In the Supreme Court 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,

Respondents,

and

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

Real Party in Interest.

Supreme Court
Case No.: 83533

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

BRIEF OF AMICUS CURIAE NEVADA HOSPITAL ASSOCIATION; VALLEY HEALTH SYSTEM, LLC; RENOWN REGIONAL MEDICAL CENTER; RENOWN SOUTH MEADOWS MEDICAL CENTER; DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL – ROSE DE LIMA, ST. ROSE DOMINICAN HOSPITAL– SIENA, AND ST. ROSE DOMINICAN HOSPITAL– SAN MARTIN IN SUPPORT OF PETITIONER

GREENBERG TRAURIG, LLP

JACOB D. BUNDICK (SBN 9772)
TAMI D. COWDEN (SBN 8994)
10845 Griffith Peak Drive, Ste. 600
Las Vegas, Nevada 89135
(702) 792-3773

Counsel for Amici Curiae in Support of Petitioner

NRAP 26.1 DISCLOSURE STATEMENT

The undersigned counsel of record certifies that the following are persons and entities as described in NRAP 26.1(a) and must be disclosed. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal:

1. *Amicus Curiae* Nevada Hospital Association is a Nevada non-profit corporation, with no parent company.

2. *Amici Curiae* Renown Regional Medical Center and Renown South Meadows Medical Center are both subsidiaries of Renown Health, which is the sole member of each entity.

3. *Amicus Curiae* Valley Health System, LLC is wholly owned by Valley Hospital Medical Center, Inc., which is an indirect subsidiary of Universal Health Services, Inc., a publicly held company.

4. *Amicus Curiae* Dignity Health d/b/a St. Rose Dominican Hospital – Rose De Lima, St. Rose Dominican Hospital – Siena, and St. Rose Dominican Hospital – San Martin, is a direct affiliate of Common Spirit Health, a Colorado nonprofit corporation.

5. Except as identified above, there are no publicly held companies that own 10% or more of the stock of any Amici Curiae.

6. Counsel for *Amici Curiae* is Greenberg Traurig, LLP.

Dated this 4th day of January, 2022.

GREENBERG TRAURIG, LLP

/s/ Tami D. Cowden
Tami D. Cowden, Esq.
Nevada Bar No. 8994
3773 Howard Hughes Parkway
Ste. 400 N
Las Vegas, Nevada 89169

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Rules

Other Authorities

INTEREST OF *AMICI CURIAE*

Amici Curiae include and represent health care providers that deliver emergency medical care to trauma patients across urban and rural communities in Nevada. *Amici* include both statutorily designated trauma centers (Level II and Level III) and non-trauma emergency care facilities that participate in Nevada's highly regulated trauma care system.

Amici have a substantial interest in the swift and proper application of Nevada's medical liability laws—including common sense limits on damages the Legislature has enacted to maintain rational boundaries on medical malpractice litigation in the State. These statutes are critical to promoting the health and welfare of Nevada residents by making available professional liability insurance for health care providers in the state and, as relevant here, ensuring the accessibility of emergency care for trauma patients both in terms of immediate triage and in stabilization for transfer to higher-level trauma centers. Without these statutes—including NRS 41.503 (the "trauma cap statute")—liability insurance costs would rise, once again making emergency trauma care less affordable and available for all Nevadans.

Because this Court has never substantively construed the trauma cap statute's applicability, the writ petition presents—as *Amici* construe the crux of the issue presented—a question of first impression of great significance to

Amici and similarly situated Nevada hospitals and doctors that treat trauma patients on an emergency basis, to wit:

> When a patient is admitted to an emergency room with traumatic injuries, does NRS 41.503 apply as a matter of law when the patient allegedly suffers personal injury or death in connection with an emergency care provider's decision to intubate or otherwise stabilize the patient for transfer by air ambulance to a higher-level verified or designated trauma center?

The answer to this question will provide much-needed guidance to *Amici*—who collectively treat and transfer thousands of trauma patients each year[1]—and all other doctors and hospitals that coordinate emergency trauma care between facilities as Nevada law requires.

Amici's participation will also help educate the Court on this case's potential impact on the practice of medicine in Nevada and state law requiring coordinated treatment of trauma patients among facilities of varying capabilities—particularly here where this Court has yet to substantively construe the trauma cap statute's scope and applicability.

---

[1] *See 2020 Annual Trauma Registry Report*, NEVADA DEP'T OF HEALTH & HUMAN SERVS., DIV. OF PUBLIC & BEHAVIORAL HEALTH (July 2021), at 14, 33 (the "*Nevada Trauma Report*"), *available at* https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/EBV/Docs/2020NevadaTraumaRegistryAnnualReport_FINAL.pdf (compiling Nevada trauma care statistics collected and reported as required by NRS 450B.238 and NAC 450B.768).

STATEMENT OF THE CASE AND UNDISPUTED MATERIAL FACTS

Amici Curiae take no position in this appeal as to any defendant's alleged professional negligence. The case, however, involves certain allegations and undisputed facts[2] that illustrate a scenario that frequently arises when health care providers like *Amici* coordinate and deliver emergency trauma care services. This scenario can be summarized in three stages: a traumatic event (like a car accident or shooting); admission to the nearest emergency room for triage and diagnostic tests; and, finally, decisions regarding whether and how to transfer a patient to a trauma care center better equipped to treat the patient's injuries. *Amici* discuss these facts for the purpose of framing the context in which district courts should be required to apply the trauma cap statute as a matter of law.

