office five (5) calendar days before the deposition.**

CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of June, 2020, I caused a true and correct copy of the foregoing **PLAINTIFF'S SECOND AMENDED NOTICE OF TAKING THE VIDEOTAPED DEPOSITION OF DEFENDANT PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL'S N.R.C.P. 30(b)(6) WITNESSES,** on the following person(s) via US Mail:

VIA US MAIL Casey W. Tyler, Esq. James W. Fox, Esq. HALL PRANGE & SCHOOVELD, LLC 1160 N. Town Center Drive, Suite 200 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital*	***VIA US MAIL*** Keith A. Weaver, Esq. Danielle Woodrum, Esq. LEWIS BRISBOIS BISGAARD & SMITH, LLP 6385 S. Rainbow Blvd., Suite 600 Las Vegas, NV 89118 *Attorneys for Defendant, David Garvey, M.D.*
VIA US MAIL Todd L. Moody, Esq. HUTCHISON & STEFFEN, PLLC. 10080 West Alta Drive, Suite 200 Las Vegas, NV 89145 James T. Burton, Esq. KIRTON MCCONKIE 36 S. State Street, Suite 1900 Salt Lake City, UT 84111 *Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees*	***VIA US MAIL*** Robert C. McBride, Esq. Chelsea R. Hueth, Esq. CARROLL KELLY TROTTER FRANZEN MCBRIDE & PEABODY 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113

/s/ Jackie Abrego

_____

An Employee of CLAGGETT & SYKES LAW FIRM

KEITH A. WEAVER
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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 TO STRIKE THE DECLARATION OF SETH WOMACK, M.D.

DEFENDANT DAVID GARVEY, M.D., by and through his counsel of record, LEWIS BRISBOIS BISGAARD & SMITH, LLP, hereby files this Motion to Strike the Declaration of Seth Womack, M.D. in support of his Motion for Partial Summary Judgment to Statutorily Limit Damages.

/ / /

Defendant's pleading is based upon the pleadings on file, the memorandum contained herein, and any oral argument permitted on the motion.

DATED this 26th day of August, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick

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

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

In Support of Plaintiff's Opposition to Dr. Garvey's Motion for Partial Summary Judgment to Statutorily Limit Damages, Plaintiff attached the Declaration of Seth Womack, M.D. Dr. Womack makes several references to Dr. Garvey's care and treatment of Mr. Schwartz, using the "buzz words" for a claim for punitive damages. However, not only are punitive damages not pled in this case, they never will be, pursuant to this Court's Order denying Plaintiff's Motion to Amend the Complaint to add a claim for punitive damages with prejudice. It appears that Plaintiff's counsel was not aware the Motion to Amend the Complaint was denied **with prejudice**, as she declared in her own separate declaration in support of her Opposition to Dr. Garvey's Motion for Partial Summary Judgment that the Motion to Amend the Complaint to add a claim for punitive damages was denied without prejudice.

Each of Dr. Womack's references to Dr. Garvey's care and treatment of Mr. Schwartz as "reckless," "grossly negligent," "in bad faith," and "wanton conduct," must be stricken as a claim for punitive damages is outside of the pleadings and Dr. Womack cannot competently testify to the legal conclusion whether the facts constitute gross negligence, wanton conduct, recklessness or bad faith. Dr. Womack is limited to testifying to issues relating to the standard of care.

Further, Dr. Womack makes misleading comments regarding Donna Kevitt, RN's documentation, where he selectively quotes from her documentation, but fails to address her deposition testimony where she clarified and explained her documentation. Accordingly, Dr. Womack's incomplete citations to Nurse Kevitt's documentation should be stricken and incomplete and misleading.

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II. ARGUMENT

A. Dr. Womack's Statements Regarding Gross Negligence, Reckless Conduct, Bad Faith and Wanton Conduct Must Be Stricken.

Throughout his 31-page declaration, Dr. Womack makes several references to Dr. Garvey's care and treatment of Mr. Schwartz stating the care was "grossly negligent," "in bad faith," "reckless" and constituting "wanton conduct."

Dr. Womack's declares that "Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence." Womack Decl., 22. He states that it was "extraordinary negligence to a high degree." Womack Decl., 23.

Dr. Womack further accuses Dr. Garvey of acting in "bad faith." Womack Decl., 24. He states Dr. Garvey acted in bad faith by focusing on explaining the risks of not intubating Mr. Schwartz, rather than thoroughly explaining the risks of intubation. He further states that Dr. Garvey acted in bad faith by not explaining alternative treatments to Mr. Schwartz. Womack Decl., 25.

Each of Dr. Womack's statements regarding "gross negligence" "wanton conduct" and "bad faith" must be stricken because they are legal conclusions relating to terms that are not pled and won't be. Dr. Womack is a physician and cannot competently to testify whether the facts constitute gross negligence or bad faith. Moreover, this Court has already ruled that Plaintiff cannot plead a claim for punitive damages, forestalling Plaintiff's ability to skirt around the limitations of the trauma cap by attempting to use her expert to claim exceptions to the trauma cap by virtue of bad faith, wanton conduct or gross negligence.

B. Dr. Womack's Statements that Mr. Schwartz Was Breathing Without Difficulty Must Be Stricken.

In his declaration, Dr. Womack states that Mr. Schwartz was "breathing without difficulty." *See* Womack Decl. 5, 12. Dr. Womack states elsewhere in his declaration that Dr. Garvey noted Mr. Schwartz had pain with breathing and movement, that Nurse Kevitt observed Mr. Schwartz had diminished breath sounds in his right posterior, middle and

lower lung lobes, and that the paramedics documented that Mr. Schwartz had diminished lung sounds due to not wanting to take a deep breath. *See* Womack Decl., 5. These comments belie the statement of Dr. Womack that "he was breathing without difficulty."

Dr. Womack also claims "Nurse Kevitt evaluated Mr. Schwartz on multiple occasions, before and after CT scan, never noting any sign of being unstable." Womack Decl., 13. This is inaccurate. Mr. Schwartz's vital signs show a significant deterioration of oxygen saturations from 2053 hours when his saturation was 94% on 4 L/min to 91% at 2317 hours which persisted until 2345 hours while on Venti-mask. Dr. Womack conveniently omits the entry of Nurse Kevitt at 2337 hours which documents that he was placed on a 40% Venti mask because of deterioration of his oxygen saturations on nasal cannula supplementation. Nurse Kevitt then documents that he was placed on a non-rebreather mask at 15 L/min at 2351 hours because of further deterioration of his respiratory status which could not be controlled with the Venti mask.

Moreover, Dr. Womack's failed to address Nurse Kevitt's deposition testimony where her charting was explained and clarified. Nurse Kevitt observed that Mr. Schwartz was not stable on room air and had compromised breathing sounds. Kevitt Depo, **Exhibit D** to Dr. Garvey's Motion for Partial Summary Judgment at 78:23-79:6; 94:7-96:19. She clarified that upon arrival she noted in the medical record that he was breathing without difficulty, but she was only observing him from across the room. *Id.* at 37:11-38:12.

Accordingly, Dr. Womack's statements that Mr. Schwartz was "breathing without difficulty," must be stricken as inaccurate, incomplete and misleading.

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III. CONCLUSION

Based on the foregoing, each reference that Dr. Garvey's care and treatment of Mr. Schwartz was "grossly negligent," "in bad faith," "reckless" and constituting "wanton conduct," should be stricken from Dr. Womack's declaration. Further, Dr. Womack's statements regarding Donna Kevitt, RN's documentation that Mr. Schwartz was breathing without difficulty must be stricken and it is incomplete and misleading.

DATED this 26th day of August, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick

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

AFFIRMATION

PURSUANT TO NRS 239B.030

The undersigned does hereby affirm that the preceding document does not contain the social security number of any person.

