IN THE SUPREME COURT OF THE STATE OF NEVADA

DAVID GARVEY, M.D., an individual.

Petitioner,

vs.

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

Respondent,

and

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

Real Party In Interest.

Supreme Court No.

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

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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.

PLAINTIFFS' OPPOSITION TO DEFENDANT DAVID GARVEY M.D.'S MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES, AND ALL JOINDERS THERETO

Plaintiffs hereby Oppose Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders thereto filed by co-Defendants. While Douglas Schwartz sustained an injury that brought him into the NNRH Emergency Room, his injury does not meet the special definition of "traumatic injury" as defined by statute under these circumstances. Furthermore, Douglas Schwartz was "stable" when Defendants herein recklessly and in conscious disregard of his wellbeing attempted to improperly intubate him thereby causing his death.

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This Opposition is based upon the pleadings on file herein, the points and authorities attached hereto, and any oral arguments that they may be allowed at the hearing of this Motion.

DATED this 18th day of August, 2020.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich

_____

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DECLARATION SHIRLEY BLAZICH, ESQ., IN SUPPORT OF PLAINTIFF'S OPPOSITION DEFENDANT DAVID GARVEY M.D.'S MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES, AND ALL JOINDERS THERETO

I, Shirley Blazich, Esq., declare under penalty of perjury as follows:

1. I am a partner at Claggett & Sykes Law Firm, counsel of record for Plaintiff Diane Schwartz, in the above-named action. I have personal knowledge of, and am competent to testify to, the facts contained in this Declaration, except on those matters stated upon information and belief, and as to those matters, I believe them to be true. I make this Declaration in support of Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders thereto.

2. On June 22, 2017, Plaintiff filed her Complaint.

3. On August 21, 2017 the parties agreed to Amend the Complaint to correct the name of two of the Defendants.

4. Plaintiff filed her Amended Complaint on October 7, 2017. Plaintiff erroneously removed her Punitive Damages claim from the Complaint at that time.

5. Plaintiff later moved to Amend to claim Punitive Damages. The Court denied

Plaintiff's Motion, but noted the denial was without prejudice.

6. Discovery in this matter closes on February 3, 2021. And while a bulk of the discovery has been completed, the parties are still squarely within the middle of the discovery period.

7. Pursuant to NRCP 56(d), time is needed to conduct discovery to allow Plaintiff to properly respond to Defendants' Motion. Plaintiff needs to conduct the following discovery to intelligently respond to Defendants' assertions:

- The deposition of Nancy Abrahms of NNRH
- The deposition of Ronnie Lyons of Reach Air
- 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 of Ruby Crest
- The deposition of Dr. Jones of Ruby Crest
- Initial Expert Disclosures
- Rebuttal Expert Disclosures
- The depositions of all expert witnesses

I declare under penalty of perjury that the foregoing is true and correct.

DATED this 18th day of August, 2020.

/s/ Shirley Blazich

SHIRLEY BLAZICH, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

This case arises from professional negligence that led to the death of Douglas Schwartz. On or around June 22, 2016, Douglas was struck by a car while he was walking.[1] Douglas was transported to Northeastern Nevada Regional Hospital by Elko County Ambulance on a **"non-emergent"** transport, arriving approximately a half an hour later.[2] During transport to the hospital Douglas's vitals were within **normal** limits and a heart monitor was placed showing **normal** sinus rhythm. Douglas

[1] Dr. Scissors Affidavit, attached hereto as **Ex. "1."**

[2] Id.

was alert, awake, laughing, and joking with his family. Dr. Garvey examined Douglas, and then contacted Dr. Ray at the University of Utah who accepted Douglas for transfer.[3] Dr. Garvey made the decision to intubate Douglas prior to transport. Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Defendant Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.[4] Douglas's vital signs were **stable** up until that point.[5] Multiple intubation attempts failed—Douglas aspirated his gastric contents and ultimately died as a result.

While Plaintiffs concede that Douglas Schwartz sustained a traumatic injury when he was hit by a motor vehicle while crossing the street, his traumatic injury does not meet the special definition of "traumatic injury" as defined by NRS 41.503 under these circumstances. Furthermore, Douglas Schwartz was "stable" when Defendants herein recklessly and in conscious disregard of his wellbeing attempted to improperly intubate him thereby causing his death. If the Court were to rule as a *matter of law* to determine *issues of fact* pertaining to the ultimate applicability of the trauma statute, and its $50,000 cap, it would be dangerously crossing over into the role of the jury.

In deciding this Motion, and all Joinders thereto, the Court need only consider the following:

1. Douglas Schwartz did not sustain a "traumatic injury" as defined by NRS 41.503(4)(b), which states that "traumatic injury" involves a **significant risk of death or the precipitation of complications or disabilities**.

2. Assuming arguendo, that Douglas Schwartz did sustain a "traumatic injury" when he was hit by a motor vehicle, the negligent acts and omissions alleged in the Complaint were **unrelated to the original traumatic injury**.

3. Assuming arguendo, the Douglas Schwartz did sustain a "traumatic injury" when he was hit by a motor vehicle, he was **stabilized** as far as that trauma was concerned and capable of receiving treatment as a non-emergency patient at the time of the negligent acts and omissions alleged in Plaintiffs' Complaint.

[3] Id.

[4] See Dr. Scissors Aff. At Exhibit **"1."**

[5] Id.

4. Defendants' Motion presents genuine issues of material fact which can only be decided by the trier of fact, the jury.

5. The trauma statute does not apply because Defendants conduct was not in **good faith** and was **reckless, willful and/or wanton**.

6. The legislative history for NRS 41.503 is consistent with Plaintiffs' interpretation of the statute herein.

II.

FACTUAL BACKGROUND

This case arises from professional negligence that led to the death of Douglas Schwartz. On or around June 22, 2016, Douglas was struck by a car while he was walking.[6] He had just finished eating dinner at a nearby restaurant with the Board of Directors at Elko Federal Credit Union, where he worked as their CEO. Douglas was transported to Northeastern Nevada Regional Hospital by Elko County Ambulance on a **"non-emergent"** transport, arriving approximately a half an hour later.[7] During transport to the hospital Douglas's vitals were within **normal** limits and a heart monitor was placed showing **normal** sinus rhythm. In the emergency room, Donna Kevitt, RN was Mr. Schwartz's nurse.[8] Nurse Kevitt documented that Mr. Schwartz's airway was patent with good air movement, and he was breathing without difficulty.[9] Mr. Schwartz was awake, alert, and oriented to person, place, and time.[10]

Defendant David M. Garvey, M.D., performed a physical examination of Douglas.[11] Dr. Garvey's assessment revealed that Douglas had mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.[12] Douglas

[6] Dr. Scissors Affidavit, attached hereto as **Ex. "1."**

[7] Id.

[8] Dr. Womack Report, attached hereto as **Ex. "2."**

[9] Id.

[10] Id.

[11] Dr. Scissors Affidavit, attached hereto as **Ex. "1.";** Dr. Womack Report, attached hereto as **Ex. "2."**

[12] Id.

had a **normal heart rate** and rhythm, and **did not display signs of respiratory distress**.[13] Douglas's respirations were **normal** with **clear** breath sounds throughout. Douglas's neurological status and abdominal evaluation were **normal**.[14] **Douglas's condition was stable.** [15]

The testimony in this case reflects what was actually happening prior to Douglas's intubation. Douglas was alert, awake, and joking around.[16] In fact, the now Chief of Surgery at NNRH, Dr. Patton, is critical of the decision to intubate Douglas that night.[17] And while Dr. Patton, is not an expert in this case, and was merely there as a family friend, it does not change the fact that the Chief of Surgery saw Douglas prior to the intubation attempt and disagrees with that decision at the time because of Douglas's condition.

Moreover, Diane Schwartz testified that Douglas did not have difficulty breathing prior to intubation, and he was not given oxygen at any point while he was in the ER.[18] When Diane left the room, Douglas was fine.[19] She did not understand why Douglas was intubated at all.[20]

At 9:02 p.m., several diagnostic studies were ordered to further evaluate Douglas's injuries.[21] Notably, these studies were done before Douglas was intubated, further demonstrating that his airway and breathing was stable. If it was not, Dr. Garvey would have had to intubate Douglas first before sending him for diagnostic and imaging studies. At 11:17 Douglas's pulse ox was 91%—at 11:30 Douglas's pulse ox is 92%.[22] Dr. Garvey contacted Dr. Ray at the University of Utah who accepted Douglas for transfer.[23] According to Dr. Garvey's chart note, Dr. Ray requested that a

[13] Id.

[14] Id.

[15] Id.

[16] Dr. Patton Dep., 15:9-11; 27:2-6; 30:3–23, attached hereto as **Ex. "3."**

[17] Id. at 32:6-12.

[18] Diane Schwartz Dep., 49:23-24; 62:19–63:3, attached hereto as **Ex. "4."**

[19] Id. at 70:13-15.

[20] Id. at 136:8-12.

[21] Id.

[22] Dr. Womack Report, attached hereto as **Ex. "2."**

[23] Id.

chest tube be placed and that Douglas "possibly" be intubated for transfer.[24] The air ambulance crew from Defendant Reach Air arrived at NNRH to transport Douglas to the airport for an air ambulance transport to the University of Utah Hospital.[25] Notably, Defendant Reach Air's response mode is noted as being **without** their lights and sirens on.[26]

Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Defendant Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.[27] Douglas's vital signs were **stable** up until that point.[28] Defendant Reach Air's records indicate that Douglas had a 10% pneumothorax on his right side and a flail chest segment, but that he was "tolerating it well at this time."[29] The receiving physician had recommended that Douglas be intubated with chest tube placement pre-flight.[30] When Defendant Reach Air's flight crew arrived, Douglas was **"talking"** with his family.[31]

Mr. Bartlett first attempted intubation at 12:20 a.m., unsuccessfully.[32] A large aspiration of gastric contents occurred after this initial intubation attempt and 13 minutes were spent suctioning his airway and re-oxygenating him with BVM.[33] Mr. Bartlett attempted intubation again at 12:23a.m. and 12:33 a.m. and was again unsuccessful.[34] Apparently, Mr. Bartlett attempted both "tooled and digital intubations" during this time.[35] Dr. Garvey stepped in to attempt to intubate 3 separate times, all

[24] Id.

[25] Id.

[26] See Reach Air Records attached as Exhibit **"5."**

[27] See Dr. Scissors Aff. At Exhibit **"1."**

[28] Id.

[29] See Reach Air Records at Exhibit **"5.";** Dr. Womack disagrees that Douglas had demonstrated a flail chest at this time. Dr. Womack Report, p. 17, attached hereto as **Ex. "2."**

[30] Id.

[31] Id.

[32] See Dr. Scissors Aff. At Exhibit **"1."**

[33] See Reach Air Records at Exhibit **"5."**

[34] Id.