Mr. Schwartz's "mechanism of injury" was being struck by a vehicle reportedly traveling at least 35 miles per hour while crossing the street. (PA8:653; *see also* PA4:156.) The impact threw him "up and over" the car and onto the roof before falling to the ground. (*Id.*; *see also* PA6:463.) He

[2] Because Plaintiff/Real Party in Interest claims favorable presumptions and inferences as the nonmovant, *Amici* focus on facts that are either undisputed in the parties' briefing or cited from Plaintiff's pleadings and supporting evidence. References to the Petitioner's Appendix are in the form "(PA[vol]:[page].)." References to the Real Party in Interest's Appendix are in the form "(RPA[vol]:[page].)."

was transported by ambulance—without sirens—to the emergency department at Northeastern Nevada Regional Hospital (NNRH), a rural hospital in Elko, for emergency care.

As is common with small, rural hospitals, NNRH has no trauma surgeons, pulmonologists, or other physicians with the specialized training and expertise to treat significant multi-trauma patients like Mr. Schwartz. (*See, e.g.*, PA3:120–21.) Thus, after triaging the patient in the emergency room and running a variety of diagnostic tests, it is undisputed that Dr. Garvey consulted with a physician at Level I trauma care facility (Dr. Ray at the University of Utah Hospital) who agreed to accept Mr. Schwartz as a trauma transfer patient. Dr. Garvey and Dr. Ray discussed a chest tube (recommended) and intubation (possibly) for the air ambulance flight. During intubation, Mr. Schwartz vomited, aspirated his stomach contents, and died in the emergency room while "in the process of being prepared for transportation to the University of Utah Hospital via air ambulance." (PA13:1136.)

The parties and experts undeniably disagree, in hindsight, regarding the extent and severity of Mr. Schwartz's occult (*i.e.*, not immediately apparent) injuries or relative stability when he arrived at the NNRH emergency room—and on that basis the district court concluded a fact

question prevented summary judgment. (PA13:1137–38.) *Amici* propose that this fact dispute focuses on the wrong inquiry—whether Mr. Schwartz's traumatic injuries appeared to be life-threatening or severe or minimal is not material to the existence of a traumatic injury for the purposes of the trauma cap statute in the first instance.

In this case, it appears undisputed that contemporaneous medical records reflected a genuine concern that Mr. Schwartz had suffered multiple serious internal traumatic injuries as a result of being hit by a vehicle—including "blunt force trauma" to the head and back (*see, e.g.*, PA8:636, 638), loss of consciousness at the scene (PA13:646), multiple "acute" rib fractures (PA8:643) (which Dr. Garvey apparently believed indicated a bilateral flail chest injury, a conclusion with which Plaintiff adamantly disagrees), a traumatic pneumothorax (punctured lung) with diminished breath sounds (6PA:467), "possible acute injury to his lower thoracic spine," and possible internal abdominal bleeding. (*See, e.g.*, PA6:63–64, 74–75 (Plaintiff's expert report).)

And in summary judgment briefing, Plaintiff candidly "concede[d] that Douglas Schwartz sustained a traumatic injury when he was hit by a motor vehicle while crossing the street," and that he "had serious injuries which required medical care in order for them to improve and heal." (PA6:433, 439,

441.) She simply argued that his admittedly traumatic injuries did not satisfy NRS 41.503's standard that they "involved a significant risk of death or the precipitation of complications or disabilities" (*see* PA6:441)—while ignoring the statute's reference to "standardized criteria for triage in the field." NRS 41.503(4)(b).

Even assuming a factual dispute among litigation experts as to the existence or severity of a particular injury (*e.g.*, a bilateral flail chest injury (PA13:1137)), the contemporaneous medical records are relevant to—and support—application of the trauma cap in the context of the broader regulations and standards governing trauma care discussed *below*:

- "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." (PA2:80 (emphasis in original); *see also* PA6:441; PA7:561; PA8:648.)

- According to an expert affidavit attached to Plaintiff's opposition to summary judgment, "Dr. Garvey discussed Mr. Schwartz with Dr. Ray at University of Utah who accepted Mr. Schwartz transfer. Dr. Ray requested that a chest tube be placed and possible intubation prior to air medical transport due to flail segment, pulmonary contusions, low oxygen saturations, and a traumatic right pneumothorax." (PA6:476.)

- Plaintiff claims the traumatic injuries were not life-threatening and disagrees with Dr. Garvey's decision to intubate after consulting with Dr. Ray—but Plaintiff does not dispute that the injuries were so serious that "Mr.

Schwartz needed a chest tube as a preventive measure before [the air ambulance] flight" transporting him to Utah. (*See, e.g.*, 6PA:488.)

- Mr. Schwartz's intended air ambulance transport to Utah was "summoned … for transfer to the University of Utah hospital for trauma services" and designated as "Service Level: Critical Care Transport" and "Urgency: Immediate." (PA7:560–61.)

- A form signed by a nurse certifying Mr. Schwartz for transport to Utah cited "multi system trauma" as the "MEDICAL CONDITION … AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance," for the purpose of receiving "services needed at 2nd facility not available at 1st facility." (8PA:634.)