DATED this 26th day of August, 2020.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Alissa Bestick

KEITH A. WEAVER
Nevada Bar No. 10271
ALISSA N. 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 26th day of August 2020, a true and correct copy of **DEFENDANT DAVID GARVEY, M.D.'S MOTION TO STRIKE THE DECLARATION OF** was sent via electronic mail to the following:

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

Richard De Jong Esq.
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HALL PRANGLE & SCHOOVELD, LLC
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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 REPLY IN SUPPORT OF 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, hereby Replies to Plaintiff's Opposition to the Motion for Partial Summary Judgment to Statutorily Limit Damages. Plaintiff improperly opposes this Motion by claiming Dr. Garvey did not render treatment to Mr. Schwartz in good faith, even though her complaint fails to allege the absence of good faith and this Court denied leave to amend **with prejudice**. Nor can Plaintiff raise a disputed factual element as to the remaining elements of the Trauma Cap statute. Mr. Schwartz sustained life-threatening injuries that required intubation prior to his transport to a Level I trauma hospital via air ambulance. Mr. Schwartz's oxygen saturation was decompensating in the few hours he was at the hospital, and it was only a matter of time before he would experience respiratory failure due to his thoracic injuries (i.e., pulmonary contusions, flail chest, and traumatic pneumothorax). Dr. Garvey appropriately determined that Mr. Schwartz needed to be intubated in order to protect and control his airway during air transfer and in order to adequately oxygenate and ventilate him in a setting of rapidly deteriorating respiratory status. Loss of his airway was a near certainty and intubation in flight would have been nearly impossible. This Court should grant the motion and apply the "Trauma Cap" codified at NRS 41.503 to statutorily limit civil damages to $50,000 as a matter of law.

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This reply is made and based on the pleadings and papers on file herein, the attached memorandum of points and authorities, the declaration of David Barcay, M.D., the concurrently filed Motion to Strike the Declaration of Shirley Blazich, the concurrently filed Motion to Strike the Report of Seth Womack, M.D. and any oral argument permitted at the time of hearing on this matter.

DATED this 26th day of August, 2020.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ *Alissa N. Bestick*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiff raises no material factual dispute that would warrant a jury trial on Nevada's "Trauma Cap" statute, NRS 41.503. Mr. Schwartz sustained life-threatening thoracic injuries leading to impending respiratory failure. His respiration was unstable because it was deteriorating and he required intubation. Mr. Schwartz also required transport to a Level I trauma hospital via air ambulance, and the high altitude would have caused his respiration to decompensate even further, with loss of his airway a near certainty. Attempting intubation in flight would have had disastrous consequences.

In her zeal to paint Dr. Garvey as a physician lacking a modicum of good faith, Plaintiff ignores the elephants in the courtroom – her failure to plead bad faith *and* the fact that leave to amend was denied with prejudice. Gliding over these facts, she actually claims this Court denied leave to amend **without prejudice**.[1] False. Leave to amend was denied **with prejudice** due to unreasonable delay. Although she has no basis for pleading bad faith, Plaintiff casts Dr. Garvey in the role of Dr. Frankenstein: he never intended to intubate Mr. Schwartz, but decided to do so in order to garner favor with the U o fU trauma hospital, or to obtain teaching opportunities with Reach Air; he was negligent because he served in a dual role at the Hospital and as Medical Director for Reach Air; and, he was responsible for that "something" that was missing from the trauma cart – whatever it was – that would have saved Mr. Schwartz's life. Even though the evidence is crystal clear that Mr. Schwartz sustained life-threatening thoracic injuries that would lead to respiratory failure without intubation, Plaintiff speculates, without substantiating, that further discovery will help her overcome summary judgment. **None of these emotional or eleventh hour arguments have any merit, and Plaintiff provides no support for her outlandish claims**.

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[1] *See* concurrently filed Motion to Strike the Declaration of Shirley Blazich, Esq.

Plaintiff is the master of her own pleadings. She failed to plead bad faith, she was denied leave to amend, and that decision is now final. Since the Complaint defines the outer limits of materiality for purposes of summary judgment, as a matter of law, Plaintiff may not oppose this motion by claiming Dr. Garvey acted in bad faith or with reckless, willful, or wanton conduct. At best, she can try to show he breached the standard of care, which he absolutely did not do, but even if he did, the Trauma Cap applies to a physician's ordinary negligence and a defense summary judgment motion can still be granted. The only way for Plaintiff to defeat the motion is to introduce evidence creating a disputed fact as to some other element of the Trauma Cap statute. This she cannot do.

Even though Dr. Scissors submitted an affidavit based on ordinary negligence, Plaintiff now submits a contradictory affidavit from Seth Womack, M.D., who not only claims Dr. Garvey acted in bad faith, but that Mr. Schwartz did not sustain a life-threatening injury, was stable, and did not need to be intubated. This Court must exercise its gatekeeping function of examining whether this expert's conclusions are logically supported by the evidence. Dr. Womack's are not.[2]

Dr. Womack's opinions do not create disputed factual issues regarding the remaining elements of the Trauma Cap statute because he ignores Mr. Schwartz's respiratory deterioration at the Hospital and the effect air transport would have on his thoracic injuries. Further, Dr. Womack must ignore the direct observation of paradoxical chest wall movement in order to conclude there was no flail chest injury, even though flail segments are diagnosed through clinical observation, not just diagnostic tests. He ignores the fact that Dr. Garvey conferred with Dr. Ray at U of U regarding the diagnosis before concluding intubation was appropriate. In essence, Dr. Womack places Dr. Garvey in the penalty box for protecting his patient's airway in a situation where his respiratory status was deteriorating quickly. Had Dr. Garvey not done so, Dr. Womack would be accusing him of

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[2] Dr. Womack's statements accusing Dr. Garvey of bad faith and recklessness are improper and are addressed in Dr. Garvey's concurrently filed Motion to Strike the Declaration of Seth Womack, M.D.

recklessness for putting Mr. Schwartz on the air ambulance without intubation, where he most certainly would have lost his airway without the staff and equipment available in a hospital.

Plaintiff cannot create a triable issue as to the Trauma Cap statute. The Legislative mandate to cap damages at $50,000 applies here and the present Motion should be granted in its entirety.

II. ARGUMENT

A. This Court Should Disregard Plaintiff's Attempt to Defeat Summary Judgment with an Unpled Claim of Gross Negligence/Recklessness in Section 5 of Her Opposition.

Plaintiff does not dispute her own failure to plead gross negligence, reckless, or willful or wanton conduct; she simply attempts to defeat summary judgment with an unpled claim that *could have* circumvented the Trauma Cap. Dr. Garvey alerted the Court to this possibility and that is exactly what happened, but Dr. Garvey never anticipated Plaintiff would actually claim she had a right to seek leave to amend. *See* MPSJ, 15-16. Plaintiff states:

> Defendant Garvey argues that Plaintiffs have moved for punitive damages, and such request was denied by this Court. But Defendant ignores that Plaintiffs' Motion was denied without prejudice. Moreover, that was prior to the discovery period. Plaintiffs now believe they have more than sufficient evidence obtained and forthcoming that will more than support an amendment on punitive damages claim.

See Pl.'s Opp., 18:15-19. Plaintiff is mistaken. On October 16, 2019, this Court denied Plaintiff's motion to for leave to file a third amended complaint to add punitive damages to all five claims of relief. It denied leave to amend with prejudice. *See* **Exhibit M** to MPSJ. As already detailed in the moving papers, Plaintiff had included boilerplate punitive damages allegations in the fourth claim for relief in her initial complaint and then filed a first and second amended complaint omitting all punitive damages allegations. When she sought to reinsert the same allegations into all five claims of relief, this Court denied the request, making the following observations:

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> Plaintiff delayed seeking leave to amend, after which she was or should have been aware of the problem, for at least five months, and for possibly as many as seven months. Plaintiff amended two times after her original complaint, both times excluding the issue of punitive damages. The amendment now sought by Plaintiff not only includes punitive damages as sought in the original complaint, it now adds the issue of punitive damages, where none existed before, to four claims for relief. Finally, the proposed Third Amended Complaint does not even contain a prayer for punitive damages. This is simply too much. The allegations made by Plaintiff are of the utmost seriousness. She alleges that the actions of these defendants led to the death of her husband. Surely, Plaintiff's counsel could have paid more attention to this case than she apparently has.
>
> Plaintiff asks that any denial of her Motion to Amend be without prejudice so that she can seek to amend at a later date. A denial without prejudice will not cure the problems caused by Plaintiff's undue delay and previous failures to correct the deficiencies.
>
> Therefore, IT IS ORDERED that Plaintiff's Motion to Amend Complaint is **DENIED** with prejudice.

Exhibit M to MPSJ at p. 6 (emphasis added.)