[35] Id.

unsuccessfully.[36] Intubation attempts continued at 12:40a.m., 12:44a.m., 12:47a.m., 12:52a.m. and 12:53a.m.[37] After another unsuccessful intubation attempt, a cric (surgical airway) was initiated by Dr. Garvey and Mr. Bartlett.[38] Over the course of over 33 minutes, a total of 9 intubation attempts are documented by Defendant Reach Air's flight crew.[39] After multiple aspiration events and failed intubation attempts, Douglas's vital signs and oxygenation indicated cardiopulmonary arrest so CPR was administered.[40] CPR was unsuccessful and Douglas was pronounced dead at 1:33a.m.[41] From the time the first drug was given for rapid sequence intubation (RSI) until Dr. Garvey pronounced Mr. Schwartz deceased was 1 hour and 15 minutes.[42] During this time, neither Dr. Garvey nor Barry Bartlett were able to establish a definitive airway for Mr. Schwartz.[43]

After Douglas's death NNRH had an Occurrence Report completed by one of its staff following Douglas' many failed intubation attempts which noted that he was "stable and ready for transfer."[44] Contributing factors to this incident occurring were noted to be: "Staff – use of Float Staff"; "Staffing issue"; "Task – training issue"; Work Envmt – Inadequate Equipment Availability."[45] In addition, the Occurrence Report notes that the "trauma cart" was "open" and "not fully stocked – Supplies had to be obtained from 2 other rooms and store room."[46] NNRH has policies and procedures in place to ensure that the crash cart is always fully stocked and ready for use if a patient is experiencing a Code Blue—policies Dr. Garvey was required to follow.[47] This policy requires crash

[36] Id.

[37] Id.

[38] Id.

[39] Id.

[40] Id.

[41] Id.

[42] Dr. Womack Report, attached hereto as **Ex. "2."**

[43] Id.

[44] See Occurrence Report, attached hereto as **Ex. "6."**

[45] Id.

[46] Id.; Dr. Womack Report, attached hereto as **Ex. "2."**

[47] See NNRH's Code Blue Procedure & Crash Cart Maintenance Policy, attached hereto as **Ex, "7."**

carts to be locked and their inventory checked daily.[48] Despite requests to NNRH to produce documentation of their daily crash cart checks, to date no such documentation has been provided. The facts of this case show more than just negligence, they show gross negligence and reckless, willful and wanton conduct.

III.

ARGUMENT

A. LEGAL STANDARD FOR SUMMARY JUDGMENT

Pursuant to NRCP 56(c) summary judgment is only appropriate if "there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Summary judgment is appropriate under NRCP 56 when the pleadings, depositions, answers to interrogatories, admissions and affidavits, if any, that are properly before the court demonstrate that no genuine issue of material fact exists, and the moving party is entitled to judgment as a matter of law.

"A factual dispute is genuine when the evidence is such that a rational trier of fact could return a verdict for the nonmoving party. In reviewing a request for summary judgment, the facts must be viewed in the "light most favorable to the non-moving party" and a Court must "give that party the benefit of all favorable inferences that may be drawn from the subsidiary facts.

In the present case, genuine issues of material fact preclude Summary Judgment. At the very least, Summary Judgment is premature, and Plaintiff is entitled to conduct discovery and, if necessary, have an evidentiary hearing.

B. DEFENDANT'S MOTION IS PREMATURE AS DISCOVERY IS CONTINUING

Defendants Motion is premature as Plaintiffs have been unable to complete essential discovery including the following:

- The deposition of Nancy Abrahms of NNRH
- The deposition of Ronnie Lyons of Reach Air
- 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 of Ruby Crest
- The deposition of Dr. Jones of Ruby Crest

[48] Id.

- Initial Expert Disclosures
- Rebuttal Expert Disclosures
- The depositions of all expert witnesses

It is important to note that Plaintiffs have been trying to complete several of the above listed depositions *for months*, and have been met with resistance from Defendants, at every turn. Now, without the benefit of significant remaining discovery, Dr. Garvey asks this Court to nevertheless decide that the trauma statute does in fact apply based upon the incomplete discovery completed to date. Expert disclosures have not even taken place yet. Many of the issues raised by Dr. Garvey's Motion will be further clarified at the time of initial expert disclosures, when top experts in the field will weigh in on Douglas's condition prior to intubation, the decision to intubate, and the conduct of each of the Defendants herein.

C. THE TRAUMA STATUTE CAP DOES NOT APPLY

While Plaintiffs will concede that Douglas Schwartz suffered a traumatic injury related to being hit by a car on June 22, 2016, the trauma statute found at NRS 41.503 nevertheless does not cap Plaintiffs potential recovery herein. In order for the cap to apply, *all* of the statutory elements must apply to the facts of the case, and *none* of the exceptions. That is not the case here. According to the statute:

> **NRS 41.503 Hospital care or assistance necessitated by traumatic injury; presumption regarding follow-up care.**
>
> 1. Except as otherwise provided in subsection 2 and NRS 41.504, 41.505 and 41.506:
>
> (a) A hospital which has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to NRS 450B.237 and which is a nonprofit organization;
>
> (b) A hospital other than a hospital described in paragraph (a);
>
> (c) An employee of a hospital described in paragraph (a) or (b) who renders care or assistance to patients;
>
> (d) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a) or (b), whether or not the care or assistance was rendered gratuitously or for a fee; and
>
> (e) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS:
>
> (1) Whose liability is not otherwise limited pursuant to NRS 41.032 to 41.0337, inclusive; and
>
> (2) Who renders care or assistance in a hospital of a governmental entity that has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services

pursuant to NRS 450B.237, whether or not the care or assistance was rendered gratuitously or for a fee,

that **in good faith** renders care or assistance necessitated by a **traumatic injury demanding immediate medical attention**, for which the patient enters the hospital through its emergency room or trauma center, may not be held liable for more than $50,000 in civil damages, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance **if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct**.

2. The limitation on liability provided pursuant to this section **does not apply** to any act or omission in rendering care or assistance:

(a) Which occurs **after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient**, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation on liability provided by subsection 1 applies to any act or omission in rendering care or assistance which occurs before the stabilization of the patient following the surgery; or

(b) **Unrelated to the original traumatic injury**.

3. If:

(a) A physician or dentist provides follow-up care to a patient to whom the physician or dentist rendered care or assistance pursuant to subsection 1;

(b) A medical condition arises during the course of the follow-up care that is **directly related to the original traumatic injury** for which care or assistance was rendered pursuant to subsection 1; and

(c) The patient files an action for malpractice based on the medical condition that arises during the course of the follow-up care,

there is a rebuttable presumption that the medical condition was the result of the original traumatic injury and that the limitation on liability provided by subsection 1 applies with respect to the medical condition that arises during the course of the follow-up care.

4. For the purposes of this section:

(a**) "Reckless, willful or wanton conduct,"** as it applies to a person to whom subsection 1 applies, shall be deemed to be that conduct which the person **knew or should have known** at the time the person rendered the care or assistance would be likely to result in injury so as to affect the life or health of another person, taking into consideration to the extent applicable:

(1) The extent or serious nature of the prevailing circumstances;

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

(3) The lack of a prior medical relationship with the patient;

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

(5) The time constraints imposed by coexisting emergencies.

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

1. DOUGLAS SCHWARTZ DID NOT SUSTAIN A "TRAUMATIC INJURY" AS DEFINED BY NRS 41.503.

NRS 41.503(4)(b), states that "traumatic injury" means any acute injury which, according to standardized criteria for triage in the field, **involves a significant risk of death or the precipitation**

of complications or disabilities. Although Douglas Schwartz was hit by a motor vehicle and suffered injuries, he was not in significant risk of death or the precipitation of complications or disabilities. In fact, the medical records and evidence to date only prove conclusively that Douglas's condition, while traumatic in nature, did not meet the statutory definition of a "traumatic injury…involving a **significant risk of death or the precipitation of complications or disabilities**." The Nevada Legislature specifically chose to give us the definition of "traumatic injury" that they wanted us to use and apply. Not all "trauma" poses a "**significant risk of death or the precipitation of complications or disabilities**." Sometimes "trauma" just means an injury but does not bring the injury within the scope of NRS 41.503. (See Section 6 below for a more in-depth discussion of Nevada legislative intent pertaining to NRS 41.503.)

For NRS 41.503 to apply in the first case, it requires a traumatic injury that involved a **significant risk of death or the precipitation of complications or disabilities.** Defendants have offered absolutely no evidence, or argument, that Doug's condition prior to the failed intubation attempts by Defendants' presented a "significant risk of death or the precipitation of complications or disabilities" or that his condition required "immediate" medical care. Dr. Seth Womack, Plaintiffs' emergency medicine expert, concluded:

> **Mr. Schwartz did not have injuries that were an immediate or imminent threat to life. Mr. Schwartz had rib fractures.** Mr. Schwartz's rib fractures were not an immediate or imminent threat to his life. Mr. Schwartz was stable and maintaining an oxygen saturation greater than 91% with a simple oxygen mask -- even with inadequately treated pain. Radiology could not declare with certainty whether he had lung contusions or areas of the lungs not filling completely with air. CT images of lungs that have pulmonary contusions that are an immediate or imminent threat to life can be declared with certainty.[49]

Certainly, Douglas had serious injuries which required medical care in order for them to improve and heal, however, he was not in an immediate or significant risk. The ambulance that transported Douglas to NNRH did so without its lights and sirens on and took over 30 minutes to arrive at NNRH. Furthermore, Dr. Garvey was seemingly not initially planning on intubating Douglas until the receiving physician at the University of Utah suggested that he "possibly" intubate Douglas.

[49] Dr. Womack Report, pp.15-16, attached hereto as **Ex. "2."**

Notably, it was not until Douglas's healthcare providers inappropriately decided to intubate him, and then completely botched that intubation, that Douglas's condition became life-threatening.

NRS 41.503 requires that the alleged "traumatic injury" require "immediate medical attention." Defendant cites to the Nevada Supreme Court case of Brice v. Second Judicial District Court regarding its support of the interpretation of the trauma statue in the "early stages." Brice involved a paragliding accident and two subsequent surgeries, which also applied to subsection (2) of the trauma statute because two surgeries were needed to address the patient's emergency medical condition which was **directly related** to the *original traumatic injury*. This is separate and distinct from the facts of this case.

2. EVEN IF DOUG SCHWARTZ DID SUSTAIN A "TRAUMATIC INJURY" THE NEGLIGENT ACTS AND OMISSIONS ALLEGED IN THE COMPLAINT WERE UNRELATED TO THE ORIGINAL TRAUMATIC INJURY

In order for the trauma statute to apply, the negligent acts and omissions at issue must be **directly related** to the *original traumatic injury*. One of the main issues in dispute in this case between the Plaintiffs and Defendants is whether or not Douglas's condition was life threatening so as to require intubation. It is Plaintiffs' position, and the evidence will show, that Douglas was not in any immediate or serious risk, yet Defendants' herein inappropriately decided to intubate him anyway. Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him.[50] When he arrived at the hospital, he was without breathing difficulty.[51] Mr. Schwartz could protect his own airway.[52] Mr. Schwartz was not in respiratory distress.[53] Mr. Schwartz did not have a flail chest.[54] Dr. Garvey should have removed Mr. Schwartz from the hard backboard as well as the cervical collar.[55] Dr. Garvey should have placed a chest tube after numbing up Mr. Schwartz's chest wall with local lidocaine.[56] Dr.

[50] Dr. Womack Report, p.12 attached hereto as **Ex. "2."**

[51] Id.

[52] Id.

[53] Id.

[54] Id.

[55] Id.

[56] Id.

Garvey should have transferred Mr. Schwartz to a higher level of care on oxygen delivered via a simple face mask (Venturi).[57]

Therefore, the decision to intubate, and the botched intubation attempts, were not "directly related" to the original traumatic injury as Defendants' claim. Instead, they were completely *unrelated* and were done for reasons that had nothing to do with Douglas's care and treatment.