- A "patient transfer" form signed by Plaintiff acknowledged that Mr. Schwartz was being transferred to Utah for "immediate access to specialized practitioner / equipment / monitoring, specifically: Trauma." (PA8:626.)

- Plaintiff claimed it was "notabl[e]" that the air ambulance did not use lights or sirens, but she does not appear to dispute the necessity and propriety of life-flighting Mr. Schwartz to the University of Utah's Level I trauma center for further treatment. (*See, e.g.*, PA10:812.)

- As described by the district court, Mr. Schwartz died "in the process of being prepared for transportation to the University of Utah Hospital via air ambulance." (PA13:1136.)

Plaintiff's citation of expert testimony, prepared in hindsight, that Mr. Schwartz's injuries were not so severe to warrant intubation during air transport might support a fact issue that might go to the question of

professional negligence. But it should not preclude application of the trauma cap statute as a matter of law.

INTRODUCTION

Petitioner's mandamus presents this Court with an opportunity to provide much-needed guidance to Nevada courts applying the trauma cap statute and to emergency health care providers facing lawsuits related to their triage and transfer of patients to trauma care centers. The precedential significance of this Court's holding extends far beyond this case—as a question of first impression, deciding the issue presented here will impact every professional negligence case involving trauma care.

Amici submit that—in any professional negligence case—when a treating emergency room physician is presented with information indicating the possibility of injuries that trigger consultation with a higher-level trauma care center and subsequent transfer of the patient, the trauma cap statute should be applied as a matter of law. Otherwise, health care providers without specialized trauma resources and training will be forced to gamble on whether their concerns are well-founded and specialized care was unnecessary.

The Court should grant Petitioner's mandamus, reverse the district court's summary judgment order holding that a fact question exists, and

direct entry of summary judgment in Petitioner's favor that the trauma cap statute applies to Plaintiff's claim.

ARGUMENT

I. PETITIONER'S DECISION TO INTUBATE MR. SCHWARTZ FOR TRANSPORT BY AIR AMBULANCE TO A LEVEL I TRAUMA CENTER IS A COMMON SCENARIO THAT IS EXPRESSLY CONTEMPLATED BY NEVADA LAW GOVERNING TRAUMA CARE.

Dr. Garvey's consultation with a Trauma I trauma care physician in deciding whether to intubate and transfer a patient is both common in the Nevada trauma care system[3] and central to resolving this appeal in the broader regulatory context for trauma care.[4] Consistent with generally-accepted guidelines published by the American College of Surgeons (ACS) and Nevada law, the provision of emergency care to trauma patients across the state and within a trauma system includes decisions a health care provider makes in the course of triaging, diagnosing, stabilizing, *and*

---

[3] In 2020, 1,392 out of 11,325 trauma cases in Nevada were transferred from an initially treating facility to more qualified trauma centers. *Nevada Trauma Report*, *supra*, at 33.

[4] Official records from the regulatory agencies and organizations cited *infra* are promulgated or incorporated by Nevada law, or otherwise are properly subject to judicial notice. NRS 47.150(1), NRS 47.130(2)(b); *see also Mack v. Est. of Mack*, 125 Nev. 80, 91, 206 P.3d 98, 106 (2009) ("[W]e may take judicial notice of facts generally known or capable of verification from a reliable source, whether we are requested to or not."); *see also Peardon v. Peardon*, 65 Nev. 717, 737, 201 P.2d 309, 319 (1948) ("We believe we have the right to take judicial notice of the official acts of the head of an executive department or agency of the government, of general public interest.").

transferring trauma patients to facilities with the requisite expertise and resources to fully treat serious traumatic injuries.

The Nevada State Board of Health adopts regulations establishing standards for designating hospitals "as centers for the treatment of trauma," which incorporate by references "the standards adopted by the American College of Surgeons," in ACS's *Resources for Optimal Care of the Injured Patient*.[5] NRS 450B.237(2), NRS 450B.239; *see also* NAC 450B.786, NAC 450B.838–.866. Currently, Nevada has only one "Level I" trauma center—the University Medical Center of Southern Nevada in Las Vegas—and four trauma centers certified as Level II or III (some of whom are *Amici* here).[6]

None of Nevada's emergency care facilities operates in a vacuum when it comes to meeting Nevadans' trauma care needs. For example, a Level III trauma center—the lowest designation in Nevada—is equipped to "treat and

---

[5] *Resources for Optimal Care of the Injured Patient*, AM. COL. SURGEONS (2014), *available at* https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/resources-for-optimal-care.ashx.

