IN THE SUPREME COURT OF THE STATE OF NEVADA

CASIANO R. FLAVIANO, M.D.,

Petitioner,

v.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA ex rel. THE COUNTY OF CLARK, AND THE HONORABLE JUDGE BITA YEAGER,

Respondent,

and

ARLIS NEASON, as Heir of the Estate of JEFFREY NEASON,

Real Party in Interest,

and

DIGNITY HEALTH MEDICAL GROUP, NEVADA, LLC, a domestic limited-liability company; SUSHIL R. PATEL, M.D.; DOES I through X; and ROE BUSINESS ENTITIES I through X; inclusive,

Additional Parties in Interest.

Supreme Court No.:

District Court No.: A-20-824585-C

PETITIONER'S APPENDIX TO PETITION FOR WRIT OF MANDAMUS VOL. 2

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CERTIFICATE OF MAILING

I hereby certify that on this 22nd day of November, 2021, I served the foregoing **PETITIONER'S APPENDIX TO PETITION FOR WRIT OF MANDAMUS VOLUME 2** upon the following parties by placing a true and correct copy thereof in the United States Mail in Las Vegas, Nevada with first class postage fully prepaid:

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EXHIBIT 15

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DISTRICT COURT

CLARK COUNTY, NEVADA

ARLIS NEASON, as Heir of the Estate of JEFFREY NEASON, Plaintiff, vs. DIGNITY SELECT NEVADA, LLC, a foreign limited-liability company; CASIANO R. FLAVIANO, MD; SUSHIL R. PATEL, MD; DOES I through X; and ROE BUSINESS ENTITIES I through X; inclusive, Defendants.	CASE NO.: A-20-824585-C DEPT. NO.: XXXI **SUPPLEMENTAL OPPOSITION TO DEFENDANT CASIANO FLAVIANO, M.D.'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT** **And** **SUPPLEMENTAL OPPOSITION TO DEFENDANT CASIANO FLAVIANO, M.D.'S MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT** **And** **SUPPLEMENTAL OPPOSITION TO**

Case Number: A-20-824585-C

DEFENDANT SUHIL R. PATEL, MD'S SUBSTANTIVE JOINDER

COMES NOW, Plaintiff, Arlis Neason, as Heir of the Estate of Jeffrey Neason (hereafter, "Plaintiff"), by and through her attorneys of record, Dillon G. Coil, Esq. of GGRM Law Firm and Breen Arntz, Esq. of Arntz Associates, hereby files her Supplemental Opposition to Defendant Casiano Flaviano, M.D.'s Motion to Dismiss Plaintiff's Complaint (filed January 19, 2021), Supplemental Opposition to Defendant Casiano Flaviano, M.D.'s Motion to Dismiss Plaintiff's First Amended Complaint (filed January 20, 2021), and Supplemental Opposition to Defendant Suhil R. Patel, MD's Substantive Joinder.

This Supplemental Opposition is made and based upon the attached Memorandum of Points and Authorities, all papers and pleadings on file herein, and any oral argument permitted.

Dated this 9th day of June, 2021.

GGRM LAW FIRM

/s/ Breen Arntz

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This matter was heard originally by this court without the benefit of Dr. Davoren's deposition testimony which was ordered to be conducted on the topic of his qualifications to opine about the specific professional negligence issue involved in this case under NRS 41A.071 standards. That deposition was taken on May 18, 2021 and shed considerable light on the issue of malpractice specifically involved in this matter.

Among other things, Dr. Davoren explained in his deposition the reasons why a general surgeon is fully qualified to testify regarding the issues of decreasing hemoglobin in a patient on an Eliquis regimen for clotting. The question ultimately is can a general surgeon testify regarding the breach of the standard of care of a physiatrist on the topic of decreasing hemoglobin where the foundation for treatment is general medicine, not a sub-specialty? To summarize his testimony, the foundation for the standard of care for such a medical issue is acquired in medical school, not in a residency or fellowship for physiatry.