Discovery is still ongoing, but the evidence in this case suggests that Douglas was either intubated as a sort of professional courtesy to the University of Utah, with whom NNRH had a written patient transfer agreement, or as a teaching opportunity by Defendant Dr. Garvey for the flight crew of Defendant Reach Air, who Dr. Garvey also worked for as an Assistant Regional Medical Director. Either way, the issue of why Douglas was intubated, and whether or not his condition warranted intubation, is a question of fact for the jury in this case to decide.

3. DOUGLAS SCHWARTZ WAS STABILIZED AS FAR AS ANY TRAUMA WAS CONCERNED AND WAS CAPABLE OF RECEIVING TREATMENT AS A NON-EMERGENCY PATIENT AT THE TIME OF THE NEGLIGENT ACTS AND OMISSIONS.

At the point that Douglas's vital signs were stabilized, and his breathing was unlabored, he was "stable" as far as any alleged traumatic injury. NRS 41.503 ceases to apply once the patient is stable. However, Dr. Garvey's negligence continues well after this point in his decision to intubate a patient with stable vital signs, who had just eaten a big meal, and who was speaking clearly and breathing on his own.

Notably, in the expert affidavit of Dr. Kenneth Scissors, Dr. Scissors opines that Dr. Garvey breached the standard of care when he decided to intubate Douglas "without clinical indications for intubation."[58] Dr. Scissors opines that Douglas's condition was stable.[59] This was evidenced by the testimony of the witnesses present at the hospital that night. Douglas was laughing and joking[60]. Intubation is reserved for patients who are unable to breathe adequately on their own, yet Douglas was

[57] Id.

[58] See Dr. Scissors Aff. At Exhibit **"1."**

[59] Id.

[60] Dr. Patton Dep., 15:9-11; 27:2-6; 30:3–23, attached hereto as **Ex. "3."**

breathing without difficulty and had adequate oxygen levels on simple oxygen supplementation.[61] Dr. Scissors further notes that this was a "non-emergent" and "non-essential" invasive procedure in an awake, cognitive patient which was "risky and unnecessary."[62]

The NNRH medical records also note that Douglas was not displaying signs of respiratory distress, his respirations were normal, his breath sounds were normal and clear throughout.[63] Furthermore, Douglas's airway was noted to be patent with good air movement and that he was breathing without difficulty.[64]

After Douglas was stabilized, then NRS 41.503 ceases to apply. Although Defendants' take the contrary position, the affidavit of Dr. Scissors demonstrates that Douglas was stable and "non-emergent." Therefore, he was capable of receiving care as a non-emergency patient. Although Plaintiffs believe that there is ample evidence in this case to prove that Douglas Schwartz was stabilized prior to the unnecessary failed intubation attempts by Defendant, the final determination of this *issue of fact* must be made by the *trier of fact*, the jury in this case. It is inappropriate for this Court to decide this issue as a matter of law, especially when significant discovery is still remaining to be completed.

4. DEFENDANT GARVEY'S MOTION PRESENTS GENUINE ISSUES OF MATERIAL FACT WHICH CAN ONLY BE DECIDED BY THE TRIER OF FACT, THE JURY.

Defendant Garvey's position as to the applicability of the trauma statute contains issues of fact which will need to be decided upon by the jury. The applicability of the trauma statute is not a legal question, it is a factual one. As such, this Court must defer to the trier of fact to determine the ultimate answers to several important questions pertaining to the applicability of the trauma statute which will necessarily be included on the verdict form for this case. Those questions will include the following:

Did Douglas Schwarz's condition at NNRH meet the definition of traumatic injury under NRS 41.503?

[61] See Dr. Scissors Aff. At **Ex. "1."**

[62] Id.

[63] See NNRH medical records attached hereto as **Ex. "8."**

[64] Id.

Was Douglas Schwartz's intubation directly related to the motor vehicle accident or not?

Was Douglas Schwartz's condition stable before the alleged negligent acts occurred?

Was Defendants' treatment rendered in good faith?

Was Defendants' treatment grossly negligent, reckless, willful or wanton?

It would not be appropriate for the Court here to decide, prior to the completion of discovery, an issue of fact and rule that the trauma statute, and its $50,000 cap, apply to this case. The only thing the Court can do is deny the Motion at this time and potentially review the issue again after the close of discovery or during trial at which time the jury will decide the answers to the above questions.

5. THE TRAUMA STATUTE DOES NOT APPLY BECAUSE DEFENDANTS CONDUCT WAS NOT IN GOOD FAITH AND WAS RECKLESS, WILLFUL AND/OR WANTON.

While "gross negligence" is not defined by the statute, "reckless, willful or wanton conduct" does have a statute specific definition:

> (a) **"Reckless, willful or wanton conduct,"** as it applies to a person to whom subsection 1 applies, shall be deemed to be that conduct which the person **knew or should have known** at the time the person rendered the care or assistance would be **likely to result in injury so as to affect the life or health of another person**, taking into consideration to the extent applicable:
> (1) The extent or serious nature of the prevailing circumstances;
> (2) The lack of time or ability to obtain appropriate consultation;
> (3) The lack of a prior medical relationship with the patient;
> (4) The inability to obtain an appropriate medical history of the patient; and
> (5) The time constraints imposed by coexisting emergencies.

A myriad of specific, admissible, facts exist to demonstrate that the Defendants' conduct was not in good faith and was reckless, grossly negligent, willful, or wanton. Dr. Garvey seeks a ruling that NRS 41.503 applies to the entire instant action. However, if the Plaintiffs can show that Defendants' conduct was not in good faith, or was grossly negligent, reckless, willful, or wanton, the cap does not apply. Notably, there is evidence in this case that Defendants, including Dr. Garvey, were responsible for a minimum of 9 intubation attempts unsuccessfully before turning to a surgical airway. This is not only a breach of the standard of care, but is grossly negligent, reckless, willful and wanton in light of the fact that clinical evidence based protocols indicate that no more than 3 intubation attempts should be made before a surgical airway is done. These evidence based protocols exist because the risk of not following them is death. Something Dr. Garvey should have known at the time

of treating Douglas Schwartz. Further evidence of this conduct is outlined by Dr. Womack, who specifically concluded:

> **Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence.** Dr. Garvey not performing a cricothyrotomy while Mr. Schwartz was suffocating on his own vomit was negligence significantly greater in magnitude than ordinary negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. 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. According to the testimony[65] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.[66]

Moreover,

> **Dr. Garvey acted with reckless conduct.** It is my understanding that reckless conduct is deemed to be that conduct in which the person knew or should have known at the time the person rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Dr. Garvey made the decision for two separate very serious and meticulous procedures (intubation and chest tube insertion) to be performed upon Mr. Schwartz simultaneously. Dr. Garvey should have known at the time that his conduct would likely result in injury that would affect the life or health of Mr. Schwartz. Dr. Garvey's decision was for Barry Bartlett to intubate Mr. Schwartz, who Dr. Garvey identified as having a high risk difficult airway, while Dr. Garvey cut a hole in Mr. Schwartz's chest for a chest tube to be placed in Mr. Schwartz's chest cavity (chest tube thoracostomy). Dr. Garvey had never talked to Barry Bartlett about Barry's education, training, or experience. Barry Bartlett was still in his internship with REACH. Each of these procedures performed in the proper sequence one at a time have life threatening consequences if something goes wrong. In emergency medicine, first and foremost, a patient's airway comes before most any of the other problems that they could have. It is the ABC's of emergency medicine (A=Airway, B=Breathing, C=Circulation). Airway issues are to be managed before breathing issues; breathing issues are to be managed before circulation issues; and Circulation issues are to be managed before other issues such as disability (neurologic). Once an emergency medicine physician decides to intubate, the airway must be secure and protected before anything else happens including chest tube placement in Mr. Schwartz's situation. Once an ETT is correctly placed, placement is confirmed by

[65] Deposition of Barry Bartlett; Page 78, Line 1 – Page 79, Line 8, attached hereto as **Ex. "9."**

[66] Dr. Womack Report, p. 22-23, attached hereto as **Ex. "2."**

> direct visualization, end tidal CO2 detection, listening for breath sounds, and performing a chest x-ray. Mr. Schwartz's should not have been intubated. To place the chest tube, rather than sedation and paralysis of a patient with a high risk difficult airway, Dr. Garvey simply needed to numb Mr. Schwartz's chest wall with lidocaine. Instead, Dr. Garvey proceeded with reckless conduct.[67]

Finally:

> **Dr. Garvey acted in bad faith.** Dr. Garvey acted in bad faith by not reasonably explaining the risks of intubation to Mr. and Mrs. Schwartz that could occur by intubating Mr. Schwartz for the flight. Dr. Garvey mainly explained the risks of not intubating. By not reasonably explaining the risks of intubation, Dr. Garvey was unreasonable and unfair. By not reasonably explaining the risks of intubation, Dr. Garvey infringed upon Mr. Schwartz's right to know his risks of the procedure as a patient… Dr. Garvey acted in bad faith by not reasonably explaining the alternative treatments to Mr. and Mrs. Schwartz, regarding intubation. Dr. Garvey did not explain alternative treatments. By not explaining alternative treatments, Dr. Garvey was unreasonable and unfair. By not explaining alternative treatments, Dr. Garvey infringed upon Mr. Schwartz's right to know his alternative treatment options as a patient.[68]

In viewing the evidence in the light most favorable to the Plaintiffs, Defendants will not be able to avail themselves of the trauma statute because their actions were not in good faith.

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 a punitive damages claim.

Defendants "knew or should have known" that deviations from clinical evidence based protocols in performing intubations can and would result in death. To ignore these clinical evidence based protocols, is to ignore the very real risk of death. This is not good faith. This is grossly negligent, reckless, willful and wanton conduct. Dr. Garvey, as the physician overseeing Douglas's intubation attempts, knew or should have know of the risks of a failed intubation and the required clinical evidence based protocols. He ignored both.

[67] Id. at 23-24.

[68] Id. at 24-25.

Furthermore, Dr. Garvey was not only an Emergency Room physician working at NNRH at the time he rendered care to Douglas. Dr. Garvey was also a Regional Medical Director of Defendant Reach Air. This fact is undisputed. This fact is also significant because Dr. Garvey's very decision to intubate and transfer Douglas by Defendant Reach Air is in question due to Dr. Garvey's dual role at the time. A dual role that was explicitly prohibited by Dr. Garvey's contract with his employer, Defendant Ruby Crest.[69]

Defendants also knew or should have known that failure ensure the crash cart inventory was properly stocked, so that all necessary life saving equipment was available at the patient's bedside during a code blue, could and would result in death. The evidence in this case shows that NNRH had an Occurrence Report completed by one of its staff following Douglas' many failed intubation attempts which noted that he was "stable and ready for transfer."[70] Contributing factors to this incident occurring were noted to be: "Staff – use of Float Staff"; "Staffing issue"; "Task – training issue"; Work Envmt – Inadequate Equipment Availability."[71] In addition, the Occurrence Report notes that the "trauma cart" was "open" and "not fully stocked – Supplies had to be obtained from 2 other rooms and store room."[72] NNRH has policies and procedures in place to ensure that the crash cart is always fully stocked and ready for use if a patient is experiencing a Code Blue—policies Defendants were required to follow.[73] This policy requires crash carts to be locked and their inventory checked daily.[74] Despite requests to NNRH to produce documentation of their daily crash cart checks, to date no such documentation has been provided.