[6] According to the American College of Surgeons website, there are currently only five verified trauma centers in Nevada. *See* 5 Verified Trauma Centers matching your search, AM. COL. OF SURGEONS, https://www.facs.org/search/trauma-centers?state=NV (last visited January 4, 2022).

stabilize" a trauma patient but will need to transfer "patients that exceed the facility resources to Level I and Level II trauma centers."[7]

Nor is this coordinated effort limited to verified trauma centers. The ACS standards for trauma care centers also note that "[r]ural facilities often need to transfer patients outside the community to centers that can offer a higher level of care," and describe "guidelines for transferring patients"—which include communication and coordination between an intake facility and a receiving trauma center.[8] And as described by the Southern Nevada Health District—which oversees the Southern Nevada Trauma System[9]—coordinating these decisions is integral to a full and efficient trauma system if it is going to meet the needs of Nevadans:

> A trauma system is an organized, coordinated, comprehensive injury response network of essential resources that promote injury prevention and control initiatives and provides specialized care for the injured. *The system facilitates appropriate triage and transportation of trauma patients through the emergency medical services system to designated health care facilities that*

---

7 *2020 Clark County Trauma Needs Assessment Review*, S. NEV. HEALTH DIST. OFFICE OF EMERGENCY MED. SERV'S & TRAUMA SYS., at 5, *available at* https://media.southernnevadahealthdistrict.org/download/ems/2021/2020-clark-county-trauma-needs-assessment-review.pdf.

8 *See, e.g.*, *Resources for Optimal Care*, *supra*, at 33, 96.

9 *See* NRS 450B.237(3)(b).

> *possess the capability, competence, and commitment to providing optimum care for trauma victims.*[10]

Within the trauma system, therefore, non-trauma centers like NNRH provide emergency services that "contribute to [the] inclusive trauma system" and "provide prompt assessment, resuscitation, emergency operations, and stabilization and also arrange for transfer to a designated trauma center."[11]

The regulatory goal of ensuring efficient transfer of trauma patients for appropriate care is consistent with the Nevada Legislature's declaration "that prompt and efficient emergency medical care and transportation is necessary for the health and safety of the people of Nevada." *See* NRS 450B.015.

II. THE TRAUMA CAP'S OVERARCHING PURPOSE IS TO RETAIN HEALTHCARE PROVIDERS FOR TRAUMA PATIENTS BY LIMITING LITIGATION COSTS, THEREBY REDUCING MALPRACTICE INSURANCE PREMIUMS.

The trauma cap statute was passed as part of a 2002 special legislative session called in direct response to a crisis caused by ever-increasing medical malpractice insurance costs. *See, e.g.*, *Borger v. Eighth Jud. Dist. Ct. ex rel. Cty. of Clark*, 120 Nev. 1021, 1023, 102 P.3d 600, 602 (2004) (discussing

---

[10] *2020 Clark County Trauma Needs Assessment Review*, *supra*, at 4 (emphasis added).

[11] *Id.* at 7, 48. Numerous *Amici* (or their affiliates or members) are non-trauma center hospitals that participate in the Southern Nevada Trauma System. *Id.* at 8.

reforms). "As a direct consequence of the insurance crisis, physicians began closing their practices if they were unwilling to pay the exorbitant premiums or unable to obtain malpractice coverage altogether." Justin Shiroff, *Shielding Hippocrates: Nevada's Expanded Pleading Standard for Medical Malpractice Actions and the Need for Legislative Reform*, 12 NEV. L.J. 231, 236 (2011).

This crisis significantly impacted the availability of trauma care in Nevada and reached a tipping point when "University Medical Center (UMC), Southern Nevada's state-designated Level I Trauma Center, closed its doors to patients in response to mass resignations by doctors unable to secure malpractice insurance." *Id.* (citing Joelle Babula, *Liability Concerns: Trauma Center Closes; ERs Gear Up*, LAS VEGAS REV.-J., July 4, 2002, at 1A). By July 2002, all but one orthopedic surgeon at Nevada's only Level I trauma center resigned because they could not afford rising premiums. *See* Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice*, 15 HEALTH L. 15, 16 (2002) (describing crisis and closure of Nevada's trauma center). The trauma center's closure left citizens without any Level I trauma center in the state. Vandecruze, *supra*, at 16.

This event was just one example in an ongoing diaspora of physicians from Southern Nevada due to heightened premiums. Dmitri Shalin, et al., *The Law and Politics of Tort Reform,* 4 NEV. L. J. 377, 395–396 (2003).

It was in response to the UMC trauma center closure that Governor Kenny Guinn called a 2002 special legislative session for the specific purpose of enacting tort reform measures to ensure the availability of healthcare at trauma centers like UMC. Shiroff, *supra*, at 236; *see also Zohar v. Zbiegien*, 130 Nev. 733, 737, 334 P.3d 402, 405 (2014). Governor Guinn asked the Legislature to consider a range of measures to reign in medical malpractice litigation including, *inter alia*:

- limiting liability occurring in certain centers for treatment of trauma;
- reducing the statute of limitations for medical malpractice, strengthening reporting requirements;
- requiring judges to receive training in medical malpractice litigation; and
- mandating that attorneys personally pay costs resulting from their unreasonable conduct in litigation.

A Proclamation by the Governor (July 31, 2002), *available at* https://www.leg.state.nv.us/18thSpecial/proclamation.pdf.

These efforts, like the KODIN medical tort reforms embodied in NRS Chapter 41A originally enacted in the same special session as the trauma cap statute, were adopted to lower costs, reduce frivolous lawsuits, ensure

medical malpractice actions are filed in good faith, and encourage settlement. *See Tam v. Eighth Jud. Dist. Ct.*, 131 Nev. 792, 798, 358 P.3d 234, 239 (2015) (discussing 2002 reforms in Chapter 41A, which were enacted to ensure "greater predictability and reduce costs for health-care insurers and, consequently, providers and patients"); *see also Szydel v. Markman*, 121 Nev. 453, 459, 117 P.3d 200, 204 (2005); *Zohar*, 334 P.3d at 405.