II. LEGAL ARGUMENT

A. Dr. Davoren's Affidavit Complies with NRS 41A.071

Dr. Davoren's affidavit complies with NRS 41A.071, which requires that a medical malpractice action must be filed with "an affidavit, supporting the allegations contained in the action." Zohar v. Zbiegien, 334 P.3d 402, 405 (Nev. 2014). As discussed in the original opposition to this motion, the purpose of the expert affidavit requirement in NRS 41A.071 is "to lower costs, reduce frivolous lawsuits, and ensure that medical malpractice actions are filed in good faith based upon competent expert medical opinion." Szydel v. Markman, 121 Nev. 453 (2005). The affidavit requirement "is intended primarily to foreclose frivolous medical malpractice suits at the pleading stage, *not to block meritorious suits on narrow technical grounds*."

NRS 41A does not, however, define the level of detail required to adequately "support" a plaintiff's allegations. Zohar, 334 P.3d at 405. The Nevada Supreme Court held that "reason and public policy dictate that courts should read the complaint and plaintiff's NRS 41A.071

expert affidavit together when determining whether the expert affidavit meets the requirements of NRS 41A.071." *Id.* NRS 41A.071's affidavit requirement is a preliminary procedural rule subject to the notice-pleading standard, and thus, it must be "liberally construe[d]…in a manner that tis consistent with our NRCP 12 jurisprudence." *Id.*

B. Dr. Davoren Practices Medicine, The Only Area of Medicine Needed to Qualify Him to Testify In This Action

Dr. Davoren is qualified to render opinions regarding the medical issues presented in the subject case. He artfully describes the area of medicine necessary for this review in his deposition as follows:

> Q. Let me ask this way. What did you review, if anything, in order to render your opinion that Dr. Flaviano fell below the standard of care other than the medical records?
>
> A. So I reviewed both the package insert for Eliquis, I reviewed the prevailing articles out there on Eliquis and gastrointestinal hemorrhage, I reviewed medical school texts I have that discuss decreasing hemoglobin and looking for signs (sic) of bleeding and then also just my own basic knowledge of patients who have a documented decrease in hemoglobin on a repetitive basis in terms of what would be expected from a physician. Not specifically a PMR physician, but any physician. ….. In this case, my – what [I'm] looking for was all the different things that could have possibly caused a gastrointestinal hem ran on the patient with Crohn's disease (Deposition of Dr. Davoren, pg. 19 ln. 4 thru pg. 20 ln. 25, a true and correct copy attached hereto as Exhibit 1).

The Legislature has not provided an explanation or guidance for courts to resolve disputes over whether an affiant practices in an area that is "substantially similar to the type of practice engaged in at the time of the alleged malpractice." Borger v. Dist. Ct., 102 P.3d 600, 605 (Nev. 2004). Nevada turned to Connecticut law that held, "[t]he threshold question of admissibility is governed by the scope of the witness' knowledge and not the artificial classification of the witness by title." *Id.* Thus, NRS 41A "allows medical experts to testify in medical malpractice cases where their present or former practice reasonably relates to that

engaged in by the defendant at the time of the alleged professional negligence." *Id.* In Borger, a gastroenterologist was qualified to opine as to the medical malpractice of a general surgeon. In Zohar, an emergency physician was qualified to testify as to the malpractice of nurses in the emergency department. Zohar, 334 P.3d at 407 (both Summerlin Hospital and Dr. Zbiegien are parties in this case).

In Borger, the defendant surgeon moved to dismiss the plaintiff's claims against him because the affidavit submitted was executed by a gastroenterologist and not a surgeon. The Nevada Supreme Court found that the affidavit by the gastroenterologist was sufficient, explaining:

> Although [NRS 41A.071] does not allow unrestricted use of medical expert witnesses who testify based upon acquired knowledge outside the witness' area of present or former practice and prohibits testimony based upon knowledge solely obtained for the purpose of litigation, the legislation allows medical experts to testify in medical malpractice cases where their present or former practice ***reasonably relates*** to that engaged in by the defendant at the time of the alleged professional negligence.
>
> …
>
> [T]he statute does not require that the affiant practice in the same area of medicine as the defendant; rather it requires that the affiant practice in an area "substantially similar" to that in which the defendant engaged, giving rise to the malpractice action.
>
> Borger, 102 P.3d at 605 (emphasis added).