The facts of this case show more than just negligence, they show gross negligence and reckless, willful and wanton conduct. There are a multitude of facts in this case go beyond mere negligence, and demonstrate that Defendants actions were taken "knowingly, wantonly, willfully, and/or

[69] Dr. Garvey's Contract with Ruby Crest was produced pursuant to a Stipulated Confidentiality Agreement, and therefore a copy is not attached hereto.

[70] See Occurrence Report, attached hereto as **Ex. "6."**

[71] Id.

[72] Id.

[73] See NNRH's Code Blue Procedure & Crash Cart Maintenance Policy, attached hereto as **Ex. "7."**

[74] Id.

maliciously" and in "conscious disregard." Based upon the supporting evidence, this Court cannot conclude that the trauma statute, and its $50,000 cap, apply to this case *as a matter of law*. It can only rule to deny Defendant's Motion because the facts of this case must be decided by a jury and because important discovery remains to be completed.

While Brice favors the resolution of issues of applicability of a statute early on in the litigation process, it does not mandate that a Court overlook important questions of fact, especially when those questions of fact go to the very issue of the applicability of the trauma statute and whether the instant case "qualifies" for application of the trauma statute. It is impossible for this Court to determine that the trauma statute, and its $50,000 cap, apply to this case without determining that all of the elements of NRS 41.503 have been met, and that none of the exceptions apply. This cannot be determined as a matter of law.

6. THE LEGISLATIVE HISTORY IS CONSISTENT WITH PLAINTIFFS INTERPRETATION OF THE TRAUMA STATUTE

Legislative history notes for NRS 41.503 dictate that the **nature** of the injury dictates if a physician would qualify for the $50,000 cap. In legislative session, the statutory language of NRS 41.503 was being debated. Various witnesses of the bill noted that the language of the proposed statute was purposefully limited. Events one might typically assume to be "traumatic" and which are life and death, such as a heart attack, were considered by the authors of the bill to be non-traumatic. "Dr. Daubs echoed the testimony of Dr. McBride and stated **it was never the intent to include all medical cases, such as heart attacks**."[75] Certainly a heart attack is more traumatic and life-threatening than Douglas's injury at issue herein. Yet, Defendants claim that that Douglas's injury qualifies for statutory protection. Defendants have utterly failed to meet their burden of establishing that NRS 41.503 qualifies in the case at bar.

Additionally, whether a specific event, such as discharge by the treating physician, would trigger "stabilization" of the patient and end the protections of the cap was debated.[76] The legislature did not include a triggering event because the issue was a difficult one to be assessed *on a case by*

[75] Legislative history, attached hereto as **Ex. "10."**

[76] Id.

case basis depending on the nature of the injury and course of treatment. Based upon the facts of this case, Douglas was stabilized when Defendants charted that he had stable vital signs and was breathing on his own and talking with no signs of respiratory distress. This Court cannot ignore these facts or place undue weight on the facts presented by the Defendants herein. The weighing of the available evidence is the job of the jury.

Dr. Garvey made the decision to intubate Douglas, despite stable vital signs and no signs of respiratory distress. Dr. Garvey failed to inform Douglas or his wife of the risks of undergoing an intubation. Dr. Garvey, as an Assistance Regional Medical Director of Defendant Reach Air, elected to have a flight nurse attempt to perform a difficult intubation. Plaintiffs have alleged that Dr. Garvey, Ruby Crest, and NNRH all are responsible for the decision to intubate Douglas, despite stable vital signs and no signs of respiratory distress. The conduct of Defendants presents genuine issues of material fact which can only be decided by a jury.

D. THE TRAUMA STATUTE DOES NOT APPLY TO REACH AIR

On August 18, 2020, Defendant Reach Air joined Defendant Garvey's Motion. As noted above, the trauma statute is not applicable to the facts of this case, but even if it did, Defendant Reach Air could not benefit based on the plain language of the statute. NRS 41.503 applies to hospitals, employees of hospitals, and physicians only.[77] Reach Air does not fit into any of these categories. As such, this Court need not consider Reach Air's Joinder.

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[77] NRS 41.503.

IV.

CONCLUSION

Justice requires that Defendants questions about the potential applicability of NRS 41.503, and it $50,000 cap, be decided by the jury at the time of trial, not by this Court prior to the completion of all relevant discovery. For the reasons stated herein, Plaintiffs' respectfully request that this Court Deny Defendant Garvey's Motion, and all Joinders thereto, in their entirety.

DATED this 18th day of August, 2020.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich

Sean K. Claggett, Esq.
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Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on the 18th day of August, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO DEFENDANT DAVID GARVEY M.D.'S MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES, AND ALL JOINDERS THERETO** on the following person(s) by the following method(s) pursuant to NRCP 5(b):

VIA US MAIL Casey W. Tyler, Esq. James W. Fox, Esq. HALL PRANGE & SCHOOVELD, LLC 1140 N. Town Center Drive, Suite 350 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital*	***VIA US MAIL*** Keith A. Weaver, 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. L. Kristopher Rath, 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. MCBRIDE HALL 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113 *Attorneys for Defendant, Crum, Stefanko, & Jones, LTD dba Ruby Crest Emergency Medicine*

/s/ Jackie Abrego

_____

An Employee of CLAGGETT & SYKES LAW FIRM

EXHIBIT 1

AFFIDAVIT OF KENNETH N. SCISSORS, M.D.

I, Kenneth N. Scissors, MD, being duly sworn, under oath, state that the following assertions are true to the best of my personal knowledge training, experience and belief;

1) I am licensed by the Colorado Board of Medical Examiners to practice medicine in the State of Colorado.

2) My licenses are current with the appropriate State and Federal agencies.

3) My additional qualifications to serve as an expert are set forth in my Curriculum Vitae, attached as Exhibit 1.

4) Based on my training, background, knowledge and experience, I am familiar with the applicable standard of care for the treatment of the signs, symptoms, and condition presented by Mr. Schwartz in the emergency department. I am familiar with the team approach involved in the emergency room to include but not limited to transport teams and nursing care. The areas covered in this report overlap and based on my experience and training I am familiar and qualified in the areas addressed in this report to provide opinions.

5) I am qualified on the basis of my training background, knowledge, experience to offer an expert opinion regarding the accepted standard of medical care of the emergency room physician and the nurse who attempted to intubate Douglas Schwartz, the breaches thereof and the resulting injuries and damages arising therefrom.

Documents Reviewed

1.) Northeaster Nevada Regional Hospital Medical Records
2.) Elko County Ambulance Medical Records
3.) Certificate of Death

4.) Autopsy Protocol
5.) NMS Lab Report
6.) Elko County Sheriff's Office Investigation Report
7.) Radiology Disc from Northeastern Nevada Regional Hospital

Summary of Medical Care at Northern Nevada Regional Hospital Emergency Department on June 22, 2016

On June 22, 2016 Mr. Douglas Schwartz was struck as a pedestrian by a moving vehicle. Paramedics were called at 8:17 p.m. and arrived at the scene within a few minutes. Mr. Schwartz was placed in full C-spine precautions. During his transport to the hospital his vitals were within normal limits, 4L of 02 was started routinely, a monitor was placed showing normal sinus rhythm. Mr. Schwartz was given 4 mg Zofran IVP followed by 100 mcg Fentanyl IVP which helped with his pain. He was transported by Elko County Ambulance to Northern Nevada Regional Hospital on a "non-emergent" transport mode arriving at 8:48 p.m.

Dr. David Garvey performed a physical evaluation of Douglas Schwartz upon arrival to the emergency department. He noted that Douglas Schwartz sustained mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions of the right bicep, elbow, and knee. Mr. Schwartz had a normal heart rate and rhythm. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout. Mr. Schwartz's neurological status was normal. His abdominal evaluation was also within normal limits. Mr. Schwartz's condition was stable.

At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including CT scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

Dr. Garvey contacted Dr. Ray at University of Utah trauma service who accepted the patient for transfer. According to Dr. Garvey's chart note, Dr. Ray requested that a chest tube be placed and possibly intubation prior to air medical transport.

Dr. Garvey elected to have the flight nurse, Barry, perform the intubation after Rocuronium and Ketamine administration at 0018 hours. The vital signs were stable up until this point. The intubation was first attempted at 0020 unsuccessfully, followed quickly by deterioration of oxygenation and vital signs. Intubation was again unsuccessful at 0033 and a large aspiration of gastric contents was noted. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered. CPR continued and several subsequent intubation attempts were unsuccessful. At 0120 Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 0133

Deviations from the Standard of Care.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, Dr. David Garvey who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine are required to properly hire, train, supervise and/or retain employees, including Dr. David Garvey to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Dr. David Garvey breached the standard of care in several ways:

1. Deciding to intubate Mr. Schwartz without clinical indications for intubation. Preventive intubation for air flight is not the standard of care. Intubation has inherent risks, especially in a patient who likely has food in the stomach. Intubation is reserved for patients who are unable to breath adequately on their own, yet Mr. Schwartz was breathing without difficulty and had adequate oxygen levels on simple oxygen supplementation.
2. Even if there was a pressing but non-emergent need to intubate Mr. Schwartz with likely food in the stomach, the standard of care would be to request an anesthesiologist to perform the intubation due to the high

risk of aspiration. It is a deviation from the standard of care for an emergency room physician to assign a RN to perform a high risk semi-elective intubation in a patient with likely gastric contents when highly skilled physicians are available.

3. Since this was a non-emergent and non-essential invasive procedure in an awake, cognitive patient, informed consent was required. That means more than just telling the patient what is to be done. The patient must be told the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician. Dr. Garvey deviated from the standard of care by not giving Mr. Schwartz the opportunity to decline this risky and unnecessary procedure.
4. Once the initial intubation was unsuccessful, Dr. Garvey elected to continue with the same plan of having a RN attempt intubation rather than trying it himself or supporting the patient with a bag-mask technique and calling in an anesthesiologist as the standard of care would require. This led to a large aspiration of gastric contents and a fatal cardiopulmonary arrest.

Reach Air Medical Services through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, identified as "Barry RN" who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Reach Air Medical Services is required to properly hire, train, supervise and/or retain employees, including "Barry RN" to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Nurse Barry violated the standard of care in two instances:

1. Nurse Barry should not have agreed to attempt to intubate Mr. Schwartz given that he did not have clear indications for intubation and had a high risk of aspiration of gastric contents. In this situation, a RN should defer to a qualified physician, preferably an anesthesiologist.

2. Nurse Barry should not have attempted a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but still supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician at this point rather than repeating the same mistake he made initially. The second failed attempt caused a fatal aspiration.

All of the aforementioned breaches of the standard of care caused or contributed to the death of Mr. Schwartz.

All of my opinions expressed herein are to a reasonable degree of medical certainty.

I reserve the right to amend, modify, and add to my opinions upon further review of any additional documents and/or information.

Further Affidant Sayeth Not.

Dated this 21 day of June, 2017

MD

KENNETH N. SCISSORS, M.D.