By enacting reasonable limits on health care providers' liability, tort reform measures like the trauma cap statute have served their purpose by lowering medical liability insurance premiums, increasing physician supply, improving patient access to care, lowering defensive medicine and health care costs, and lowering claim severity and frequency. *See, e.g.*, Am. Med. Ass'n, *Medical Liability Reform NOW!*, at 11–13 (2018 ed.); Patricia Born et al., *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses*, 76 J. RISK & INS. 197, 209 (2009); W. Kip Viscusi & Patricia Born, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance*, 72 J. RISK & INS. 23, 27 (2005).

If Nevada's medical liability climate is not stable, doctors will practice elsewhere. *See* Chiu-Fang Chou & Anthony Lo Sasso, *Practice Location Choice by New Physicians: The Importance of Malpractice Premiums, Damage Caps, and Health Professional Shortage Area Designation*, 44

HEALTH SERV. RES. 1271, 1284–54 (2009); *see also* Vandecruze, *supra*, at 16 (noting that before Nevada's 2002 reforms, "[m]any Nevada physicians [were] exiting their practices altogether or moving to California," which had enacted reforms to protect healthcare providers against uncapped tort liability).

III. APPLICATION OF THE TRAUMA CAP STATUTE MUST BE CONSTRUED IN THE CONTEXT OF NEVADA LAW GOVERNING TRAUMA CARE AND EMERGENCY SERVICES, AND THE LEGISLATURE'S INTENT IN LIMITING MEDICAL TORT LIABILITY.

The trauma cap statute limits civil damages to $50,000 when a claim is brought against a health care provider such as Dr. Garvey who "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." NRS 41.503(1) (emphasis added). Here, the district court declined to apply the statute based on a purported fact question as to whether Mr. Schwartz actually suffered a traumatic injury at all. This result is untenable and squarely undermines the public policy concerns underlying the trauma cap statute limits.

"Traumatic injury" is defined to mean "any acute injury which, *according to standardized criteria for triage in the field*, involves a significant risk of death or the precipitation of complications or disabilities." NRS 41.503(4)(b) (emphasis added). This definition is consistent with

"trauma" as defined in statutes governing licensed emergency medical service providers. NRS 450B.105 ("'Trauma' 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.").

The parties debate at length whether and to what extent Mr. Schwartz's injuries involved "a significant risk of death or the precipitation of complications or disabilities," *see* NRS 41.503(4)(b), each citing evidence and expert testimony. The district court concluded, based on conflicting evidence of the "state" of Mr. Schwartz's injuries when he arrived at the NNRH emergency room, that "a genuine issue of material fact existed as to whether the decedent suffered a traumatic injury [to which] the trauma cap applies." (PA13:1138.)

Amici respectfully submit that fact questions regarding the apparent "state" of a patient's traumatic injuries when admitted to an emergency room for triage are immaterial in the summary judgment context if, as in this case, the pleadings and evidence objectively qualify as traumatic "according to standardized criteria for triage in the field." *See* NRS 41.503(4)(b); *see also* NRS 450B.105. Because those *objective* and specific criteria for identifying a "traumatic injury" have been adopted as Nevada law, other disputed facts are immaterial in deciding whether the trauma cap applies. *Wood v. Safeway,*

*I*nc., 121 Nev. 724, 731, 121 P.3d 1026, 1031 (2005) ("The substantive law controls which factual disputes are material and will preclude summary judgment; other factual disputes are irrelevant.").[12]

Although "standardized criteria for triage in the field" is not defined in the trauma cap statute itself, Nevada regulations governing standards for "initial identification and care of patients with traumas" expressly incorporate "the national standard set forth by the National Highway Traffic Safety Administration of the United States Department of Transportation, the American College of Surgeons or an equivalent standard approved by the Administrator of the Division to identify and care for patients with traumas." NAC 450B.770(1).

This regulation is a plain reference to the national standards for trauma field triage set forth in the *Guidelines for Field Triage of Injured Patients* published by the Centers for Disease Control and Prevention (CDC) in collaboration with, *e.g.*, the National Highway Traffic Safety Administration

---

[12] *See also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247–48 (1986) ("[T]he mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment.... [T]he substantive law will identify which facts are material. Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted.").

and the American College of Surgeons.[13] *See id*. The CDC's *Guidelines for Field Triage* detail specific and objective "criteria" for identifying a traumatic injury, which fall into four general categories: physiological, anatomic, mechanism of injury, and special considerations.[14] Those guidelines have been expressly incorporated into Nevada regulations governing emergency trauma care and the Southern Nevada Trauma System.[15] NAC 450B.772(1) (eff. 2018).[16]

Under the objective "mechanism" criteria, a patient may readily qualify as suffering a "traumatic injury" *even if* they outwardly appear stable. In particular, even without overt signs of physical trauma, a patient who:

> meets the *mechanism of injury* criteria for transport to a center for the treatment of trauma prescribed by the guidelines adopted

---

[13] Centers for Disease Control & Prevention, *Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage—Recommendations and Reports* (Jan. 13, 2012), *available at* https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/6_guidelines-field-triage-2011.ashx (pdf printable format) and https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6101a1.htm (official CDC website). The pdf version, published in vol. 61, no. 2 of the CDC's Morbidity and Mortality Weekly Report, is cited herein as the "*Guidelines for Field Triage*."