This Court specifically considered and rejected Plaintiff's argument that leave to amend be denied without prejudice. This ship has now sailed. Plaintiff cannot oppose summary judgment by arguing the bad faith element of the Trauma Cap statute. Thus, this Court should disregard the section of Plaintiff's opposition entitled **"5. THE TRAUMA STATUTE DOES NOT APPLY BECAUSE DEFENDANT'S CONDUCT WAS NOT IN GOOD FAITH AND WAS RECKLESS, WILLFUL AND/OR WANTON".** Pl.'s Opp. 16:10-20:12. The arguments contained in Section 5 fall outside the pleadings because bad faith is not alleged in Plaintiff's operative pleading or in the supporting affidavit of Dr. Scissors that was filed with every version of the Complaint.

Plaintiff also ignores all authorities in the moving papers that a plaintiff may not raise unpled issues for the first time in opposing summary judgment. (See *Young v. Mercury Cas. Co.* 2016 U.S. Dist. LEXIS 100227 *13; *Hasan v. E. Wash. State Univ.*, 485 Fed. Appx. 168 170-171 (9th Cir. 2012.) She also fails to distinguish *Marshall v. Eighth Judicial District Court,* 108 Nev. 459, 461, 836, P.2d 47, 49 (1992), where the Supreme Court granted a defense motion for summary judgment when the plaintiff failed to plead the bad faith exception to statutory immunity. *Id.* at 466, 836 P.2d at 52. **By failing to address**

these authorities, Plaintiff concedes she has no basis for opposing summary judgment with an unpled issue. Having failed to plead the bad faith exception to the Trauma Cap statute, Plaintiff cannot allege bad faith is a material factual issue in this case. Dr. Garvey preemptively objected to Plaintiff raising unpled issues and renews that objection here. At best, section 5 of the opposition attempts to raise disputed facts as to ordinary negligence only. Ordinary negligence is covered by the Trauma Cap, and would not defeat the present motion.

B. It is Beyond Cavil that Mr. Schwartz Sustained Life-Threatening Injuries.

Plaintiff attempts to create a disputed "fact" as to whether Mr. Schwartz sustained a traumatic injury within the meaning of the Trauma Cap statute by relying upon Dr. Womack's opinion he sustained no life-threatening injuries; he just had a few rib fractures.

1. Plaintiff Claims Transfer was Needed for Non-Life-Threatening Injuries.

At first blush, Plaintiff's position is untenable. She does not challenge the decision to transfer Mr. Schwartz, yet she maintains his injuries were not life-threatening. Plaintiff does not dispute that the Hospital is a rural hospital, not a trauma center, and lacks a pulmonary surgeon, a trauma surgeon, and an anesthesiologist (*See* exhibits attached to MPSJ, Garvey Depo., **Exhibit C** at 95:17-19; 96:4-5; 126:18-127:10; 133:23-24; Olson Depo., attached as **Exhibit F** at 72:22-73:3; License, **Exhibit G**); that 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); or that Mr. Schwartz would be under the care of a U of U trauma surgeon for several days and would need to be evaluated for bleeding in his abdomen. (*See* Garvey Depo, **Exhibit C,** at 95:10-16; 103:12-19.) Dr. Garvey made the decision to transfer Mr. Schwartz to a trauma hospital and arranged for early transport via air ambulance to a Level I trauma center based on emergent findings and compromised respiration. *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, **Exhibit E**.

Simply put, if Mr. Schwartz could be treated non-emergently, then there was no need for him to be transferred to a Level I trauma hospital via air ambulance.

In addition, this Court should disregard Dr. Womack's opinion that Mr. Schwartz sustained no life-threatening injury because (1) a flail chest is diagnosed based on clinical indications in conjunction with diagnostic tests; (2) pulmonary contusions often do not surface on diagnostic tests; (3) any injury requiring a chest tube is life-threatening; and (4) an assessment of whether a patient has sustained life-threatening injuries cannot ignore respiratory decompensation.

2. Dr. Womack Ignores Clinical Observations of a Flail Chest Injury.

A flail chest presents an immediate threat to life. Dr. Womack does not dispute that a flail segment is one of the "deadly dozen" life-threatening injuries. *See* Garvey Depo, **Exhibit C** at 97:5-9; 114:17-21. Instead, he claims the injury was misdiagnosed because Mr. Schwartz did not have two consecutive ribs broken in two places, which is the technical definition for a flail chest. Womack Report at 17. He also claims the fractures were not bilateral based on speculation that the left rib fractures were CPR related.

Regardless of whether the flail chest was bilateral or not, Dr. Womack fails to consider the clinical indications, in conjunction with the diagnostic test and the autopsy report. The radiologist reported right-sided rib fractures of ribs four through seven, with the fourth and sixth ribs fractured in two places. But the autopsy report showed that right sided ribs two through seven were fractured. Dr. Barcay, an emergency physician and critical care specialist, opines it is likely the radiologist missed the right-sided fractures in ribs two and three as well as a second fracture in rib five. It is highly likely that right ribs two and three were fractured initially and not due to the chest compressions during CPR because these ribs are high up in the thoracic cage and are not subject to extraordinary mechanical pressures of CPR. If the radiologist missed these fractures, it is also possible he missed the second fracture in the right fifth rib. Supp Barcay Decl., ¶ 9. This would mean that the fourth, fifth and sixth ribs were each fractured in two places. **It is more likely than not that the fifth rib was fractured in two places due to the collision and not CPR, because Dr.**

Garvey observed Mr. Schwartz had paradoxical movement of the chest wall.[3] Dr. Garvey's observations are consistent with a destabilized section of chest wall between right ribs fourth through six. *Ibid.*

Dr. Womack concludes Mr. Schwartz misdiagnosed a flail chest injury and therefore the injuries were not life-threatening **based solely** on his interpretation of diagnostic testing, without reading the autopsy report, and without regard to Dr. Garvey's clinical diagnosis. But the undisputed evidence establishes **Dr. Garvey observed paradoxical chest wall movement** – the telltale sign for a flail chest – in addition to reviewing the CT scan revealing four right consecutive broken ribs (ribs four through seven), with ribs four and six broken in two places. MPSJ, 3. He documented this in a discussion with Dr. Ray at U of U, and "Dr. Ray requested that a chest tube be placed and possibly intubation prior to medical transport due to flail segment, pulmonary contusions, low O2 sats and a traumatic R pneumothorax." *See,* Hospital Record, **Exhibit B** at NEN000005; Garvey Depo., **Exhibit C** at 111:22-113:9. Dr. Barcay observes "the diagnosis of flail chest was made clinically by Dr. Garvey, relayed to Dr. Ray and was appropriate." Supp. Barcay Decl. ¶ 9. Dr. Garvey's judgment call that Mr. Schwartz was at risk for respiratory failure was based on his review of the diagnostic results **and his own clinical observations**, documented in the record. Dr. Garvey's clinical diagnosis of flail chest makes it highly likely that the radiologist missed additional fractures, making ribs four through six a flail segment consistent with Dr. Garvey's observations.

Dr. Womack does not go so far as to state the diagnosis should be made without regard to the treating physician's clinical observations, but that is what he does here. Dr. Garvey's deposition testimony setting forth his clinical observations were quoted in the moving papers, but they are ignored in the opposition. Dr. Garvey testified:

> Q. And what are the symptoms that are associated with flail chest?

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[3] Paradoxical movement occurs when a segment of the chest wall is destabilized due to fractures in several adjacent ribs. The injured chest wall moves paradoxically–in during inspiration and out during expiration. Ventilation is inefficient because of the paradoxical movement.

> 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, emphasis added. Dr. Womack never examined Mr. Schwartz, and he provides no reason why the observations of a treating physician should be disregarded. An expert opinion that does not account for such material facts in rendering an opinion is unreliable and does not create a disputed material fact as to whether a life-threatening injury was sustained.