State of Colorado
County of Mesa
On this 21 day of June, 2017 Kenneth Scissors, MD
personally appeared before me,
X who is personally known to me,
whose identity I verified on the basis of CO - DL .
whose identity I verified on the oath/affirmation of _____ ,
a credible witness,
to be the signer of the foregoing document, and he/she acknowledged that he/she signed it.

Therese Luellen
Notary Public
My Commission Expires 4-5-2021

THERESE LUELLEN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20014010801
MY COMMISSION EXPIRES 04/05/2021

EXHIBIT 2

Seth P. Womack, MD FAAEM
2115 Dueling Oaks Drive
Tyler, Texas 75703
Womack@erdoctor.com

Claggett & Sykes Law Firm
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107

Re: Douglas Schwartz

Introduction and Qualifications

I, Seth P. Womack, MD am a licensed physician. You have asked me to render an opinion concerning the standard of care performed by Dr. David James Garvey regarding the care of Douglas Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital (NNRH). I am board certified in emergency medicine by the American Board of Emergency Medicine (ABEM). I completed a residency in emergency medicine at the Medical College of Wisconsin in Milwaukee, Wisconsin. During residency I was a flight physician. I have treated patients before, during, and after flight transport from the scene and from hospital to hospital. I have made decisions as to intubate or not intubate patients prior to flight transport. I have worked in emergency rooms and on flights that transferred trauma patients to trauma centers for injuries similar to Mr. Schwartz. I have been working as a full time emergency physician in a level one trauma center for over ten years. I am certified in Advance Trauma Life Support (ATLS), and I am an ATLS instructor. I have intubated hundreds of emergency room patients. I have given presentations on difficult patient airways and airway management. I have completed the Difficult Airway Course specific to the specialty of emergency medicine. I currently work approximately 12 -15 shifts in the emergency department where I work with flight nurses and flight paramedics. When I was a flight physician, I would manage and transport patients with a flight nurse or flight paramedic. I am familiar with the standard of care in this case by virtue of my knowledge, education, experience, training, and skill.

Records Reviewed

I have reviewed the records, case related documents, and definitions regarding the case of Douglas Schwartz that you have provided to me. These consist of the following:

1. Reach Air Medical Records (9pages)
2. Northeastern Nevada Regional Hospital (157 pages)
3. Police Report and Autopsy (30 pages)
4. Elk Count Ambulance Record (18 pages)
5. Elite Investigations Norther Nevada (19 pages)
6. Certificate of Death (1 page)
7. Workman's Compensation (4 pages)
8. Billing Statements from Northeastern Nevada Regional Hospital (7 pages)
9. Posts about Douglas Schwartz (4 pages)
10. 2013-2017 Tax Returns (59 pages)
11. Douglas Schwartz Work Contract (7 pages)
12. Costs for Funeral (3 pages)
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25. Deposition of Dr. John Patrick Patton (67 pages)
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27. Deposition of Diane Schwartz (163 pages)
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44. Mr. Schwartz's radiographic imaging studies (June 22, 2016)
    i. CT Brain without contrast
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45. Northeastern Nevada Regional Hospital Patient Safety Plan
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48. Northeastern Nevada Regional Hospital Provision of Care Event for the Unexpected Death of Douglas Schwartz (5 pages) (Evers Exhibit 5)

Facts

Douglas Schwartz was 58 years old on the night of June 22, 2016 when he was stuck by a car while walking out of a restaurant. The Elko County ambulance arrived on the scene at approximately 8:19 pm. Mr. Schwartz complained of right sided body pain. Mr. Schwartz was thrown upon the hood and onto the roof before falling to the ground. Mr. Schwartz had pain to his right ribs. He had diminished lung sounds due to not wanting to take a deep breath. The ambulance crew started an IV, placed Mr. Schwartz in c-spine precautions, and placed oxygen at 4 liters (L) just for precaution. The ambulance crew administered 4 mg of Zofran and 100 mcg of Fentanyl which helped with Mr. Schwartz's pain. At 8:41 pm, the ambulance transported Mr. Schwartz three miles to the emergency room of Northeastern Nevada Regional Hospital without lights and sirens. Mr. Schwartz arrived in the emergency room at 8:51 pm.

Upon arrival to the emergency room, Mr. Schwartz's presenting complaints were right sided rib pain, right knee pain, and right shoulder pain. Mr. Schwartz's pulse ox was 94% on 4 liters of oxygen via nasal cannula[1] (NC).

Donna Kevitt, RN was Mr. Schwartz's nurse. Nurse Kevitt documented that Mr. Schwartz's airway was patent with good air movement, and he was breathing without difficulty. Nurse Kevitt documented that Mr. Schwartz complained of pain in his right supraclavicular area, diaphragm, and right breast. Mr. Schwartz appeared uncomfortable and had diminished breath sounds in his right posterior middle and lower lung lobes. Nurse Kevitt documented that Mr. Schwartz possibly experienced a loss of consciousness. Mr. Schwartz was awake, alert, and oriented to person, place, and time. Nurse Kevitt noted some abrasions to his right scalp, right outer arm, right elbow, and right knee.

Dr. David Garvey was Mr. Schwartz's emergency physician. Dr. Garvey documented[2] that Mr. Schwartz sustained injury to his head, chest, right bicep, right elbow, and right knee. Dr. Garvey noted that Mr. Schwartz had pain with breathing and movement. Dr. Garvey documented that Mr. Schwartz experienced a brief loss of consciousness. Dr. Garvey documented that Mr. Schwartz's symptoms, at their worst, were moderate and unchanged in the emergency department. Mr. Schwartz had a past medical history of hypertension. On Dr. Garvey's review of systems, Mr. Schwartz was positive for chest pain, back pain, and abrasions; he was negative for shortness of breath, nausea, and vomiting. On physical examination, Dr. Garvey documented the following:

1. Appears awake, in obvious pain, uncomfortable
2. Abrasions that are mild to the forehead
3. Moderate chest tenderness to palpation of the right lateral posterior chest
4. Moderate back pain that is moderate of the left scapular and subscapular area

[1] Oxygen tubing with two soft prongs that are inserted into the openings of the patient's nostrils. The oxygen concentration delivered varies from 25 to 40 percent depending on the patient's rate of breathing, volume of air breathed in, and extent of mouth breathing. The flow rates are typically 2-4 L/minute.

[2] A scribe transcribed Dr. Garvey's note. Dr. Garvey reviewed and agreed with the scribe's documentation on Dr. Garvey's behalf.

5. Abrasion to the right knee, elbow, and bicep
6. Normal external neck
7. No cervical midline tenderness, not intoxicated, normal mental status, no focal neurological deficits, and no painful distracting injuries are present
8. Normal heart rate and regular rhythm
9. Does not display signs of respiratory distress; normal respirations, breath sounds are normal and clear throughout
10. Normal appearance of abdomen, normal bowel sounds, abdomen is soft and nontender in all quadrants
11. Normal appearance of skin except for affected areas
12. Normal orientation to person, place, and time; immediate and remote memory is intact; recent memory is impaired
13. Behavior/mood is pleasant and cooperative

Dr. Garvey ordered CT scans on Mr. Schwartz.

At 9:33 pm or 9:40 pm, Mr. Schwartz was moved to CT scan.

At 10:33 pm, Nurse Kevitt administered Dilaudid 1 mg IV and Zofran 4 mg IV to Mr. Schwartz.

At 11:00 pm, Mr. Schwartz was moved back from CT scan to room 12.

At 11:07 pm, the radiologist verified receipt of Mr. Schwartz's CT abdomen and pelvis with Cheryl in the ER for Dr. Garvey.

The radiology report of Mr. Schwartz's CT abdomen and pelvic contained the following:

1. Trace hyperdense fluid just below the right liver lobe as well as next to the left colon. No clear CT evidence for spleen or liver contusion or laceration, however finding should

be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low grade solid organ injury is not excluded.

2. No free air to suggest bowel perforation.

At 11:17 pm, Mr. Schwartz's pulse ox was 91%.

At 11:19 pm, Nurse Kevitt administered Zofran 4 mg IV to Mr. Schwartz.

At 11:27 pm, Mr. Schwartz's pulse ox was 91%.

At 11:30 pm, Mr. Schwartz's pulse ox was 92%.

At 11:36 pm, REACH Air Medical Service's dispatch was notified.

At 11:37 pm, respiratory placed Mr. Schwartz on a Venti (Venturi[3]) mask. Mr. Schwartz's oxygen saturations were 92% and 93%.

At 11:41 pm, REACH Air Medical Service crew was dispatched.

At 11:45 pm, REACH Air Medical Service crew was enroute.

At 11:45 pm, Mr. Schwartz's pulse ox was 91%.

At 11:47 pm, the radiologist verified receipt of Mr. Schwartz's CT chest, CT head, and CT T-spine with Dr. Garvey.

The radiology report of Mr. Schwartz's CT chest contained the following:

[3] Simple mask that fits loosely over the nose and mouth. The mask can provide oxygen concentrations of 35 and 50 percent depending on the rate of breathing, volume of air breathed in, and mask fit. The flow rates are typically 6 – 10 L/minute.

1. Small right anterior pneumothorax (less than 10%).
2. Acute fractures of the 4th through 7th ribs as described. There are acute anterolateral fractures of the right 4th through 7th ribs with the 4th and 6th ribs fractured in 2 places (nondisplaced fractures also noted). Comminution and displacement of the 7th fracture is present.
3. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or sequela of aspiration.

The radiology report of Mr. Schwartz's CT head contained the following:

1. Symmetrical hyperdensity along the bilateral tentorium likely reflects hemoconcentration/dehydration. Trace subdural blood products would be considered much less likely. If indicated, follow up head CT could be performed to assess for stability.

The radiology report of Mr. Schwartz's CT C-spine contained the following:

1. No CT evidence of acute cervical fracture or traumatic subluxation.

The radiology report of Mr. Schwartz's CT T-spine contained the following:

1. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.

Dr. Garvey discussed Mr. Schwartz with Dr. Ray at University of Utah who accepted Mr. Schwartz in transfer. Dr. Ray requested that a chest tube be placed and possible intubation[4] prior to air medical transport due to flail segment, pulmonary contusions, low oxygen saturations, and a traumatic right pneumothorax. At 11:57 pm, the REACH team arrived at Mr. Schwartz's bedside to find Mr. Schwartz talking to his family as Dr. Garvey assembled his team

[4] Dr. Garvey testified that he had already planned to intubate, and that Dr. Ray did not tell him to conclusively intubate Mr. Schwartz; leaving that decision up to Dr. Garvey. (Deposition of Dr. Garvey; Page 113, Lines 2-16)

and equipment. Dr. Garvey's plan was place the chest tube while the Reach crew (Barry Bartlett, EMT-Paramedic) performed the intubation. Mr. Schwartz vomited and aspirated a large amount of gastric contents. Suctioning was difficult due to large food particles occluding the suction. Multiple suction machines were used to no avail. Multiple attempts at intubation were made. Intubation was without success. Vomitus in the airway could not be completely cleared. Mr. Schwartz went into cardiac arrest (coded). ER staff tried to suction copious amounts of vomit throughout the code. From the time the first drug was given for rapid sequence intubation (RSI) until Dr. Garvey pronounced Mr. Schwartz deceased was 1 hour and 15 minutes. Mr. Schwartz would regain his pulse at times but would go back into cardiac arrest. During this time, Dr. Garvey nor Barry Bartlett were able to establish a definitive airway for Mr. Schwartz. Once, they were able to increase Mr. Schwartz's pulse ox to 79%-82% with a King airway, but Mr. Schwartz deteriorated again, and his oxygen saturation started dropping[5]. Approximately 46 minutes after the first intubation attempt, Dr. Garvey performed a cricothyrotomy (cric) and placed a trach tube in the correct location (the trachea). The procedure was complicated by vomit. Initially the trach tube was placed but quickly became occluded with gastric contents. The trach tube became dislodged while attempting to clear the vomit. Ultimately, Mr. Schwartz was bagged through his cricothyrotomy via a 5-0 endotracheal tube (ETT) but most of the bagged air expelled from the mouth. Mr. Schwartz's oxygen saturations did not improve, and he went into cardiac arrest, again.