[14] *Id*. at 8, 9, 11, 13, 16.

[15] *2020 Clark County Trauma Needs Assessment Review*, *supra*, at 10, 12, 21.

[16] The version of NAC 450B.772 in effect in 2016 when Mr. Schwartz was admitted for emergency care did not expressly incorporate the CDC publication, but the other provisions in effect at the time are sufficient to reach the same conclusion. *See, e.g.*, NAC § 450B.770(1).

> by reference in subsection 1 [the *Guidelines for Field Triage*] must be transported to a level I, II or III center for the treatment of trauma, and the medical directions for the treatment of the patient must originate at that center.

NAC 450B.772(2)(b) (emphasis added).

The Southern Nevada Health District has implemented these same Trauma Field Triage Criteria, and describes the "Mechanism" criteria as follows:

> A trauma patient whose vital signs and level of consciousness are within normal limits. They do not appear to have an obvious serious injury. Still, they have experienced a high energy impact to the body that may have caused a severe injury that is not immediately obvious.[17]
>
> These patients vary in the severity of the mechanisms of injury. The less severe, which represent a larger number of patients, are awake, alert, and have normal vital signs. While they appear less injured, some patients have significant, often occult injuries.[18]

One of the enumerated events that automatically qualifies as a traumatic injury based on the objective mechanism criteria is squarely at issue in this case: "automobile versus pedestrian/bicyclist thrown, run over, or with significant (>20mph) impact."[19] (*Compare, e.g.*, PA8:653

---

17 *Nevada Trauma Report*, *supra*, at 12.

18 *Id.* at 28.

19 *Guidelines for Field Triage* at 6, 11; *see also Nevada Trauma Report*, *supra*, at 56.

(identifying "mechanism of injury" as pedestrian v. vehicle moving 35 mph or more *and* throwing Mr. Schwartz "up and over" the car).)

Based on this sole undisputed fact, the trauma cap applies because Mr. Schwartz objectively suffered a "traumatic injury" requiring intervention based on the *manner* in which he was injured in the first instance—not his apparent condition when he arrived at the hospital. *Id.*; *see also* NAC 450B.772(2)(b).

Amici urge that emergency healthcare providers should be entitled to rely on objective criteria for identifying the existence of traumatic injury based on the events before them—here, a mechanical injury that facially qualifies under "standardized criteria for triage in the field"—rather than after-the-fact quarrels among experts alleging negligence in the treatment of undisputed trauma.

IV. NEITHER UNPLEADED STATUTORY EXCEPTIONS NOR IMMATERIAL DISPUTED FACTS ARE SUFFICIENT TO AVOID APPLICATION OF THE TRAUMA CAP STATUTE AS A MATTER OF LAW.

Plaintiff defends the district court's order in part based on alleged fact questions regarding the statute's exception for "gross negligence or reckless, willful, or wanton conduct." (Resp. at 12, 18, 21–25.) *See* NRS 41.503(1). But

neither the Plaintiff's operative complaint as to Dr. Garvey[20] nor the expert affidavit attached to it alleges gross negligence, bad faith, or reckless, willful or wanton conduct, nor does it plead a claim for punitive damages. (PA2:62–83.)

Moreover, according to the record, Plaintiff attempted to amend her complaint to add such allegations and a claim for punitive damages—and the district court denied leave to amend with prejudice. (PA2:100; PA13:1142.) In September 2020—*after* Petitioner filed his motion for partial summary judgment (PA3:109)—Plaintiff again requested leave to file a third amended complaint to allege bad faith and punitive damages (PA13:1142), but the district court denied the request as follows:

> Bringing those punitive claims back now would be unduly prejudicial to Defendants Garvey and NNRH, who have not only *not* been put on notice that punitive damages might be an issue in this case but would be excused for being under the natural belief that punitive damages could no longer be raised against them on these grounds as Plaintiff's last motion to amend was denied with prejudice more than two years ago.

(PA13:1143.) Plaintiff cannot now rely on a statutory exception predicated on allegations of gross negligence and similar conduct where the district court

---

[20] Plaintiff filed her original and first amended complaints in 2017 (PA1:10, 33), and Plaintiff's operative Second Amended Complaint was filed February 12, 2018. (PA2:75.) Dr. Garvey filed his motion for partial summary judgment seeking application of the trauma cap statute as a matter of law more than two years later, on July 27, 2020. (PA3:109.)

repeatedly denied leave to add such allegations. *Cf. Soebbing v. Carpet Barn, Inc.*, 109 Nev. 78, 84, 847 P.2d 731, 736 (1993) ("[C]ourts should be cautious of last-second amendments alleging meritless claims in an attempt to save a case from summary judgment.").

This Court rejected similar procedural machinations in the context of Chapter 41A, holding, as a matter of law, that a plaintiff could not invoke an unpleaded statutory exception to circumvent limits on a health care provider's liability in Chapter 41A. *See Peck v. Zipf*, 133 Nev. 890, 891, 407 P.3d 775, 777 (2017) ("Because appellant's complaint failed to show that any object left in his body was the result of 'surgery,' the appellant's complaint did not satisfy the elements for the statutory exception of *res ipsa loquitur*.") (applying NRS 41A.100).