3. Ignoring Possible Pulmonary Contusions Falls Below the Standard of Care.

Dr. Womack disregards the near certainty of pulmonary contusions because they were not clearly visible on the diagnostic test. Womack Report at 16. A pulmonary contusion is a large bruise that can cause dangerously low levels of oxygen in the blood stream. The radiological presentation of a pulmonary contusion is not necessarily immediately manifest. It may take several hours to show up on a diagnostic test, and they are almost always seen with other chest injuries. Supp. Barcay Decl. ¶ 5. The autopsy report confirms Mr. Schwartz had two pulmonary contusions and the standard of care would be to give the patient the benefit of the doubt and provide preventative care, not wait for the contusions to show up on the radiological report. *Ibid.*

4. Patient Requiring a Thoracostomy Have Life-Threatening Injuries.

Any patient requiring a chest tube in the presence of multi-rib fractures is in a life-threatening situation. Supp. Decl. Barcay ¶ 7. A chest tube is a life-saving instrument and the primary aim in the management of chest trauma are prompt restoration of normal cardiorespiratory functions and to avoid the possibility of developing a tension pneumothorax and promotes lung re-expansion. *Ibid.* Tension pneumothorax is a life-threatening condition that can occur with chest trauma when air is trapped in the pleural cavity leading to a cascading impact, including a rapid deterioration of a patient's ability to maintain oxygenation. *Ibid.*

5. Dr. Womack Ignores Mr. Schwartz's Respiratory Status and the Totality of Circumstances.

Most importantly, Dr. Womack ignores Mr. Schwartz's respiratory status, undermining his own conclusions. Dr. Barcay observes: "Dr. Womack states that 'Mr. Schwartz did not have injuries that were an immediate or imminent threat to life." I disagree with his conclusion. His rapidly deteriorating respiratory status over a short period of time required increasing levels of supplemental oxygen, first by nasal cannula, then by Venti-mask when he continued to desaturate, and finally by a non-rebreather mask at 15 L/min, which is the maximum amount of oxygen which can be delivered without intubation and mechanical ventilation. His chest injuries were clearly severe and would have led to continuing deterioration especially on the planned transfer by air ambulance. This conclusion was clear to both Dr. Garvey and to Dr. Ray, the receiving physician at the University of Utah Medical Center. Dr. Ray requested that Dr. Garvey insert a chest tube and consider intubating the patient prior to transport by air. Dr. Womack agrees that the patient required a chest tube placement. Any patient who requires a chest tube thoracostomy has an injury which is an imminent threat to life. Any patient who sustains multiple trauma with multiple rib fractures, pulmonary contusions, a traumatic pneumothorax, a flail chest, and traumatic intra-abdominal injuries has injuries that are an imminent threat to life." Supp. Decl. Barcay ¶ 7.

Dr. Womack's opinion should be disregarded because he looks at Mr. Schwartz's injuries in isolation and fails to consider his declining respiratory status, even before air transport was to take place.

For each of the foregoing reasons, there can be no doubt Mr. Schwartz sustained life-threatening injuries when he was hit by a drunk driver.

C. Mr. Schwartz was not Stable, and Could not be Transferred Without Securing his Airway.

The Trauma Cap does not apply once a patient is stabilized. According to the Legislature, stabilization depends on the circumstances of each case and is based on expert medical opinion. MPSJ 17; *See*, NRS 41.503, subpart 2; Special Session, Day 2, **Exhibit J** at p. 3. It occurs when a patient is capable of receiving medical treatment on a non-emergent basis. *Id.* at 4. Dr. Womack claims Mr. Schwartz was stable until Dr. Garvey tried to intubate him.[4] Womack Report at 13-15. Dr. Womack misinterprets the record. Mr. Schwartz was rapidly decompensating and compromised.

In fact, the fundamental flaw in Dr. Womack's opinion is that he assumes Mr. Schwartz's respiratory status was stable in spite of the undisputed evidence in the medical record. Dr. Womack stats that "Mr. Schwartz did not have respiratory decompensation or compromise; he was talking, laughing, and joking."[5] Womack Report at 15. Dr. Barcay disagrees:

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[4] Dr. Womack ignores the fact that Mr. Schwartz was 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), the testimony of Bartlett, who observed Schwartz had unstable oxygenation (*see*, Bartlett Depo., **Exhibit H** at 58:5-23), and the fact that air transport was ordered (*see*, Hospital Records, **Exhibit B** at NEN000046) in order to transfer Mr. Schwartz to the care of another emergency physician, Dr. Ray, at U of U, and then a trauma surgeon. *See*, Garvey Depo., **Exhibit C** at 112.

[5] Dr. Barcay observes: "Mr. Schwartz was unquestionably rapidly decompensating and compromised. One can be certain that he was not talking, laughing, and joking while wearing a full face mask with the loud hissing of maximal oxygen flow and while struggling to maintain adequate oxygen saturation on a non-rebreather mask, the last step in maximal supplemental oxygen delivery before the need for intubation." Supp. Barcay Decl. ¶ 11.

> All of Dr. Womack's opinions are based on his mistaken interpretation that Mr. Schwartz's respiratory status was stable. His respiratory status was unstable and deteriorating over a more than two-hour time period and then more rapidly over a fourteen-minute time period due to the multiple chest and abdominal trauma that he sustained. He required increasing levels of supplemental oxygen barely maintaining adequate oxygenation at each level and then further deteriorating, ultimately requiring a non-rebreather mask at 15 L/min, which is the maximal supplemental oxygen that can be delivered short of endotracheal intubation and mechanical ventilation support.
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> His oxygen saturation on a 40% Ventimask was 91%. (*See* 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.) This calculates to an Alveolar-arterial (A-a) oxygen gradient of 220 mm Hg. A normal A/a gradient is less than 20 mm Hg. His a/A ratio was 0.27. A normal a/A ratio is greater than 0.75. **Both these values show a severe disturbance in the pulmonary function of oxygenation**. When he was placed on a non-rebreather mask at maximum oxygen flow rate of 15 L/min, his oxygen saturation was 97%. We can calculate his A/a gradient to be approximately 570 mm Hg assuming the delivery of a fraction of inspired oxygen (FIO2) of 100%. His a/A ration was 0.168. **These values show a critical failure of oxygenation which alone would indicate the need for endotracheal intubation and mechanical ventilation**. These values would not pass the threshold for weaning parameters to extubate a patient off of a mechanical ventilator. These were values obtained before either the chest tube thoracostomy or the intubation procedure were begun."

Supp. Barcay Decl. ¶ 12, emphasis added. A critical failure to oxygenate means Mr. Schwartz had unstable respiration.

Dr. Womack, however, claims Mr. Schwartz was stable because "[t]he ambulance that transported Mr. Schwartz to NNRH did not use lights and sirens." Womack Report at 12. Dr. Barcay makes the following observations:

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> The use of lights and sirens has no bearing on whether a patient is stable but rather is a judgment call by the ambulance attendants. In a rural setting, the speed of the ambulance may be the maximum legal limit without lights and sirens. The paramedics had none of the information that was subsequently obtained in the emergency department after a thorough physical examination, laboratory and imaging studies and thus had limited information upon which to judge whether or not the patient is stable. The paramedics are not physicians and their judgment cannot be relied upon to decide whether or not a patient is "stable". Furthermore, his "stable" status before entry to the emergency department has nothing to do with Dr. Womack's conclusions that he was "stable before Dr. Garvey attempted to intubate him" as the records clearly show that his respiratory status deteriorated during the more than three hours that he was in the emergency department before intubation. He required increasing inspired fraction of oxygen (FIO2) via 40% Venti mask and subsequent increase to a non-breather mask to reach even borderline oxygen saturations. Dr. Womack's first 'proof' is absurd. It proves nothing about Mr. Schwartz's condition in the minutes before Dr. Garvey decided to intubate him.

Supp. Barcay Decl. ¶ 1.

Dr. Womack also states that "[t]he ambulance that transported Mr. Schwartz to NNRH placed him on oxygen via NC at 4 L/min as a precaution." Womack Report at 12. However, Dr. Barcay explains that by Dr. Womack's own documentation shows Mr. Schwartz was anything but stable:

> The Elko County Paramedic records document the initial oxygen at 20:30 hours was 90%. This is unquestionably an abnormally low oxygen saturation. By Dr. Womack's own documentation, Mr. Schwartz's oxygen saturation on arrival to the emergency department was 94% **on 4 L/min supplemental oxygen**. The initial hypoxemia of 90% on paramedic arrival and the borderline 94% saturation on significant supplemental oxygen which is the equivalent of approximately 35% FIO2 cannot be interpreted as 'a precaution' and certainly is not evidence that he was 'a stable patient.'

Supp. Barcay Decl. ¶ 2, emphasis added; EMS Records, **Exhibit A** at 0004; Hospital Records, **Exhibit B** at NEN00003, NEN000008; Garvey Depo., **Exhibit C** at 82:22-83:12; Kevitt Depo., **Exhibit D** at 23:4-24:19. Dr. Womack also emphasizes that "[w]hen Mr. Schwartz arrived, he was breathing without difficulty." Womack Report at 12. But Dr. Womack states elsewhere in his report that Dr. Garvey noted Mr. Schwartz had pain with breathing and movement," that nurse Kevitt observed he had diminished breath sounds in his right posterior, middle and lower lung lobes, and that the paramedics documented that Mr. Schwartz had diminished lung sounds due to not wanting to take a deep breath.