According to the REACH Air Medical Service record, multiple operators attempted to intubate Mr. Schwartz at least 9 times over the time span of approximately 48 minutes. The documentation of the REACH record contained the following:

- 0020 – Once the drugs took effect, Paramedic Bartlett opens the airway and places the C-Mac device resulting in copious amounts of emesis and large food chunks fulminating from the mouth and nose. Intubation is immediately stopped, and the airway is suctioned, which promptly plugs the suction tubing and yankauer tip.

[5] Deposition of Dr. Garvey; Page 153, Lines 5-8

- Over the course of the next 13 minutes, Mr. Schwartz vomits several more times and numerous attempts are made a clearing/maintaining his airway and reoxygenating him with BVM on high flow oxygen.
- 0023 – ETT placement attempt unsuccessful
- 0033 – ETT placement attempt unsuccessful
- In addition to the factors that are making this procedure very difficult (airway contamination, difficulty in keeping the suction devices flowing, difficulty in getting a good facial seal and very stiff bagging effort) his airway is reportedly very inferior/anterior making it a challenge to visualize.
- Paramedic Bartlett attempts several tooled and digital[6] intubations, all of which are unsuccessful.
- 0035 – Mr. Schwartz loses pulses and CPR is initiated for approximately one minute and pulse is restored.
- The airway is again suctioned and a king airway[7] is placed. Bag valve mask (BVM) bagging remains very difficult and shortly afterward the king is removed after becoming plugged by emesis and food particles.
- A 3rd suction unit is placed in play and Mr. Schwartz's oxygen saturation is 47% on high flow oxygen.
- 0040, 0044, and 0047 – Intubation attempts continue with various size ETTs, stylets, bougie introducers, and airway adjuncts. The emesis is almost continuous and proving very difficult to get cleared.
- 0050 – Mr. Schwartz's oxygen saturation is approximately 50%.
- 0052 -- ETT placement attempt unsuccessful; airway suctioned and oxygen is at 55%
- 0053 – ETT placement attempt unsuccessful; several operator changes
- 0054 – Mr. Schwartz's oxygen saturation is 42% with bagging and suctioning at every opportunity. A cricothyrotomy is discussed and the kit prepared.

[6] Attempting intubation with fingers without visualization of the airway
[7] Dr. Garvey testified that he did not have a King airway in the ER. He used the EMS crew's King airway. (page 151; Line 9-14)

- Mr. Schwartz is becoming abdominally distended and a nasal-gastric (NG) tube is attempted in each nostril. The NG tube will not pass, and Mr. Schwartz's nose starts bleeding.
- Facial seal remains a challenge due to vomit and wet face.
- An oral-gastric (OG) tube placement attempt is also unsuccessful and abandoned.
- 0058 – Mr. Schwartz's oxygen saturation is 68% and the third operator is again in place as efforts to reoxygenate are minimally effective and bagging effort is very high.
- Cric airway is kit is being prepared.
- 0102 – Mr. Schwartz's oxygen saturation is 75%.
- Another intubation attempt is unsuccessful.
- 0106 -- The cric is initiated by Dr. Garvey and paramedic Bartlett. The tube is very difficult to advance into the trachea. The tube begins to fill up with vomit. The tube is pulled and replaced two additional times with the same results.
- 0117 – Pulses are lost and CPR resumes.
- Emesis continues and additional suction units and methods of airway clearance are discussed.
- 0120 – The monitor is displaying asystole (flat line, no heartbeat). CPR is ongoing.
- 0122 – A pulse of 52 is noted on the monitor.
- CPR continues. Gastric distention is increasing and cannot be evacuated.
- 0125 – CPR ongoing by ER staff
- 0128 – We note an oxygen saturation reading of 64% on the monitor.
- 0129 – Bilateral needle thoracostomy is performed with no results and no air escape.
- 0133 – CPR is stopped, and Mr. Schwartz is pronounced deceased.

Dr. Garvey documented that Mr. Schwartz's cardiac arrest was due to asphyxiation[8].

[8] Act of causing asphyxia: a state of asphyxia: suffocation (Merriam-Webster Unabridged)

Opinion

It is my professional opinion that Dr. David James Garvey breached the applicable standard of care for Mr. Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital. Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey fell below the applicable standard of care by not performing a cricothyrotomy on Mr. Schwartz sooner. Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. Mr. Schwartz could protect his own airway. Mr. Schwartz was not in respiratory distress. Mr. Schwartz did not have a flail chest. Dr. Garvey should have removed Mr. Schwartz from the hard backboard as well as the cervical collar. Dr. Garvey should have placed a chest tube after numbing up Mr. Schwartz's chest wall with local lidocaine. Dr. Garvey should have transferred Mr. Schwartz to a higher level of care on oxygen delivered via a simple face mask (Venturi). Instead, Dr. Garvey breached the standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey not only breached the standard of care, Dr. Garvey acted with reckless conduct, in bad faith, and was grossly negligent.

It is my professional opinion that Northeastern Nevada Regional Hospital breached the applicable standard of care by not completely stocking the trauma cart that was used in the care of Mr. Schwartz. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.

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Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. The fact that Mr. Schwartz was stable before Dr. Garvey's attempt to intubate is supported by the following:

1. The ambulance that transported Mr. Schwartz to NNRH did not use lights and sirens.
2. The ambulance that transported Mr. Schwartz to NNRH placed him on oxygen via NC at 4L/min as a precaution.
3. When Mr. Schwartz arrived, he was breathing without difficulty.

4. Nurse Kevitt evaluated Mr. Schwartz on multiple occasions, before and after CT scan, never noting any sign of being unstable.
    i. 9:31 pm: visited this patient and evaluated for pain, information, needs, and comfort
    ii. 11:00 pm: Mr. Schwartz moved back to room 12 from CT
    iii. 11:17 pm: visited this patient and evaluated for pain, information, needs, and comfort
    iv. 11:27 pm: visited this patient and evaluated for pain, information, needs, and comfort
    v. 11:31 pm: visited this patient and evaluated for pain, information, needs, and comfort
5. Mr. Schwartz's pulse (P), respiratory rate (RR), and blood pressure (BP) were stable and within normal limits (WNL). 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. Patients with these injuries have severe pain when they expand their chest wall on the effected side when they breath. This pain makes them not want to take a deep breath that expands the effected side. This is called splinting. The cornerstone of rib fracture management is pain control. Early and adequate pain relief is essential to avoid complications from splinting and not completely filling a lung with air (atelectasis). Dr. Garvey had only given Mr. Schwartz one dose of pain medicine approximately 1 hour and 45 minutes prior to attempting intubation. Mr. Schwartz's recorded vital signs prior to intubation attempt were as follows:

    i. 11:17 pm: BP 116/75, P 67, RR 16, pulse ox 91%
    ii. 11:27 pm: BP 115/74, P 67, RR 17, pulse ox 91%
    iii. 11:30 pm: BP 120/78, P 67, RR 18, pulse ox 92%
    iv. 11:45 pm: BP 114/73, P 68, RR 18, pulse ox 91%
    v. 12:10 am: P 66, RR 17, pulse ox 97% on nonrebreather mask

vi. 12:15 am: P 73, RR 19, pulse ox 99% on nonrebreather mask

Mr. Schwartz's vital signs did not become unstable until the time of the intubation attempt at 0020.

6. Multiple witnesses gave testimony that describes Mr. Schwartz in stable condition.
   i. Regarding the time around Mr. Schwartz's initial evaluation, Diane Schwartz testified[9] that Mr. Schwartz did not complain of any difficulty breathing.
   ii. Diane Schwartz testified[10] that Mr. Garvey did not have any difficulty breathing while he was in the ER nor did he have on a nasal cannula or oxygen mask.

> Q – Did Doug have any difficulty Breathing while he was in the ER?
>
> A – No
>
> Q – Do you remember him receiving any type of oxygen while he was in the ER?
>
> A – No
>
> Q – Did he have anything up his nose?
>
> A – No
>
> Q – Did he ever have a facemask on?
>
> A – No

   iii. Diane Schwartz testified[11] that when she left Mr. Schwartz; he was fine.
   iv. Diane Schwartz testified[12] that she couldn't understand why they intubated him in the first place that night given the condition he was in and the fact that he was breathing fine and he was okay.
   v. Dr. John Patton (a friend) testified[13] that Mr. Schwartz was stable and doing fine. Dr. Patton was with Mr. Schwartz and Mrs. Schwartz during the CT scan until

[9] Deposition of Diane Schwartz, Page 49; Lines 23-24
[10] Deposition of Diane Garvey; Page 62, Line 19 – Page 63, Line 3
[11] Deposition of Diane Garvey; Page 70, Lines 13-15
[12] Deposition of Diane Garvey; Page 136, Lines 8-12
[13] Deposition of Dr. John Patton; Page 13, Line 11 – Page 14

about 45 minutes afterwards. Their conversation with Mr. Schwartz was an interesting conversation as Mr. Schwartz was in a lot of pain.

vi. Dr. John Patton testified[14] that when he and Diane left Mr. Schwartz, Mr. Schwartz was speaking, talking, joking, and laughing. It was uncomfortable for Mr. Schwartz to laugh.

vii. Dr. John Patton testified[15] that he was critical of Dr. Garvey's decision to intubate.

> Q – And is it fair to say that if you don't have an opinion on what happened there, are you – do you have an – are you critical of the decision to intubate?
>
> A – I am critical of that decision, yes.
>
> Q – On what grounds?
>
> A – Because he was stable, laughing, and communicative when we left him.

viii. Dr. John Patton testified[16] that he never noticed Mr. Schwartz gasping for breath and; in general, Mr. Schwartz had conversational breathing.

ix. Carmen Gonzalez (admitting and discharge clerk) testified[17] that Mr. Schwartz seemed normal and that he was laughey and smiley when she went to put his wristband on.