This Court's holding in *Peck* is consistent with clearly established law that a nonmoving plaintiff may not raise new legal claims for the first time in response to a summary judgment motion by a defendant. *See Navajo Nation v. United States Forest Serv.*, 535 F.3d 1058, 1080 (9th Cir. 2008) ("Nevertheless, our precedents make clear that where, as here, the complaint does not include the necessary factual allegations to state a claim, raising such claim in a summary judgment motion is insufficient to present the claim

to the district court.").[21] Permitting a plaintiff to do otherwise raises concerns of efficiency and judicial economy, *see Gilmour v. Gates, McDonald & Co.*, 382 F.3d 1312, 1315 (11th Cir. 2004), as well as concerns of unfair surprise to the defendant. *Tucker*, 407 F.3d at 788.

V. THIS COURT SHOULD GRANT MANDAMUS RELIEF BECAUSE EARLY RESOLUTION OF THIS IMPORTANT QUESTION OF LAW SUPPORTS THE OVERARCHING GOAL OF REDUCING LITIGATION COSTS FOR TRAUMA PROVIDERS.

The important question of first impression raised in this case is when—and by whom—the applicability of NRS 41.503 should be determined. On the one hand, Petitioner argues that the cap applies as a matter of law (Pet. at 28); and on the other, Real Party in Interest argues that the record shows material fact questions regarding whether the decedent required immediate medical attention and whether he was stable and capable of receiving medical treatment as a nonemergency patient (Resp. at 11–12). Whether or not a defendant can receive an early resolution when the challenged conduct

---

[21] *See also Wasco Prods., Inc. v. Southwall Techs., Inc.*, 435 F.3d 989, 992 (9th Cir. 2006) ("Simply put, summary judgment is not a procedural second chance to flesh out inadequate pleadings" (internal quotation omitted)); *Tucker v. Union of Needletrades, Indus., & Textile Emps.*, 407 F.3d 784, 788 (6th Cir. 2005) (clarifying that once a case has progressed to the summary judgment stage, liberal pleadings standards that permit leave to amend freely no longer apply); *Grayson v. O'Neill*, 308 F.3d 808, 817 (7th Cir. 2002) ("a plaintiff may not amend his complaint through arguments in his brief in opposition to a motion for summary judgment." (quotations omitted)).

occurs in the midst of preparing a trauma patient for emergency transport from an emergency room to a trauma center will have a tremendous effect on the costs and risks associated with medical malpractice litigation.

As this Court has recognized, pretrial resolution of whether damage caps apply can "affect the course of the litigation," *Tam*, 358 P.3d at 237, which in turn directly impacts the litigation costs that NRS 41.503 seeks to contain. Considering the impact a damage cap has on the course of litigation makes clear that this issue must be decided early in a case to fully achieve the statutory purpose. Litigation costs are often driven by the expected value of a case. Reducing the valuation range for a case may have infinite effects on the course of litigation and associated costs.

First, for instance, in enacting such a cap, the Legislature may have expected that setting a "limit [on damages] would promote settlements by eliminating the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble." *Fein v. Permanente Med. Grp.*, 695 P.2d 665, 683 (Cal. 1985) (internal quotation marks omitted), *cited by Tam*, 358 P.3d at 239.

Particularly with respect to the trauma cap, where the Legislature set a very low limit for *all* damages,[22] out-of-court resolution between the parties seems the obvious result when the plaintiff has a legitimate claim. Fully litigating these actions through trial and possibly appeal is far more expensive for both parties. By one estimate nearly two decades ago, a plaintiff's case would likely cost more than $100,000 to pursue, and that number has almost certainly risen dramatically in the interim. Shalin, et al., *supra*, at 398. Likewise, a healthcare provider and/or insurance company at risk of a judgment for hundreds of thousands or millions of dollars would expend substantial resources to defend against the suit. Forcing the parties to trial only to learn later that the case is worth a maximum of $50,000 would not only needlessly waste the parties' resources but also directly contravene the legislative purpose of reducing litigation costs.

Second, understanding the defendant's risk and plaintiff's upside not only impacts out-of-court negotiations between the parties—it also has a substantial impact on the amount of resources spent on discovery in a case,

[22] For comparison, consider the general medical malpractice cap of $350,000 on non-economic damages in professional negligence cases. Where substantial economic damages are at stake, those cases may still result in far greater judgments. NRS 41A.035.

even if that case moves through trial. Nevada Rule of Civil Procedure 26(b)(1) limits discovery to matters:

> proportional to the needs of the case, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit.

Venetian Casino Resort, LLC v. Eighth Judicial Dist. Ct., 136 Nev. 221, 224, 467 P.3d 1, 5 (Ct. App. 2020) (quoting NRCP 26(b)(1)). This rule "guard[s] against redundant or disproportionate discovery by giving the court authority to reduce the amount of discovery." *Id.* (quoting NRCP 26 advisory committee's note to 2019 amendment).