Similarly, in Zohar, the physician's affidavit submitted in support of the plaintiffs' medical negligence complaint did not specifically name all of the nurses and physicians who had violated the standard of care. 334 P.3d at 404. For that reason, the trial court dismissed the complaint for failure to comply with NRS 41A.071—a decision the Nevada Supreme Court reversed. The Nevada Supreme Court noted that the legislative history of NRS 41A.071 demonstrated that the statute was enacted to deter baseless medical malpractice litigation, and that it should be interpreted "to ensure that our courts are dismissing only frivolous cases, further, the purposes of our notice-pleading standard, and comport with the Nevada Rules of Civil Procedure. *Id*. at 405-06. The Court emphasized:

> The NRS § 41A.071 affidavit requirement is a preliminary procedural rule subject to the notice-pleading standard, and thus, it must be liberally construed in a manner that is consistent with our NRCP 12 jurisprudence.

Id. at 406.

Finally, the Supreme Court's decision in Baxter v. Dignity Health, 357 P.3d 927 (2015), again emphasized the fact that NRS 41A.071 must be liberally construed "because NRS § 41A.071 governs the threshold requirements for initial pleadings in medical malpractice cases, not the ultimate trial of such matters." The clear implication is that the threshold requirements are less stringent than the requirements for establishing a violation of the standard of care at trial.

We turn once again to the state of Connecticut that the Nevada Supreme Court relied on for further clarification. In Marshall v. Yale Podiatry Group, 496 A.2d 529 (1985), the court considered the question of whether an expert in one area of medicine can testify in a case involving allegations of against an expert in a different area of medicine where the foundation for the opinion is in the **general area of medicine**.

It turned to the court's discussion in another similar case, Fitzmaurice v. Flynn, 167 Conn. 609, 359A.2d 887 (1975).

> [T]he court found that the trial court erred in excluding the plaintiff's expert, a practicing surgeon specializing in breast cancer surgery, from testifying as to the proper medical standards of practice among obstetrician-gynecologists pertaining to breast examinations. In that case, the testimony was "that breast lump examinations are performed in exactly the same manner by obstetrician-gynecologists and surgeons; and that these two specialties are identical with respect to breast lump examination and diagnosis." Id. 615
> …
> **The threshold question of admissibility is governed by the scope of the witness' knowledge and not the artificial classification of the witness by title. Id. 618 (emphasis added.)**

Marshall, 459 A.2d at 531.

Again, in the *Marshall* case specifically relied upon by the Nevada Supreme Court in *Borger* when discussing qualified experts for purposes of NRS 41A.071, *Marshall* approvingly addressed another case, Katsetos v. Nolan, that held:

> Our appellate courts have had occasion to address this issue since that case. In Katsetos v. Nolan, 170 Conn. 637, 646-47, 368 A.2d 172 (1976),

> the court held that **where the evidence presented at trial showed that the treatment in question falls within the field of all medical specialties and the minimum standard of care was common to all specialties, the plaintiff's medical experts were competent to testify as to the applicable standard of care, although not specialists in the same field as the defendants**."

Marshall, 459 A.2d at 531.

While Katsetos was not specifically in the context of the pre-suit expert affidavit, the pre-suit expert requirements are **not** more stringent than the expert requirements during *trial*, but rather, the NRS 41A.071 pre-suit expert requirement is to be more liberally construed. As Marshall recognized, "The decisions allowing and excluding expert testimony in this area generally focus on the expert's familiarity with the school of medicine and the procedures involved." *Id*. at 532.