7. According to the Provision of Care Event, Mr. Schwartz was "stable and ready for transfer."

****

Mr. Schwartz did not have injuries that were an immediate or imminent[18] threat to life. Mr. Schwartz had rib fractures. Mr. Schwartz's rib fractures were not an immediate or imminent

[14] Deposition of Dr. John Patton; Page 15, Lines 9-12
[15] Deposition of Dr. John Patton; Page 32, Lines 6-12
[16] Deposition of Dr. John Patton; Page 60, Lines 21-25
[17] Deposition of Carmen Gonzalez; Page 9, Lines 23-25
[18] Ready to take place, happening or likely to happen very soon, impending (Merriam-Webster Unabridged)

threat to his life. Mr. Schwartz was stable and maintaining an oxygen saturation greater than 91% with a simple oxygen mask -- even with inadequately treated pain. Radiology could not declare with certainty whether he had lung contusions or areas of the lungs not filling completely with air. CT images of lungs that have pulmonary contusions that are an immediate or imminent threat to life can be declared with certainty. I reviewed Mr. Schwartz's images and did not see any pulmonary contusions that were an immediate or imminent threat to life. Radiology could not declare with certainty whether he had trace subdural brain blood or if he was just dehydrated. A subdural brain bleed that exists and is an immediate and imminent threat to life can be declared with certainty. I reviewed Mr. Schwartz's images and did not see any subdural blood. Mr. Schwartz's CT T-spine contained possible acute injury to his lower thoracic spine that was not an immediate or imminent threat to life. Radiology declared that there was no clear CT evidence for spleen or liver damage and only trace fluid that could be blood was seen in the abdomen. Radiology indicated that if there were abdominal organ injury; it was low grade. Mr. Schwartz's CT C-spine did not show any acute injuries.

Mr. Schwartz had a pneumothorax that was not an immediate or imminent threat to life. Mr. Schwartz's pneumothorax occupied less than 10% of his right lung cavity. The standard of care required Dr. Garvey to place a right chest tube as a preventative measure because Mr. Schwartz was to go on an air flight. With changes in atmospheric pressure, a pneumothorax can get bigger; and a chest tube prevents such from happening.

****

Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz.
Dr. Garvey should not have attempted to intubate Mr. Schwartz for the following reasons:

1. Mr. Schwartz had just eaten a full meal which Dr. Garvey knew[19]. It is a known principle of emergency medicine that patients who have stomachs full of food and liquid are at

[19] Deposition of Dr. Garvey; Page 107, Line 25 – Page 108, Line 3

risk of aspiration[20] and airway complications. When a paralytic drug (Rocuronium was administered) is given, the drug paralyzes the muscles that keep stomach contents from coming back up into the esophagus and airway. The drug also takes away the body's ability to protect its own airway and lungs by taking away the gag reflex. Most anything that gets around the opening of the trachea (windpipe) or vocal cords will trigger the gag reflex to prevent aspiration. The fact that Mr. Schwartz had just eaten increased his risk for complications during a rapid sequence intubation (RSI) and made him a difficult airway. Dr. Garvey knew that the attempt at intubation was high risk. Dr. Garvey testified the following[21]:

Q – Did you consider this specific intubation high risk?

A – Oh, yes.

Q – And why is that?

A – Because we have a patient that had just finished a large meal. He was on a backboard in a C collar, and his body habitus all lend to a difficult intubation.

2. Dr. Garvey thought Mr. Schwartz had a flail chest which is one of the reasons Dr. Garvey attempted to intubate him. Mr. Schwartz did not have a flail chest. A flail chest is when at least two or more adjacent (consecutive) ribs are fractured at two points allowing a freely moving segment of chest wall to move in paradoxical motion. Paradoxical motion describes the segment of chest wall that moves inward when the rest of the chest moves outward with a deep breath and vice versa. Mr. Schwartz had a fracture of his fourth rib in two places and sixth rib in two places. The fourth and sixth rib are not adjacent to one another. Mr. Schwartz did not have rib fractures consistent with a flail chest. Dr. Garvey testified that he knew what a flail chest was in the following testimony:

Q – And can you explain for the jury what a flail chest is?

[20] Sucking gastric contents (vomit or emesis) into the trachea and lungs
[21] Deposition of Dr. Garvey; Page 128, Lines 16-23

A – Multiple rib fractures, adjacent ribs fractured in multiple places. So, you've got a segment that is independent of the rest of the chest.
Q – And is it two ribs that are broken in two places or is it three ribs? How many ribs have to be broken to –
A – Two or more.
MR. WEAVER: Just let her get her whole question out before you answer.
Q – So is it two ribs broken in the same area?
A – Two or more ribs broken – broke – two or more adjacent ribs broken in multiple places, yes.

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.

Even if Mr. Schwartz did have a flail chest, it was below the standard of care to immediately intubate him. The authors of Rosen's Emergency Medicine Concepts and Clinical Practice, 8th edition write the following:

> The outcome of flail chest injury is a function of associated injuries. Because many different physiologic mechanisms have been implicated in flail chest, there is no consensus about hospital treatment. The cornerstones of therapy include aggressive pulmonary physiotherapy, effective analgesia[22], 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. Obvious problems, such as hemopneumothorax or severe pain, should be corrected before intubation and ventilation are presumed necessary. In fact, in the awake and cooperative patient, noninvasive continuous positive airway

[22] Pain control

pressure (CPAP) by mask may obviate the need for intubation. In general, the most conservative methods for maintaining adequate oxygenation and preventing complications should be used. Adequate analgesia is of paramount importance in patient recovery and may contribute to the return of normal respiratory mechanics. Patients without respiratory compromise generally do well without ventilatory assistance. Several studies have found that patients treated with intercostal nerve blocks or high segmental epidural analgesia, oxygen, intensive chest physiotherapy, careful fluid management, and CPAP, with intubation reserved for patients in whom this therapy fails, have shorter hospital courses, fewer complications, and lower mortality rates. Avoidance of endotracheal intubation, particularly prolonged intubation, is important in preventing pulmonary morbidity because intubation increases the risk of pneumonia.

Mr. Schwartz did not have respiratory decompensation or compromise; he was talking, laughing, and joking. His oxygen saturations were above 90% on a simple oxygen mask and 99% on a nonrebreather.

3. Dr. Garvey should not have intubated Mr. Schwartz based on a risk of aspiration from being on a rigid backboard and wearing a c-collar. Dr. Garvey and staff should have logrolled Mr. Schwartz off of the rigid backboard onto a regular stretcher or ER bed with a soft mattress. Dr. Garvey should have removed Mr. Schwartz's c-collar. Mr. Schwartz could have laid on his side or at 30 degrees head of the bed elevation to protect his own airway if he needed to vomit. More anti-nausea medicines could have been given. Excluding Mr. Schwartz's initial ambulance transport to the emergency room, he had no reason to be on a rigid backboard. Mr. Schwartz's exam was not consistent with any spinal cord injury (SCI). Even in patients with a spinal cord injury, backboards should be removed as soon as possible in the emergency room. In a systemic review of the literature and evidence-based guidelines: Henry Ahn, et al, in the Journal of Neurotrauma (2011) write the following:

What is the optimal type and duration of pre-hospital spinal immobilization in patients with acute SCI?

- Patients should be transferred off the hardboard on admission to a facility as soon as is feasible to minimize time on the hard board. If patients are awaiting transfer to another institution, they should be taken off the hardboard while awaiting transfer.

In addition, Mr. Schwartz did not clinically correlate with an acute spine fracture. He was not tender and did not complain of pain in the area of the irregularity mentioned on his CT T-spine. Mr. Schwartz had pain and tenderness at his scapular and subscapular level. The area mentioned on CT (T10 and T11) are at the level just above the umbilicus (belly button).

After Mr. Schwartz's initial evaluation by Dr. Garvey and Mr. Schwartz's negative CT C-spine, Dr. Garvey should have removed Mr. Schwartz's c-collar. Mr. Schwartz did not complain of any pain in his neck and had a negative physical exam of his neck by Dr. Garvey. Dr. Garvey documented that Mr. Schwartz satisfied all of the Nexus Criteria for not having a c-spine injury. The Nexus Criteria decision instrument stipulates that imaging is not necessary if patients younger than 60 years satisfy all of the following criteria:

i. Absence of posterior midline cervical tenderness
ii. Normal level of alertness
iii. No evidence of intoxication
iv. No abnormal neurologic findings
v. No painful distracting injuries

The sensitivity and negative predictive value of the Nexus Criteria is 99.6% and 99.9%, respectively in patients not receiving imaging such a CT of the c-spine. This is the sensitivity and negative predictive value without a negative CT of the c-spine, as the

Nexus Criteria are mainly used to rule out injury and decide which patients not to image. Adding a negative CT of the c-spine and satisfying all of the nexus criteria even further pushed the chance of Mr. Schwartz not having a c-spine injury towards 100%; more than adequately ruling out any c-spine injury in Mr. Schwartz. Mr. Schwartz had no reason to be in a c-collar.

Dr. Garvey should have performed a cricothyrotomy upon Mr. Schwartz sooner. The situation turned into a failed airway early in the process of trying to intubate. According to the REACH record, Mr. Schwartz began to vomit on the first attempt to intubate by Barry Bartlett at 12:20 am. Copious amounts of emesis and large food chunks began fulminating[23] from the mouth and nose. Intubation was immediately stopped. The airway could not be cleared or suctioned. The vomit clogged both the suction tubing and the yankauer which have inner diameters of only approximately 5 mm and 4 mm, respectively. Over the course of the next 13 minutes, Mr. Schwartz vomited several more times and numerous attempts were made at clearing/maintaining his airway and reoxygenating him with BVM on high flow oxygen. Mr. Schwartz could not be intubated and could not be oxygenated. In emergency medicine, this is called, "can't intubate, can't oxygenate" (CICO). Authors from the Manual of Emergency Airway Management, 3rd Edition write the following:

> The definition of a failed airway is based on one of two criteria being satisfied: (a) a failure of an intubation attempt in a patient for whom oxygenation cannot be adequately maintained with a bag and mask [BVM], or (b) three unsuccessful intubation attempts by an experienced operator and adequate oxygenation. Unlike the difficult airway, where the standard of care dictates the placement of a cuffed endotracheal tube in the trachea providing a definitive, protected airway, the failed airway calls for action to provide emergency oxygenation sufficient to prevent patient morbidity (especially hypoxic brain injury) by whatever means possible until a definitive airway can be secured.

[23] To come on suddenly and intensely (Merriam-Webster Unabridged)

Barry Bartlett attempted to intubate Mr. Schwartz again at 12:23 am, leaving Mr. Schwartz in a CICO situation for 10 minutes before Barry Bartlett's third failed attempt at 12:33. During this time, Dr. Garvey was making not taking any action to provide emergency oxygenation to Mr. Schwartz. The standard of care required Dr. Garvey to perform a cricothyrotomy immediately after Barry Bartlett's failed intubation attempt at 12:23 am. Authors from the Manual of Emergency Airway Management, 3rd Edition write the following:

> 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.

As a result of Dr. Garvey not performing a cricothyrotomy in timely manner, Mr. Schwartz remained a failed airway in a CICO situation for over an hour before he was pronounced deceased. At 12:25 am, Mr. Schwartz's pulse ox was 76%. Barry Bartlett had failed a second attempt at intubation at 12:23 am. Mr. Schwartz's airway could not be cleared, and he could not be oxygenated. At least over thirty minutes passed with Mr. Schwartz being a failed airway in a CICO situation before Dr. Garvey initiated a cricothyrotomy at 1:06 am. By this time, countless attempts of using BVM had pushed copious amounts of vomit into Mr. Schwartz's trachea and bronchi (passage that air travels to the lungs). Mr. Schwartz's trachea and bronchi were so clogged with vomit; Dr. Garvey's late cricothyrotomy could not oxygenate Mr. Schwartz's lungs.

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Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence. Dr. Garvey not performing a cricothyrotomy while Mr. Schwartz was suffocating on his own vomit was negligence significantly greater in magnitude than ordinary

negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. 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. According to the testimony[24] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.