Womack Report at 5. Dr Barcay points out that "these comments belie the statement of Dr. Womack that 'he was breathing without difficulty.'" Supp. Barcay Decl. ¶ 3. Dr. Barcay also points out that Mr. Schwartz's "respiratory status on arrival had nothing to do with his subsequent deteriorating state two to three hours later, which necessitated intubation for airway protection and support for adequate oxygenation and ventilation." Supp. Barcay Decl. ¶ 3.

Dr. Womack also claims "Nurse Kevitt evaluated Mr. Schwartz on multiple occasions, before and after CT scan, never noting any sign of being unstable." Womack Report at 13. However, Dr. Barcay points out that Dr. Womack's remarks are inaccurate.

> Vital signs show a significant deterioration of oxygen saturations from 20:53 hours when his saturation was 94% on 4 L/min to 91% at 23:17 hours which persisted until 23:45 hours while on Venti-mask. Dr. Womack conveniently omits the entry of nurse Kevitt at 23:37 hours (NEN000010) which documents that he was placed on a 40% Venti mask because of deterioration of his oxygen saturations on nasal cannula supplementation. Nurse Kevitt then documents that he was placed on a non-rebreather mask at 15 L/min at 23:51 hours (NEN000010) because of further deterioration of his respiratory status which could not be controlled with the Venti mask. This deteriorating respiratory status in the emergency department before intubation is anything but stable.

Supp. Barcay Decl. ¶ 4. Dr. Womack continues, claiming "Mr. Schwartz's pulse, respiratory rate and blood pressure were stable and within normal limits," that his "pulse ox readings were stable and within normal limits of what is expected in a trauma patient with rib fractures and a pneumothorax, especially a patient with inadequate pain control," and that his "vital signs did not become unstable until the time of the intubation attempt at 0020." Womack Report at 13-14. But Dr. Barcay observes that "Dr. Womack is mistaken in his evaluation of the pulse ox readings as discussed in the previous paragraph. His respiratory status was extremely unstable and in fact the **deterioration** that was witnessed and documented is exactly what is expected in a trauma patient with multiple rib fractures, pulmonary contusions, a flail chest, and a pneumothorax. It would be a breach in the standard of care to interpret normal pulses and normal blood pressures as a sign of a stable patient in the setting of multiple rib fractures, pulmonary contusions, flail chest and traumatic pneumothorax with a rapidly deteriorating respiratory status. A reasonable and

prudent physician does not wait until the blood pressure drops or the patient becomes tachycardic before he/she intervenes in such a case." Supp. Barcay Decl. ¶ 5.

Dr. Womack also states that "[m]ultiple witnesses gave testimony that describes Mr. Schwartz in a stable condition." Dr. Barcay observes: "Dr. Womack relates the observations of Plaintiff and Carmen Gonzales [admitting and discharge clerk] in an attempt to justify his conclusion that Mr. Schwartz was in a stable condition. Neither of these two people have any medical training and their testimony regarding medical issues cannot be relied upon." Supp. Barcay Del. ¶ 6.

The medical records establish Mr. Schwartz was in a deteriorating respiratory condition even before he was to be transported via air ambulance to a Level I trauma hospital. Dr. Womack concludes he was stable by relying on isolated bits of evidence rather than the whole record. Dr. Womack also fails to address the effect high altitude would have on a patient with multiple rib fractures, whose O2 saturation was already low, even while on oxygen. Dr. Womack does not opine Mr. Schwartz had the ability to maintain his own airway **in flight** or that intubation in flight was an acceptable risk.[6] His failure to address these critical facts neuters his ability to create disputed factual issues concerning the other elements of the Trauma Cap statute – existence of a traumatic injury under the statute, stability, and relatedness to the original injury.

D. Intubation was Medically Necessary.

The decision to intubate Mr. Schwartz was a life-saving decision to preserve and secure his airway, and it was within the standard of care. Dr. Barcay states the following reasons: "The decision to intubate was multifactorial including a rapidly worsening respiratory status with severe hypoxia requiring maximal levels of supplemental oxygen through a non-rebreather mask, a traumatic pneumothorax, pulmonary contusions, the risk of aspiration en route and a flail chest with multiple rib fractures. All of these multiple

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[6] Dr. Garvey stated he could not defend a bad outcome by not intubating pre-flight. *See,* Garvey Depo., **Exhibit C** at 130:22-133:3.

problems made the risk of air transport without intubation prohibitive." Supp. Barcay Decl. ¶ 9. For these reasons, it was not possible to defer intubation and chest tube placement during the two-hour air ambulance ride to the trauma hospital. Both procedures were medically necessary. *Id.* at ¶ 12. Dr. Womack does not assail paramedic Mr. Bartlett's experience level or the manner in which he attempted intubation. Mr. **Bartlett had more experience intubating patients than Dr. Womack.** Compare Bartlett Depo, **Exhibit H** at 14:25-15:3; 35:5-7 with Womack Report, 1. There is no evidence Dr. Garvey's decision to delegate intubation to Mr. Bartlett was negligent as a matter of law.

Dr. Womack states that Mr. Schwartz had eaten a full meal and therefore was at risk of aspiration. Dr. Barcay responds that this is a common risk in the emergency room: "He is right about that, but all patients seen in the emergency department who require intubation are at risk for aspiration due to recent meals. Unlike situations that anesthesiologists encounter for elective procedures where their patients have fasted for eight or more hours, emergency department physicians routinely intubate patients who have recently eaten. Dr. Garvey and Dr. Ray appropriately determined that the patient needed to be intubated in order to protect and control his airway during air transfer and in order to adequately oxygenate and ventilate him in that setting of a rapidly deteriorating respiratory status. There was no option of waiting eight or more hours before transporting the patient in order to lessen the risk of aspiration from a full stomach." Supp. Barcay Decl., ¶ 8.

Dr. Womack also opines that it was below the standard of care to intubate Mr. Schwartz, even if he had a flail chest, by relying on a medical textbook that has nothing to do with transferring a patient with a flail chest via air transport. Womack Report, pp. 18-19. Dr. Barcay responds that the textbook actually supports Dr. Garvey's treatment of Mr. Schwartz:

> He cites Rosen's Emergency Medicine Concepts and Clinical Practice. Unfortunately, this citation has nothing to do with the treatment of a flail chest in anticipation of, and preparation for, air transport. This citation is for "hospital treatment." Nevertheless, the citation states that 'the cornerstone if therapy (for a flail chest) include(s) . . . selective use of endotracheal

> intubation and mechanical ventilation, and close observation or respiratory compromise. Respiratory decompensation is the primary indication for endotracheal intubation and mechanical ventilation for patients with flail chest.' Mr. Schwartz did indeed have respiratory compromise as discussed above. As stated in the citation, endotracheal intubation is the cornerstone of therapy for a flail chest. This textbook which is widely used by emergency medicine physicians actually supports Dr. Garvey's evaluation and treatment and undermines Dr. Womack's criticism.

Supp. Barcay Decl. ¶ 10.

There is simply no evidence Mr. Schwartz should not have been intubated in the face of his decompensating respiration and flail chest injury. Even if Dr. Garvey mistakenly diagnosed a flail chest injury, a mere error of judgment is not bad faith. This means the purported erroneous decision to use rapid sequence intubation on Mr. Schwartz prior to putting on a plane, where it would be next to impossible to intubate Mr. Schwartz in flight, constitutes Dr. Garvey subjective good faith belief as to what was in the best interests of his patient.

Dr. Womack states Mr. Schwartz should have been taken off the hard backboard and C-collar. However, this is not the standard of care when preparing a patient for air transport. Supp. Barcay Decl. ¶ 12. Further, the fact Mr. Schwartz was not complaining of neck pain or tenderness is irrelevant. His thoracic injuries were distracting injuries. The pain from his thoracic injuries would make it difficult for Mr. Schwartz to know if his neck or head hurt, and he would therefore fail the NEXUS criteria for his cervical spine.[7] Supp. Barcay Decl. ¶ 12.