Dr. Davoren essentially made the same point during his deposition when counsel asked a line of questioning designed to preclude him from testifying because of some artificial, not legal, standard created by a board of certification. The question and answer were as follows:

> Q. Okay. Are you familiar with the statement in the physician acting as an expert witness that was sent out by the American College of Surgeons, it's dated April 1st, 2011.
>
> A. Yes. Very Familiar with it.
>
> Q. And you're familiar with their statement that in order to act as an expert witness, as a general surgeon, that you must be actively involved in clinical practice of the specialty at the time of the alleged occurrence.
>
> A. So in this case, because t**he specialty that's involved is basic general medicine, it doesn't have anything to do with specific physical medicine rehab**. **It's basic general medicine, in terms of a patient with a decreasing hemoglobin that's been documented on a blood thinner**. That is why I felt that I was qualified to render this opinion, because this is not specific to any individual specialty within medicine. But it's just general medicine knowledge. (Davoren depo pg. 22 ln. 2 thru ln. 20).

Defendants selectively cite to "yes" and "no" non-determinative questions focused on whether Dr. Davoren is in the same exact field, or certified in the specific field, etc., but deceptively omit from their Supplements his responses that prove he is more than qualified to render the opinion in this case. For example, when specifically asked about the malpractice issue in this case, Dr. Davoren explains:

> Q. … How would you - - for the court, explain what you see as the issues in this case as it relates to malpractice?
>
> A. So the basis of this - - of the case, as I read the information and facts of the case, is that this patient Mr. Neason was admitted to the facility on a blood thinner. His hemoglobin was documented to decrease over the course of a number of days in precipitous fashion while on blood thinner. Despite this decrease, the blood thinner was continued up until the afternoon prior to the patient transferring emergently to St. Rose Dominican, where he expired … it was by bleeding, which was exacerbated by the Eliquis. So the crux of this case has nothing to do with the spec of any specialty. This is basic medicine that we learn in third year of medical school [that a] patient whose hemoglobin is decreasing over time in a demonstrable fashion, you have an obligation to try and determine and correct whatever the cause of that is. And that should be every discipline …
>
> … And the fact that blood thinners in our society, which are highly prevalent, I think numerous specialties would have the ability to identify and opine about the effects of a blood thinner whose hemoglobin is decreasing …

Id. at p.30-31.

In addition, Dr. Davoren also testified: he is president of the medical staff at Olathe Medical Center, chief of surgery, employed as a physician, and maintains clinical hours where he treats patients, operates or is in the GI lab doing colonoscopies or upper endoscopies (*id*. at p. 9-10); that his hospital has rehabilitative services and that he is actively involved in their care (*id*. at p.10-11); that he is part of the group process assessing whether a patient should receive rehabilitative services (*id*. at p.11); that a part of the treatment he interacts with the staff regularly in directing orders for the patient in their treatment (*id*. at p.12); that he has referred patients to physical medicine rehabilitation ("PMR") specialists (*id*. at p.14); that he creates and devises

treatment plans for patients on whom he does surgery (*id*. at p.13); and, among other things, that he has been previously retained as an expert to render an opinion about the acts of a PMR physician by the defense counsel in the case (*Id*. at p.18-19).

Dr. Davoren is more than qualified to testify as to the standard of care required by all defendants in the subject case. It would be an absurd result to deny him the ability to present an affidavit under NRS 41A.071. An affidavit is a preliminary procedure and must be construed liberally—as opposed to the strict testifying requirements for trial. Dr. Davoren is qualified to testify as to the standard of care of Dr. Flaviano and Dr. Patel, a nurse or other healthcare providers because the malpractice issue in this case involve areas of medicine a general surgeon is trained in. The practices are therefore substantially similar under Nevada law as shown in Borger and the case upon which it relies, Marshall, when it comes to treating patients with the issues attendant to Jeffrey here. The mere fact that the malpractice occurred at a physical rehabilitation facility does not lead one to the conclusion that only a physiatrist can testify regarding the propriety of the care Jeffrey received.