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Dr. Garvey acted with reckless conduct. It is my understanding that reckless conduct is deemed to be that conduct in which the person knew or should have known at the time the person rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Dr. Garvey made the decision for two separate very serious and meticulous procedures (intubation and chest tube insertion) to be performed upon Mr. Schwartz simultaneously. Dr. Garvey should have known at the time that his conduct would likely result in injury that would affect the life or health of Mr. Schwartz. Dr. Garvey's decision was for Barry Bartlett to intubate Mr. Schwartz, who Dr. Garvey identified as having a high risk difficult airway[25], while Dr. Garvey cut a hole in Mr. Schwartz's chest for a chest tube to be placed in Mr. Schwartz's chest cavity (chest tube thoracostomy). Dr. Garvey had never talked to Barry Bartlett about Barry's education, training, or experience[26]. Barry Bartlett was still in his internship with REACH[27]. Each of these procedures performed in the proper sequence one at a

[24] Deposition of Barry Bartlett; Page 78, Line 1 – Page 79, Line 8
[25] Deposition of Dr. Garvey; Page 128, Lines 16-23
[26] Deposition of Dr. Garvey; Page 30, Line 22 – Page 31, Line 1
[27] Deposition of Barry Bartlett; Page 19, Lines 18-20

time have life threatening consequences if something goes wrong. In emergency medicine, first and foremost, a patient's airway comes before most any of the other problems that they could have. It is the ABC's of emergency medicine (A=Airway, B=Breathing, C=Circulation). Airway issues are to be managed before breathing issues; breathing issues are to be managed before circulation issues; and Circulation issues are to be managed before other issues such as disability (neurologic). Once an emergency medicine physician decides to intubate, the airway must be secure and protected before anything else happens including chest tube placement in Mr. Schwartz's situation. Once an ETT is correctly placed, placement is confirmed by direct visualization, end tidal CO2 detection, listening for breath sounds, and performing a chest x-ray. Mr. Schwartz's should not have been intubated. To place the chest tube, rather than sedation and paralysis of a patient with a high risk difficult airway, Dr. Garvey simply needed to numb Mr. Schwartz's chest wall with lidocaine. Instead, Dr. Garvey proceeded with reckless conduct.

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Dr. Garvey acted in bad faith. Dr. Garvey acted in bad faith by not reasonably explaining the risks of intubation to Mr. and Mrs. Schwartz that could occur by intubating Mr. Schwartz for the flight. Dr. Garvey mainly explained the risks of not intubating. By not reasonably explaining the risks of intubation, Dr. Garvey was unreasonable and unfair. By not reasonably explaining the risks of intubation, Dr. Garvey infringed upon Mr. Schwartz's right to know his risks of the procedure as a patient. Dr. Garvey testified[28] the following:

> Q – Okay. So, what risks did you explain to Mr. and Mrs. Schwartz that could occur by intubating him for the flight?
>
> A – Probably not much. We all – we always assume that the patient has a full stomach, and there's also always the risk of aspiration with an intubation. But the main thing that was – that was explained to them were the risks of not intubating, and the risks of not intubating were much higher than the risks of intubating.

[28] Deposition of Dr. Garvey; Page 119, Line 4 – Page 120, Line 10

Q – Okay. So, I just want to be clear. You did not explain the risks of intubating the patient; correct?

A – No. I probably –

Mr. BURTON: I'm going to object to the extent it mischaracterizes the testimony and it's argumentative.

Mr. WEAVER: Join.

THE WITNESS: I mainly explained the risks of not intubating, which are higher than the risks of intubating.

Q – Okay. So, you explained the risks of not intubating, but you did not explain that by intubating Mr. Schwartz, he could aspirate.

MR. WEAVER: Object as to form.

Q – Correct?

MR. BURTON: And join. Also, mischaracterizes the testimony.

THE WITNESS: Yes. There is always a risk of aspiration, but that risk is low. There's a much greater risk of aspiration if he remained on a backboard in an airplane trying to transport him for two hours to the trauma center.

Dr. Garvey acted in bad faith by not reasonably explaining the alternative treatments to Mr. and Mrs. Schwartz, regarding intubation. Dr. Garvey did not explain alternative treatments. By not explaining alternative treatments, Dr. Garvey was unreasonable and unfair. By not explaining alternative treatments, Dr. Garvey infringed upon Mr. Schwartz's right to know his alternative treatment options as a patient. Dr. Garvey testified[29] the following:

Q – Okay. And I appreciate your answer, but I want to make sure it's clear. You did not explain the risks or alternative treatments to Mr. and Mrs. Schwartz besides intubating for transfer, correct?

MR. WEAVER: Object – sorry. Object as to form. It's been asked and answered.

MS. MORALES: No, he didn't—

[29] Deposition of Dr. Garvey; Page 121, Line 3 – Line 18

MR. BURTON: Several times.

MS. MORALES: -- directly answer

MR. BURTON: Several times. And I join the objection.

THE WITNESS: I said that I – there were no alternative treatments. So no, I did not explain alternative treatments because there were no alternative treatments. He had to be intubated.

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Northeastern Nevada Regional Hospital's conduct was reckless. It is my understanding that reckless conduct is deemed to be that conduct in which a hospital knew or should have known at the time the hospital rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Northeastern Nevada Regional Hospital's conduct of not completely stocking the trauma cart that was being used in the care of Mr. Schwartz was reckless.

According to the hospital's provision of care event, inadequate equipment availability was a contributing factor[30] to Mr. Schwartz's unexpected death. The brief factual description contains the following:

> Pt was prepared for transfer to University of Utah for a higher level of care. 2 REACH RN's present as well as 2 Elko EMS. EMS student also present. Pt was stable and ready for transfer. Decision was made to intubate and insert chest tube made by U of U and given to Dr. Garvey. All equipment was prepared prior to the start of the procedure. See code sheet for further documentation on code. There were complications with intubation which resulted in patient death. The only staff members present from NNRH were Dr. Garvey, myself, Nancy A, ER tech, Tom E, RT, Cindy F, RN (Travel ICU float), and Sue O, RN, house sup. Trauma cart open, not fully stocked – Supplies had to be

[30] Other contributing factors reported were (1) staff – use of float staff (2) staffing issue (3) task – training issue

obtained from 2 other rooms and storeroom. Privacy issues with other patients in the ER (Room 11 – verbal witness to trauma).

Northeastern Nevada Regional Hospital should have known that not completely stocking a trauma cart would likely result in injury so as to affect the life or health of another person and is a direct violation of their policy[31].

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Rebuttal to the Opinion of Dr. Barclay

1. Dr. Barclay opined that Mr. Schwartz sustained a bilateral flail chest injury.
    i. Dr. Barclay's opinion is based on an incorrect interpretation of the definition of a flail chest. Mr. Schwartz did not have a flail chest on his autopsy or his CT scan. There were not two or more adjacent ribs fractured in two or more places. The definition of flail chest is discussed in my opinion.
    ii. Dr. Barclays opinion concerning fractures of Mr. Schwartz's left ribs is based on a failure to consider relevant information. Mr. Schwartz did not have fractures of his left ribs on CT scan. The fractures of Mr. Schwartz's left ribs found on autopsy were likely from the CPR performed on Mr. Schwartz.

2. Dr. Barclay opined that Mr. Schwartz could not be stabilized until conservative management by a trauma surgeon ruled out impending respiratory failure, the need for mechanical respiration, and the need for surgical rib fracture fixation.
    i. Mr. Schwartz was stable and remained stabilized until Dr. Garvey's attempt to intubate him.
    ii. The reasons why Mr. Schwartz was stable are discussed in my opinion.

[31] Assuming the trauma cart and crash cart are the same

3. Dr. Barclay opined that Mr. Schwartz had clinical indications for intubation, including risk of aspiration, low oxygenation, and anticipation of a deteriorating course that leads to respiratory failure.
    i. Dr. Barclay's opinion is based on failure to consider relevant information specific to Mr. Schwartz that is discussed in my opinion. Mr. Schwartz was able to protect his own airway and not aspirate if Dr. Garvey would have removed Mr. Schwartz from the hard backboard. Mr. Schwartz's oxygenation 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. It was unlikely that Mr. Schwartz was going to have a deteriorating course that lead to respiratory failure.
    ii. The reasons why Mr. Schwartz should not have been intubated are discussed in my opinion.

4. Dr. Barclay opined that it was entirely appropriate to have a highly qualified flight paramedic perform rapid sequence intubation while Dr. Garvey performed the thoracotomy.
    i. Dr. Barclay's opinion is based on an outright mistake. Dr. Garvey was to perform a chest tube thoracostomy. Dr. Garvey was not to perform a thoracotomy, which is an incision into the pleural space of the chest to gain access to thoracic organs.
    ii. Assuming Dr. Barclay meant chest tube thoracostomy, Dr. Barclay's opinion is unreasonable and fails to recognize that Dr. Garvey made the decision for these two separate very serious and meticulous procedures to be performed upon Mr. Schwartz simultaneously. Emergency physicians are the most qualified to perform rapid sequence intubation.
    iii. The reasons why this was inappropriate and reckless are discussed in my opinion.

5. Dr. Barclay opined that since Mr. Schwartz needed a thoracostomy and intubation on an emergent basis, the disclosure Dr. Garvey provided to Mr. Schwartz and his wife, advising them of the serious nature of his injuries and the risk of not intubating is what a reasonable emergency physician would disclose under the circumstances.
    i. Dr. Barclay's opinion is based on the incorrect assumption that Mr. Schwartz needed these procedures emergently, thereby exonerating Dr. Garvey of his duty to explain the risks of these procedures to Mr. Schwartz. Mr. Schwartz did not need a chest tube thoracostomy or an intubation on an emergent basis. Mr. Schwartz needed a chest tube as a preventative measure before flight, and Mr. Schwartz did not need intubation. Further reasoning is discussed in my opinion.

6. Dr. Barclay opined that Dr. Garvey's emergency care and treatment of Mr. Schwartz was within the standard of care.
    i. I respectfully disagree for reasons discussed in my opinion.

7. Dr. Barclay opined that nothing that Dr. Garvey did or failed to do caused or contributed to Mr. Schwartz's injuries.
    i. I respectfully disagree for reasons discussed in my opinions.

8. Dr. Barclay opined that multiple attempts to intubate are within the standard of care.
    i. Dr. Barclay's opinion is based on failure to consider relevant information specific to Mr. Schwartz's situation. Specifically, Mr. Schwartz's was in a "can't intubate, can't oxygenate" situation.
    ii. The reasons that the multiple attempts to intubate Mr. Schwartz are not the standard of care are discussed in my opinions.

Based upon a reasonable degree of medical certainty, it is my opinion that Dr. Garvey did not use such care as reasonably prudent healthcare practitioners practicing in the same field would

have provided under similar circumstances. It is my opinion that the negligence of Dr. Garvey was the direct and proximate cause of Mr. Schwartz's death.

My opinions are based upon my knowledge, education, experience, skills, and training developed as an emergency medicine physician. All opinions are expressed to a reasonable degree of medical certainty. I specifically reserve the right to add to, amend, or subtract from this report as new evidence comes into discovery or as new opinions are formulated. I declare under penalty of perjury, under the Law of the State of Nevada, that the foregoing is true and correct.

Respectfully,

Seth P. Womack, MD FAEEM

Date: August 17, 2020

References

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