On a final note, given the emergency need for intubation, the disclosure falls within what a reasonable emergency physician would have done under similar circumstances, since there was no alternative to intubation. Further, Plaintiff ignores the fact that she is unaware whether her husband consented to intubation after she left his hospital room,

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[7] NEXUS (National Emergency X-Radiography Utilization Study) is a set of validated criteria used to decide which trauma patients do not require cervical spine imaging. Trauma patients who do not require cervical spine imaging require all of the following: alert and stable, no focal neurologic deficit, no altered level of consciousness, not intoxicated, no midline spinal tenderness, and **no distracting injury**.

when Dr. Garvey was preparing Mr. Schwartz for the procedure. *See*, Schwartz Depo., **Exhibit O** at 66:22-67:18; 129:8-19.

E. Because Intubation was Medically Necessary to Control and Preserve the Airway, it was Related to the Original Traumatic Injury.

Plaintiff claims the intubation complication was unrelated to Mr. Schwartz's thoracic injuries and therefore falls outside of the statute. But the need for intubation is tethered to Mr. Schwartz's thoracic injuries because he was increasingly unable to protect his airway. Dr. Womack simply ignored these considerations, and the fact that respiration would further decompensation at a high altitude. Dr. Womack opines the chest tube would prevent air from expanding in flight, but simply chooses to ignore the effect of high altitude on Mr. Schwartz's ability to protect his own airway. Dr. Garvey testified that he would never have placed Mr. Schwartz on an air ambulance without intubation because he could never defend a bad outcome for the failure to intubate. Dr. Womack's myopic opinion fails to consider the dangerous and life-threatening situation that would result in flight. It should, therefore, be given no weight.

F. The Massive Initial Aspiration Prevented an Earlier Cricothyrotomy and the Issue Relates to Negligence, Which is Covered by the Trauma Cap.

Dr. Womack opines Dr. Garvey's failure to perform a cricothyrotomy sooner was gross negligence because more and more emesis entered Mr. Schwartz's trachea with every subsequent intubation attempt. Even if that were true, which it is not, his opinion speaks to the issue of ordinary negligence, which is covered by the Trauma Cap statute, and Plaintiff may not oppose the motion with unpled gross negligence/recklessness theories.

The medical records and testimony unanimously establishes a massive aspiration on the first two intubation attempts. This would have prevented an earlier cricothyrotomy. At 12:20 a.m., paramedic Bartlett stated he was having difficulty visualizing the glottic opening, due to anterior vocal cords, a situation he 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. Mr. Bartlett initiated a second intubation attempt, but Mr. Schwartz vomited again and the tube filled with emesis. *Id.* at 78: 2-15. According to Dr. Barcay, the initial vomitus entered the trachea and would explain why Mr. Schwartz could not be ventilated, when the tube was placed into the trachea either through endotracheal intubation or through cricothyrotomy. Supp. Barcay Decl. ¶ 14. Bartlett testified the airway was swollen. This is consistent with laryngospasm, which is the sustained closure of the vocal cords in order to safeguard the airway from aspirating further food particles. Supp. Barcay Decl. ¶ 14. Laryngospasm makes it very unlikely that BVM pushed copious amounts of vomit into the trachea and bronchi, in light of the multiple logrolling efforts undertaken by the medical team and the suctioning of his airway with three suctioning units. *Ibid. See,* Hospital Records, **Exhibit B** at NEN00003; Garvey Depo., **Exhibit C** at 152:2-6; Kevitt Depo., **Exhibit D** at 52:19-55:2. The initial wave of emesis precluded a surgical airway, and an earlier cricothyrotomy would not have prevented Mr. Schwartz's death.

Dr. Womack's criticism that Dr. Garvey made no attempt to meet the standard of care to establish emergency oxygenation is not well taken. Womack Report at 22-23.

Dr. Barcay observes:

> Dr. Womack states that "the standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett's failed attempt at 12:23 AM. After 12:23 AM, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency oxygenation to Mr. Schwartz."
>
> I disagree with Dr. Womack's criticism. Dr. Garvey testified that "…during that second attempt, the patient began to regurgitate. At that point, I aborted putting the chest tube in and went to the head of the bed." (page 148). He testified that after the insertion of the King airway, "the oxygen saturations improved and the patient regained a pulse." (page 152). This testimony belies Dr. Womack's criticism that there were no reasonable attempts to establish emergency oxygenation and that Dr. Garvey was doing nothing within the standard of care.

Supp. Barcay Decl. ¶ 14.

Moreover, surgical cricothyrotomy is a last resort, and there is no cookbook formula. It is a

judgment call.[8] *Ibid.* Even if gross negligence was a material issue, which it is not, Dr. Womack is not competent to opine whether the timing of cricothyrotomy constitutes gross negligence. As a physician, he can only opine that the conduct was below the standard of care. Dr. Womack's opinion that Dr. Garvey rendered care that was not in good faith should be stricken or disregarded.

G. Plaintiff has not Demonstrated a Need for Further Discovery.

Plaintiff fails to demonstrate she lacks the ability to adequately respond to the present motion without further discovery. She claims "time is needed to conduct discovery to allow Plaintiff to respond to the Motion," Decl. Blazich, ¶ 7. This plea should fall on deaf ears, for several reasons. First, no amount of discovery pertaining to negligence or gross negligence [which is outside the pleadings], can overcome the Trauma Cap. Second, issues concerning life-threatening injury, stability and relatedness to original traumatic injury are within the purview of expert medical opinion, not the lay witness testimony. Third and finally, Plaintiff submitted a 31-page report from Dr. Womack addressing each element of the statute relevant to this motion, and thus, undercuts her own argument that more time is needed to conduct discovery. For each of these reasons, this Court should deny her request for more time pursuant to NRCP 56(d).

III. CONCLUSION

Mr. Schwartz sustained life-threatening injuries that destabilized his respiratory function. He could not be taken to a Level I trauma hospital without intubation. Plaintiff fails to demonstrate a genuine issue of material fact as to any element of the Trauma Cap statute. She failed to plead anything other than ordinary negligence, and should not be

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[8] Dr. Barcay highlights Dr. Womack's misuse of the literature: "Dr. Womack cites the authors from the Manual of Emergency Airway Management stating, 'if however, the failed airway is because of a CICO situation, then there is little time left before cerebral hypoxia will result in permanent deficit, and immediate cricothyrotomy is indicated.' Dr. Womack takes one sentence out of context with no page attribution. The procedure for rescue intubation is much more complex than that one sentence in isolation. Rescue techniques for a failed intubation include facemasks, laryngeal masks, jaw thrust and repositioning, bougie assisted intubation, King airway, and others." Supp. Barcay Decl., ¶ 13.

permitted to oppose the motion based on unpled assertions of bad faith. For these reasons, Dr. David Garvey respectfully requests that damages be limited to a maximum of $50,000.

DATED this 26th day of August, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ *Alissa N. Bestick*

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AFFIRMATION

PURSUANT TO NRS 239B.030

The undersigned does hereby affirm that the preceding document does not contain the social security number of any person.

DATED this 26th day of August, 2020

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ *Alissa N. Bestick*

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CERTIFICATE OF SERVICE

I hereby certify that on this the 26th day of August, 2020, a true and correct copy of **DEFENDANT DAVID GARVEY, M.D.'S REPLY IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES** was sent via electronic mail to the following:

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EXHIBIT A

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

You asked me to review and respond to the report of Dr. Womack dated August 17, 2020. In response, I make the following declaration.

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:

1. I was asked to review and respond to the report of Seth Womack, M.D., dated August 17, 2020. In his report, Dr. Womack states that Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. As proof of this he cites the following:

"The ambulance that transported Mr. Schwartz to NNRH did not use lights and sirens."

The use of lights and sirens has no bearing on whether a patient is stable but rather is a judgment call by the ambulance attendants. In a rural setting, the speed of the ambulance may be the maximal legal limit without lights and sirens. The paramedics document that there was "no delay" to destination. The paramedics had none of the information that was subsequently obtained in the emergency department after a thorough physical examination, laboratory and imaging studies and thus had limited information upon which to judge whether or not the patient is stable. The paramedics are not physicians and their judgment cannot be relied upon to decide whether or not a patient is "stable". Furthermore, his "stable" status before entry to the emergency department has nothing to do with Dr. Womack's conclusion that he was "stable before Dr. Garvey attempted to intubate him" as the records clearly show that his respiratory status deteriorated during the more than three hours that he was in the emergency department before intubation. He required increasing inspired fraction of oxygen (FIO2) via 40% Venti mask and subsequent increase to a non-rebreather mask to reach even borderline oxygen saturations. Dr. Womack's first "proof" is absurd. It proves nothing about Mr. Schwartz's condition in the minutes before Dr. Garvey decided to intubate him.