Defendant Flaviano's Supplement cites only to Carnes v. Wairimu, 2011 Nev.Unpub. LEXIS 504 for its statement that the 'expert must be qualified to perform or render the medical procedure or treatment being challenged as negligent.' Supplement at 7:13-14. Carnes relies upon Staccato v. Valley Hospital, 123 Nev. 526, 170 P.3d 503 (2007) concerning the qualification of an expert at the trial stage. In Staccato, the primary issue was "whether a physician is qualified to testify as to the proper standard of care in a malpractice action against a nurse when the allegedly negligent act implicates the physician's realm of expertise." *Id*. at 527, 170 P.3d at 504. In resolving this question, the Supreme Court "noted that, **in Nevada, expert qualification does not hinge on the specialty or license of the medical caregiver but, instead, turns on "whether the proposed witness's special knowledge, skill, experience, training, or education will assist the jury."** *Id*. at 531, 170 P.3d at 506; see NRS 50.275.

Thus, it held that "a physician or other medical provider is not automatically disqualified from testifying against a defendant who specializes in a different area of medicine or who practices in a different medical discipline." *Id*. at 531-32, 170 P.3d at 506-07. Consequently, the

Supreme Court "**emphasized that 'the proper measure for evaluating whether a witness can testify as an expert is whether that witness possesses the skill, knowledge, or experience necessary to perform or render the medical procedure or treatment being challenged as negligent,** and whether that witness's opinion will assist the jury.'" Id. at 527, 170 P.3d at 504. Because the emergency room physician in Staccato was qualified to administer injections—the medical procedure or treatment at issue—the Court reversed the lower court, concluding that the physician was qualified as an expert and could offer standard-of-care testimony in relation to the nurse." *Id*. at 533, 170 P.3d at 508.

This case is like Borger, the cases discussed above from *Marshall*, and *Staccato*, in that Dr. Davoren is more than qualified and competent in the treatment being challenged as negligent here, and his training, practice, experience, skill in the negligent area is substantially similar to allow for him to provide the NRS 41A.071 affidavit as an expert witness. The remainder of Defendants' arguments go more to weight or cross-examination, but not his qualification to opine on the area of negligence involved in this specific case here.

///

III. CONCLUSION

Based on the foregoing, Plaintiff respectfully requests that Defendant's Motion to Dismiss Plaintiff's Complaint and Defendant's Motion to Dismiss Plaintiff's First Amended Complaint, and Joinders therein, be denied.

Dated this 9th day of June, 2021.

GGRM LAW FIRM

/s/ Breen Arntz

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of GGRM LAW FIRM, and that on the 9th day of June, 2021, I caused the foregoing document entitled **SUPPLEMENTAL OPPOSITION TO DEFENDANT CASIANO FLAVIANO, M.D.'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT And SUPPLEMENTAL OPPOSITION TO DEFENDANT CASIANO FLAVIANO, M.D.'S MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT And SUPPLEMENTAL OPPOSITION TO DEFENDANT SUHIL R. PATEL, MD'S SUBSTANTIVE JOINDER**to be served upon those persons designated by the parties in the E-service Master List for the above-referenced matter in the Eighth Judicial Court E-filing System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules, to wit:

/s/ Rebeca Guardado

_____

An Employee of GGRM LAW FIRM

EXHIBIT 1

QUESTIONS BY MS. WRENN:

Q. Thank you, Madam Court Reporter, and also Dr. Davoren. Thank you for being available so late in the day. We appreciate it. So hopefully, this shouldn't take too long. You know, we'll try to move through things.

But could you please state and spell your name for the record?

A. Yes. It's Michael Paul Davoren, D-a-v-o-r-e-n.

Q. Thank you. And do you understand that the oath you just took here today is the same oath to tell the truth as if you were in formal Court of Law and it carries with it the same penalties of perjury?

A. I do understand.

Q. Have you ever been deposed before?

A. A few times, yes.

Q. Do you recall the time period of your last deposition?

A. It was about ten months ago.

Q. And do you recall what state you were in for that one?

A. It was a Zoom. I was here in Kansas and

24 the other parties were in Las Vegas.