Whether or not NRS 41.503 applies may thus dramatically curtail (or expand) the scope of discovery; an action where a plaintiff seeks uncapped damages, or even damages partially capped at $350,000,[23] will undergo a far different calculus than an action where the plaintiff's maximum recovery is $50,000. Indeed, the costs of discovery alone in a case where the defendant may owe millions may exceed the maximum recovery of $50,000. Failing to apply the cap early in the case makes this scenario a true possibility.

[23] NRS 41A.035 limits non-economic damages in an action against a health care provider based on professional negligence to $350,000.

Finally, decisions made throughout a case are guided by the case's potential value. In addition to determining the scope of discovery, the value will drive the extent of preparation for trial and the amount of motion practice. A defendant may choose its attorneys based on the potential amount of liability, and a plaintiff's choice may be similarly impacted as well—whether by the party's decisions or by the financial considerations of contingency-fee-based plaintiff attorneys. Decisions such as these drive the cost of litigation. Failure to apply the trauma cap statute as a matter of law at the summary judgment stage deprives trauma care providers of the statute's core purpose by forcing them to defend against disproportionate litigation and discovery.

VI. MANDAMUS RELIEF IS APPROPRIATE TO RESOLVE THIS IMPORTANT LEGAL ISSUE OF FIRST IMPRESSION.

This Court has previously recognized the dearth of precedent related to the trauma cap and the need for resolution of this important question of law—both to litigants and to the trauma care providers and citizens of Nevada.[24] The Court should take this opportunity to guide litigants and practitioners in both this and future cases. To do otherwise leaves open the

[24] *See Brice v. Second Judicial Dist. Ct.*, 127 Nev. 1121, 373 P.3d 898 (Table), 2011 WL 4390048, at *1 (2011). Although this opinion is unpublished, *Amici* cite it to demonstrate the need for a ruling on the issue that the *Brice* Court was unable to reach, not for any precedential value.

opportunity for extended litigation to waste resources and increase insurance costs until trial courts receive guidance on when and how to apply the cap.

While mandamus relief may not ordinarily be available to challenge an order denying summary judgment, "an exception applies when 'no disputed factual issues exist and, pursuant to clear authority under a statute or rule, the district court is obligated to dismiss an action.'" *Libby v. Eighth Judicial Dist. Ct.*, 130 Nev. 359, 363, 325 P.3d 1276, 1278 (2014) (quoting *Smith v. Eighth Judicial Dist. Ct.*, 113 Nev. 1343, 1345, 950 P.2d 280, 281 (1997)).

Consistent with that notion, this Court has previously granted mandamus relief to correct a district court's failure to properly apply statutes limiting liability against health care providers. *Kushnir v. Eighth Jud. Dist. Ct. in & for Cnty. of Clark*, 137 Nev. Adv. Op. 41, 495 P.3d 137, 140 (Ct. App. 2021) (granting petition for writ of mandamus where trial court denied motion for summary judgment pursuant to NRS 41A.097(2)); *see also Libby*, 325 P.3d at 1278–79; *Washoe Med. Ctr. v. Second Jud. Dist. Ct. of State of Nev. ex rel. Cnty. of Washoe*, 122 Nev. 1298, 1301–02, 148 P.3d 790, 792 (2006).

Mandamus relief is also warranted to clarify statutory construction and decide important matters of first impression. *Anse, Inc. v. Eighth Jud. Dist.*

Ct. of State ex rel. Cnty. of Clark, 124 Nev. 862, 867, 192 P.3d 738, 742 (2008) (granting mandamus in summary judgment context to clarify construction and application of statute, NRS 40.615); *see also Brice*, 2011 WL 4390048 at *1.

Both in the interest of judicial economy in this case and in *Amici* and Nevadan's interest in receiving guidance on the proper construction and application of NRS 41.503, this Court should address the substantive question presented.

CONCLUSION

For these reasons, *Amici Curiae* respectfully urge the Court to grant Petitioner's petition for mandamus and clarify the proper construction and application of NRS 41.503 to health care facilities providing trauma care to patients.

Dated this 4th day of January, 2022.

By: */s/ Jacob D. Bundick*

JACOB D. BUNDICK (SBN 9772)
TAMI D. COWDEN (SBN 8994)
GREENBERG TRAURIG, LLP
10845 Griffith Peak Drive, Ste. 600
Las Vegas, Nevada 89135
(702) 792-3773

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE WITH NRAP 28 AND 32

I hereby certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using MS Word 365 in Georgia 14-point type.

I further certify that this brief complies with the page- or type-volume limitations of NRAP 21(d) and 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is proportionately spaced, has a typeface of 14 points or more, and contains 6,526 words.

Finally, I hereby certify that I have read this amici brief, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e)(1), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Dated this 4th day of January, 2022.

GREENBERG TRAURIG, LLP

/s/ Tami D. Cowden
Tami D. Cowden, Esq.
Nevada Bar No. 8994
3773 Howard Hughes Parkway
Ste. 400 N
Las Vegas, Nevada 89169

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I certify that on January 4, 2022, a true and accurate copy of the foregoing document was filed and served to all counsel of record via this Court's e-filing system on counsel of record for all parties to the action below in this matter.

GREENBERG TRAURIG, LLP

/s/ Tami D. Cowden
Tami D. Cowden, Esq.
Nevada Bar No. 8994
3773 Howard Hughes Parkway
Ste. 400 N
Las Vegas, Nevada 89169

Counsel for Amici Curiae