2. Dr. Womack states, "The ambulance that transported Mr. Schwartz to NNRH placed him on oxygen via NC at 4 L/min as a precaution".

The Elko County Paramedic records document the initial oxygen saturation at 20:30 hours was 90%. This is unquestionably an abnormally low oxygen saturation. By Dr. Womack's own documentation, Mr. Schwartz's oxygen saturation on arrival to the emergency department was 94% **on 4 L/min supplemental oxygen.** The initial hypoxemia of 90% on paramedic arrival and the borderline 94% saturation on significant supplemental oxygen which is the equivalent of approximately 35% FIO2 cannot be interpreted as "a precaution" and certainly is not evidence that he was "a stable patient".

3. Dr. Womack states, “When Mr. Schwartz arrived, he was breathing without difficulty”.

By Dr. Womack’s own documentation, “Dr. Garvey noted that Mr. Schwartz had pain with breathing and movement.” Dr. Womack writes that “Donna Kevitt, R.N. noted that he had diminished breath sounds in his right posterior, middle and lower lung lobes.” Dr. Womack writes that the paramedics documented that “Mr. Schwartz had diminished lung sounds due to not wanting to take a deep breath.” These comments belie the statement of Dr. Womack that “he was breathing without difficulty.” Nevertheless, his respiratory status on arrival has nothing to do with his subsequent deteriorating respiratory status 2-3 hours later which necessitated intubation for airway protection and support for adequate oxygenation and ventilation.

4. Dr. Womack states, “Nurse Kevitt evaluated Mr. Schwartz on multiple occasions, before and after CT scan, never noting any sign of being unstable”.

Vital signs show a significant deterioration of oxygen saturations from 20:53 hours when his saturation was 94% on 4 L/min to 91% at 23:17 hours which persisted until 23:45 hours while on a Venti-mask. Dr. Womack conveniently omits the entry of nurse Kevitt at 23:37 hours (NEN000010) which documents that he was placed on a 40% Venti mask because of deterioration of his oxygen saturations on nasal cannula supplementation. Nurse Kevitt then documents that he was placed on a non-rebreather mask at 15 L/min at 23:51 hours (NEN000010) because of further deterioration of his respiratory status which could not be controlled with the Venti mask. This deteriorating respiratory status in the emergency department before intubation is anything but stable.

5. Dr. Womack states, “Mr. Schwartz’s pulse, respiratory rate and blood pressure were stable and within normal limits” and, “Mr. Schwartz’s pulse ox readings were stable and within normal limits of what is expected in a trauma patient with rib fractures and a pneumothorax, especially a patient with inadequate pain control…Mr. Schwartz’s vital signs did not become unstable until the time of the intubation attempt at 00:20”.

Dr. Womack is mistaken in his evaluation of the pulse ox readings as discussed in the previous paragraph. His respiratory status was extremely unstable and in fact the **deterioration** that was witnessed and documented is exactly what is expected in a trauma patient with multiple rib fractures, pulmonary contusions, a flail chest, and a pneumothorax. It would be a breach of the standard of care to interpret normal pulses and normal blood pressures as a sign of a “stable patient” in the setting of multiple rib fractures, pulmonary contusions, flail chest and traumatic pneumothorax with a rapidly deteriorating respiratory status. A reasonable and prudent physician does not wait until the blood pressure drops or the patient becomes tachycardic before he/she intervenes in such a case.

Further, Dr. Womack disregards the near certainty of pulmonary contusions because they were not clearly visible on the imaging studies. A pulmonary contusion is a large bruise that can cause dangerously low levels of oxygen in the blood stream, which may take several hours to show up on imaging studies. Pulmonary contusions are almost always present with blunt chest trauma and multiple rib fractures. Mr. Schwartz's autopsy report confirms that he had pulmonary contusions. Neglecting the likelihood of pulmonary contusions in this case of severe chest trauma would have fallen below the standard of care. It is below the standard of care to wait for the delayed radiographic signs of pulmonary contusions to show up.

6. Dr. Womack states, "Multiple witnesses gave testimony that describes Mr. Schwartz in stable condition".

Dr. Womack relates the observations of Diane Schwartz (wife), and Carmen Gonzales (admitting and discharge clerk) in an attempt to justify his conclusion that Mr. Schwartz was in stable condition. Neither of these two people have any medical training and their testimony regarding medical issues cannot be relied upon. In his deposition, John Patton, the third witness could not even recall whether Mr. Schwartz was on supplemental oxygen. See previous paragraphs for the discussion of why Mr. Schwartz was not in stable condition.

7. Dr. Womack states, "Mr. Schwartz did not have injuries that were an immediate or imminent threat to life.

I disagree with his conclusion. As discussed above, his rapidly deteriorating respiratory status over a short period of time required increasing levels of supplemental oxygen, first by nasal cannula, then by Venti mask when he continued to desaturate and finally by a non-rebreather mask at 15 L/min which is the maximum amount of oxygen flow which can be delivered without intubation and mechanical ventilation. His chest injuries were clearly severe and would have led to continuing deterioration especially on the planned transfer by air ambulance. This conclusion was clear to both Dr. Garvey and to Dr. Ray, the receiving physician at the University of Utah Medical Center. Dr. Ray requested that Dr. Garvey insert a chest tube and consider intubating the patient prior to transport by air.

Dr. Womack agrees that the patient required a chest tube placement. Chest tubes aim to promptly improve cardiorespiratory functions by avoiding the enlargement of a pneumothorax and the possible development of a tension pneumothorax. Tension pneumothorax is a life-threatening condition that can occur with chest trauma when air is trapped in the pleural cavity leading to a cascading impact, including a rapid deterioration of a patient's ability to maintain oxygenation.

Chest tubes also promote lung re-expansion. Any patient who requires a chest tube thoracostomy has an injury which is an imminent threat to life. Any patient who sustains multiple trauma with multiple rib fractures, pulmonary contusions, a traumatic pneumothorax, a flail chest and traumatic intra-abdominal injuries has injuries that are an imminent threat to life.

8. Dr. Womack states, "Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz".

Dr. Womack states that Mr. Schwartz had eaten a full meal and therefore was at risk of aspiration. He is right about that, but all patients seen in the emergency department who require intubation are at risk for aspiration due to recent meals. Unlike situations that anesthesiologists encounter for elective surgical procedures where their patients have fasted for eight or more hours, emergency department physicians routinely intubate patients who have recently eaten. Dr. Garvey and Dr. Ray, the accepting physician at University of Utah Medical Center, appropriately determined that the patient needed to be intubated in order to protect and control his airway during air transfer and in order to adequately oxygenate and ventilate him in the setting of a rapidly deteriorating respiratory status. There was no option of waiting eight or more hours before transporting the patient in order to lessen the risk of aspiration from a full stomach.

9. Dr. Womack states, "Mr. Schwartz did not have a flail chest…Despite Dr. Garvey knowing what ribs fractures are consistent with a flail chest, he still misdiagnosed Mr. Schwartz with a flail chest and based his decision to intubate Mr. Schwartz from an incorrect diagnosis".

I disagree with Dr. Womack's interpretation. The radiologist reported right sided rib fractures of ribs 4-7 with the fourth and sixth ribs fractured in two places. The autopsy report showed that right sided ribs 2-7 were fractured. It is likely that the radiologist missed the second fracture of the right fifth rib as he apparently missed the fractures of right sided ribs 2 and 3. It is highly likely that ribs 2 and 3 were fractured initially and not due to the chest compressions during CPR. These ribs are high up in the thoracic cage and are not subjected to extraordinary mechanical pressures of CPR. In fact, it is very unlikely that ribs 2 and 3 were fractured during CPR. In any case, the diagnosis of a flail chest is a **clinical diagnosis** of the observation of paradoxical motion of the chest wall in the presence of rib fractures. Dr. Garvey in his deposition (page 98) when asked:

Question: "what are the symptoms that are associated with a flail chest?"

Answer: "…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."

Question: "And was Mr. Schwartz – did Mr. Schwartz have any of those symptoms?"

Answer: "Yes he did."