25 Q. So it was -- was it a Nevada case?

1 A. Yes, it was.

2 Q. Are you okay with me skipping through the

3 admonitions or do you want me to go through those?

4 A. No, you can skip them for the sake of

5 brevity.

6 Q. Thank you very much. And also I'd like to

7 ask: What type of case was the Nevada matter that you

8 were deposed in ten months ago?

9 A. It's a colon case, a colon resection case.

10 Q. And did you provide expert testimony in

11 that case?

12 A. It's still ongoing.

13 Q. Okay. Thank you. And are you willing to

14 tell me the name, the caption for the case?

15 A. Yeah, it's -- I'll have to pull it up.

16 Hold on one moment. I'm sorry. Smith versus Chen.

17 Q. Nevada state court or federal?

18 A. It's Nevada state court.

19 Q. Thank you. So can you tell me your

20 understanding of where why you're being deposed in this

matter today?

A. Yes. I was asked to give my opinions on a case regarding a patient who was at a rehab facility and had a gastrointestinal bleed and subsequently died. And the deposition today was -- there was concerns that my

background as a surgeon might prevent me or might not qualify me to give opinions regarding the actions taken by a physiatrist.

Q. Thank you, Doctor. And I just realized, I was trying to hop in and get started, I very rudely didn't introduce myself. My name is Dione Wrenn, and I work for the law firm Gordon Rees, and we represent the rehabilitation hospital or Dignity Select in this matter.

So what did you do to prepare for your deposition today?

A. I reviewed the records for the patient, Mr. Neason, regarding the timeframe prior to this hospitalization at Dignity, while he was at Dignity and then subsequently when he was taken back to -- or taken to St. Rose Dominican by ambulance and subsequently expired.

Q. And do you have a -- is the list or the

documents that you reviewed the same ones that are listed in the affidavit that you authored?

A. Yes. Then there is -- I got an amended autopsy report that I received earlier, so that would have been different than what's on my affidavit, because I just received that, that autopsy and toxicology report today.

MR. ARNTZ: And just so you guys know -- can you hear me.

MS. WRENN: Yes.

MR. ARNTZ: Just so you know, they revised the autopsy report. I just barely saw it today, but I'll supplement the record. I can e-mail it to you all as we're sitting here if you want me to. That's a pretty recent development.

A. And that didn't change any of the bases for my opinions or the opinions themselves.

BY MS. WRENN:

Q. The opinions that you authored in the affidavit?

A. Yes.

Q. Thank you. And just for the record, I'm

going to -- I've had a quite a few of them. But just so we have it listed, I just want to put on the record that your affidavit is going to be Exhibit A. And looking at your affidavit, the records that you reviewed in preparation for today are the items listed under number nine of your affidavit, A through L, as well as an amended autopsy and toxicology report that you received today?

A. Yes.

Q. Thank you. Have you spoken to anyone in

preparation for your deposition?

A. I spoken with the plaintiff in the case.

Q. I believe plaintiff has two law firms. Which attorney did you speak with?

A. I spoke with Breen today. And then I also spoke with -- I don't know the other attorney's name, but I've spoken to another attorney from the other law firm.

MR. ARNTZ: Today.

A. No. Not today. This was two weeks ago.

MR. ARNTZ: Okay. He was just -- he wanted to talk just to tell me this that deposition had been requested. That was basically the extent of the

conversation.

Q. Thank you. And when did you speak with Mr. Breen?

A. Earlier today.

MR. ARNTZ: Right before we started.

MR. WRENN: Thank you, Counsel.

BY MS. WRENN:

Q. Were you provided any policies and procedures with respect to patient referral for Dignity Health Rehabilitation Hospital?

A. No.

Q. Have you been provided any policies and

procedures of the hospital with respect to patient admissions?

A. No.

Q. How about the policies and procedures for patient discharge?

A. No.

Q. Is it fair to say you were not provided any policies and procedures with respect to Dignity Health Rehabilitation Hospital?

A. Yes.

Q. And did you request the policies and procedures?

A. We had talked about that, yes.

Q. We being --

A. Mr. Breen and I had earlier -- prior, I had asked about getting those items.

Q. Prior to today?

A. Just earlier today. Excuse me.

Q. And was it indicated to you that you would be receiving those policies and procedures at some point?

A. My understanding was that I would be.

Q. But you didn't have them, at least for of the affidavit?

A. Correct.

Q. Now, do you maintain a job file for the work you've performed thus far in the case?

A. I do. I keep a file of records I received, invoices sent and those types of things.

Q. Is it maintained electronically?

A. It is.

Q. And could you provide that to counsel, so that the attorneys can get it from him?

A. Yeah, absolutely. I'd be happy to.
Q. Thank you. And would it be accurate to say that you reviewed the entirety of your job file in preparation for today?
A. Yes. I have reviewed it.
Q. And do you maintain a testimony list?
A. I do. And that was submitted to Mr. Breen's firm.
Q. Okay. I'll reach out to counsel about that. I only have the CV. And I didn't see your testimony list on there as well. So I'll check with them as well. Thank you. So what professional licenses do you hold?
A. The Kansas medical license.
Q. And is Kansas the only state where you're currently licensed to practice medicine?
A. It is.

Q. And is it accurate that throughout your professional career, you've not held a license or practiced in Nevada?
A. I have not.
Q. Are you board certified?

A. I am.

Q. What board certifications do you have?

A. The American Board of Surgery.

Q. Any others?

A. No.

Q. Where are you currently employed?

A. Olathe Medical Center in Olathe, Kansas, O-l-a-t-h-e.

Q. Thank you. And what is your professional title?

A. I'm president of the medical staff, chief of surgery, and then surgeon.

Q. Are you considered in private practice?

A. No, I'm an employed physician.

Q. Do you maintain or have clinical hours?

A. Yes.

Q. And just for those of us who may not know or we don't want to assume anything, what does that entail when you have your clinic?

A. During the clinic, I currently have two

half-day clinics where I see patients in the office from nine am to noon on Tuesdays and Wednesdays. And every other Friday, I have a clinic from noon to 4:00. And

the other days, I'm either operating or in the GI lab doing colonoscopies or upper endoscopies.

Q. And if we could break that down, so what is a colonoscopy for the record?

A. A colonoscopy is a test to look for lesions of the colon or abnormalities of the colon using a fiber optic basically telescope. It has a digital image that shows up on a video screen. We can look inside the colon to identify growths or other abnormalities in the colon.

Q. And how about an upper endoscopy?

A. It's similar. It's, again, a flexible fiber optic basically telescope that we utilize to observe the esophagus, stomach and the first part of the small intestine.

Q. Thank you. And the hospital that you work in, is it a rehabilitative hospital?

A. It is not a rehab hospital, no. We do have rehabilitation facilities and we maintain both in patient and outpatient rehab services.

Q. Are you actively involved in the rehabilitation services or arm of the hospital?

A. Yes. Via patients that have rehabilitation services, yes, I'm actively involved in their care.

Q. To your knowledge, do you currently have any patients who are in the rehabilitation hospital wing that you're working with?

A. So it's not actually a wing. We have the services come in. So like right now, I have a patient in the ICU whose receiving physical therapy occupational therapy and speech therapy all after a surgery for in factor Ted intestine. So I'll interact with the different techs with that and I'll interact with the other doctors regarding that care.

Q. Are any of your patients that you treated most recently or in your recent history, individuals who suffered recent strokes?

A. Yes.

Q. And would you be the physician that would recommend or send a patient or -- let me back up. Strike that.

. Would you the physician to do the assessment to determine if a patient should receive rehabilitation services?