Question: "And when you're talking about the – the, breathing pattern, did you document that anywhere in the medical record?"

Answer: "No. Well it's not obvious."

This clearly shows that Dr. Garvey observed paradoxical motion of the chest wall in the presence of multiple rib fractures. He documents that in his discussion with Dr. Ray at University of Utah Medical Center. Dr. Ray requested that a chest tube be placed and that the patient be possibly intubated prior to air medical transport due to **flail segment**, pulmonary contusions, low O2 sats and a traumatic R pneumothorax." Thus, the diagnosis of flail chest was made clinically by Dr. Garvey, relayed to Dr. Ray and was appropriate. Furthermore, the decision to intubate was due to multiple factors, flail chest being only one. In his deposition, Dr. Garvey explained that transferring Mr. Schwartz without intubating him was not an option "because of the risk of aspiration en route. I would never be able to defend a bad outcome in a patient requiring intubation inflight or aspirating inflight and me having not intubated him."

Therefore, the decision to intubate was multifactorial including a rapidly worsening respiratory status with severe hypoxia requiring maximal levels of supplemental oxygen through a non-rebreather mask, a traumatic pneumothorax, pulmonary contusions, the risk of aspiration en route and a flail chest with multiple rib fractures. All of these multiple problems made the risk of air transport without intubation prohibitive.

10. Dr. Womack writes, "Even if Mr. Schwartz did have a flail chest, it was below the standard of care to immediately intubate him."

He cites Rosen's Emergency Medicine Concepts and Clinical Practice. Unfortunately, this citation has nothing to do with the treatment of a flail chest in anticipation of, and preparation for, air transport. This citation is for "hospital treatment." Nevertheless, the citation states that "the cornerstone of therapy (for a flail chest) include(s)…selective use of endotracheal intubation and mechanical ventilation, and close observation for respiratory compromise. Respiratory decompensation is the primary indication for endotracheal intubation and mechanical ventilation for patients with flail chest." Mr. Schwartz did indeed have respiratory compromise and decompensation as discussed above. As stated in the citation, endotracheal intubation is the cornerstone of therapy

for a flail chest. This textbook, which is widely used by emergency medicine physicians, actually supports Dr. Garvey's evaluation and treatment and undermines Dr. Womack's criticism.

11. Dr. Womack then states, "Mr. Schwartz did not have respiratory decompensation or compromise; he was talking, laughing, and joking."

Dr. Womack misinterprets the record as discussed above. Mr. Schwartz was unquestionably rapidly decompensating and compromised. One can be certain that he was not talking, laughing, and joking while wearing a full face mask with a large inflated oxygen reservoir with the loud hissing of maximal oxygen flow and while struggling to maintain adequate oxygen saturation on a non-rebreather mask, the last step in maximal supplemental oxygen delivery before the need for intubation.

12. All of Dr. Womack's opinions are based on his mistaken interpretation that Mr. Schwartz's respiratory status was stable. As is convincingly outlined in the above discussion, Mr. Schwartz's respiratory status was unstable and deteriorating over a more than two hour time period and then more rapidly over a fourteen minute time period due to the multiple chest and abdominal trauma that he sustained. He required increasing levels of supplemental oxygen barely maintaining adequate oxygenation at each level and then further deteriorating ultimately requiring a non-rebreather mask at 15 L/min which is the maximal supplemental oxygen that can be delivered short of endotracheal intubation and mechanical ventilation support.

Alveolar-arterial oxygen gradients (A-a) and arterial to Alveolar ratios (a/A) are calculated from the Alveolar gas equation and are commonly used to determine the degree and severity of hypoxemia. Mr. Schwartz's oxygen saturation on a 40% Ventimask was 91%. This calculates to an Alveolar-arterial (A-a) oxygen gradient of 175 mm Hg assuming a pCO_2 of 40. A normal A-a gradient is less than 20 mm Hg. His a/A ratio was 0.255. A normal a/A ratio is greater than 0.75. Both these values show a severe disturbance in the pulmonary function of oxygenation. When he was placed on a non-rebreather mask at maximum oxygen flow rate of 15 L/min, his oxygen saturation was 97%. We can calculate his A-a gradient to be approximately 565 mm Hg assuming the delivery of a fraction of inspired oxygen (FIO_2) of 100% and a pCO_2 of 40. His a/A ratio was 0.147. These extreme values show a critical failure of oxygenation and portend imminent respiratory failure which alone would mandate the need for endotracheal intubation and mechanical ventilation. These values would not pass the threshold for weaning parameters to extubate a patient off of a mechanical ventilator. These were values obtained before either the chest tube thoracostomy or the intubation procedure were begun.

It was clear that intubation and chest tube placement could not be deferred if he were to be transported for one to two hours by air ambulance to the University of Utah Medical

Center for higher level of care given his multiple traumatic injuries and need for trauma surgical evaluation and treatment. The decisions to place a chest tube to expand the traumatic pneumothorax and protect him from developing a tension pneumothorax from decompression and changes in ambient air pressure at altitude, and to intubate him for airway protection and control of ventilation and oxygenation were medically necessary and appropriate.

Moreover, Dr. Womack states that Mr. Schwartz should have been taken off the backboard and C-collar. This is not the standard of care when preparing a patient for air transport. Whether Mr. Schwartz complained of neck pain is irrelevant, as his thoracic injuries were distracting injuries. The pain from his thoracic injuries would make it difficult for Mr. Schwartz to know if his neck or head hurt, and he would therefore fail the NEXUS criteria for his cervical spine.

13. Dr. Womack cites the authors from the Manual of Emergency Airway Management, stating, “if however, the failed airway is because of a CICO situation, then there is little time left before cerebral hypoxia will result in permanent deficit, and immediate cricothyrotomy is indicated.”

Notice that he takes one sentence out of context with no page attribution. The procedure for rescue intubation is much more complex than that one sentence in isolation. Rescue techniques for a failed intubation include facemasks, laryngeal masks, jaw thrust and repositioning, bougie assisted intubation, King airway, and others.

14. Dr. Womack states, “the standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett’s failed attempt at 12:23 AM. After 12:23 AM, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency oxygenation to Mr. Schwartz.”

I disagree with Dr. Womack’s criticism. Dr. Garvey testified that “…during that second attempt, the patient began to regurgitate. At that point, I aborted putting the chest tube in and went to the head of the bed.” (page 148). He testified that after the insertion of the King airway, “the oxygen saturations improved and the patient regained a pulse.” (page 152). This testimony belies Dr. Womack’s criticism that there were no reasonable attempts to establish emergency oxygenation and that Dr. Garvey was doing nothing within the standard of care. Surgical cricothyrotomy is a last resort. There is no cookbook formula to follow regarding when to perform surgical cricothyrotomy; it is the physician’s judgment call to make.

Moreover, initial vomitus entered the trachea and would explain why Mr. Schwartz could not be ventilated, when the tube was placed into the trachea either through

endotracheal intubation. This difficulty in ventilation is consistent with both laryngospasm, which is the sustained closure of the vocal cords in order to safeguard the airway from aspirating further food particles and mechanical obstruction due to food particles. Laryngospasm makes it very unlikely that BVM pushed copious amounts of vomit into the trachea and bronchi, in light of the multiple logrolling efforts undertaken by the medical team and the suctioning of his airway with three suctioning units.

15. In summary, I disagree with most if not all of Dr. Womack's criticisms as outlined above. It strains credulity that Dr. Womack, as an emergency medicine expert, would declare that a patient who sustained multiple chest and abdominal trauma with multiple rib fractures, traumatic pneumothorax, pulmonary contusions and a flail chest with deteriorating respiratory parameters and impending respiratory failure, would declare that such a patient is "stable". Mr. Schwartz was not in stable condition and did meet standard of care criteria for endotracheal intubation due to rapidly deteriorating respiratory status and impending respiratory failure. In fact, it would have been gross negligence to put Mr. Schwartz on the flight without being intubated and without having placed a chest tube. The likelihood of continuing deterioration leading to a respiratory arrest during a one to two-hour evacuation flight was almost a certainty. Dr. Garvey made the appropriate decision to intubate and to place a chest tube in consultation with Dr. Ray, the receiving emergency medicine physician.

I declare under penalty of perjury under the laws of the State of Nevada and the State of California that the foregoing is true and correct. This declaration was executed on AUGUST 26, 2020, in Los Angeles, California.

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