A. So I'm part of that process, yes. It's a group process. We'll get input from our physical

25 therapy department, occupational therapy department,

1 nurses, care coordinators, physicians and we all get
2 together and along with the family, of course and the
3 patient to determine where the disposition should be,
4 whether it be a skilled nursing facility, a rehab
5 facility or sometimes it's, unfortunately, palliative
6 care or even Hospice.
7 Q. And have I ever worked in the capacity of
8 being a medical director or chief physician of some sort
9 for a rehabilitation hospital?
10 A. No I have not.
11 Q. As part of the a treatment that you may
12 provide to an individual whose receiving rehabilitation
13 services, you interact with the staff regularly in
14 directing orders for the patient in their treatment?
15 A. Certain parts of it, yes.
16 Q. Could you explain further? I know it's
17 vague, but if there's an example that you have?
18 A. Right. So I have a patient whose currently
19 in the hospital who came in with increasing paralysis of
20 his lower extremities and also had a perforated gastric
21 ulcer from medications. So I did the surgery on him
22 from that. He's at high-risk for DVT, so we have him on

-- they wanted put him on anticoagulant therapy, so we had to discuss that.

He also had what turned out to be a

cervical spine lesion. And also with physical therapy and occupational therapy about what different modalities or treatment he was able to have after the surgery. So that's probably one of the better examples, recently.

Q. Thank you. Did you also review any statements or reports by Dr. Fish in this matter?

A. I did not.

MS. WRENN: I need to -- I'm going to pass the witness, given some of his answers. I need to look at something really quick and see what my last few questions are going to be. If someone wants to hop in, I don't want to waste time.

EXAMINATION

QUESTIONS BY MS. GORDON:

Q. Doctor, my name is Katie Gordon. I represent Dr. Flaviano in this case. I have a couple questions for you.

A. Sure.

Q. Are you board certified in physical

medicine and rehabilitation?

A. I'm not.

Q. Have you ever practiced in the area of physical medicine and rehabilitation?

A. I have not.

Q. Did you do an internship in physical

medicine and rehabilitation?

A. I did not.

Q. Did you do a residency in physical medicine and rehabilitation?

A. I have not.

Q. Have you ever taught any services in rehabilitation and physician services?

A. I have not.

Q. Have you ever acted as a consultant physician in the area of physical medicine or rehabilitation?

A. I have not.

Q. Have you referred patients to P M R specialists?

A. Yes.

Q. And when I say P M R, you understand that I mean physical medicine rehabilitation; right?

A. I'm aware of that.

Q. I'll just take up the rest of our hour each time if I have to say it out loud. When you refer someone to a P M R specialist, what is the purpose for doing that?

A. Usually it's in the cases of patients who have musculoskeletal or injury deficits that require a care plan. And I want their input on that portion of

their treatment. So in those cases, they will usually serve as part of a team approach, where we interact and they will discuss their recommendations for improving patients, those issues and I'll interact with them about the conditions that I'm involved in.

Q. Do you typically prepare treatment plans for your patients at -- is it Olathe Medical Center?

A. Everybody gets it wrong. It's okay. For which aspects of care?

Q. Well, would you create a treatment plan overall for any of your patients for whom you do surgery?

A. Yes.

Q. All right. And what kinds of circumstances

are there that you would then prepare the overall treatment plan for these patients?

A. Well, every patient that I do surgery on, I have a care plan for how I want to handle the perioperative period, both preoperative, operative and post-operative timeframes. So seen, every single patient has a care plan that's devised by me that I operate on.

Q. And would that care plan then end at the post-operative state?

A. So when that ends is according to

certificate it has 90 days of Medicare global days of reimbursement. To be honest, we don't get reimbursed unless it's unusual until 90 days. But I have patients that I have seen for two decades almost and I continue along with their care, seeing them every few months for different issues. Sometimes it's the same months, sometimes it's different.

Q. Do the patients for Olathe Medical Center from a primary treating physician?

A. So they have a primary care physician who coordinates outpatient care in general. Once they're in the hospital or if they've been referred to me, then

they still will keep the responsibility or else we'll do a team approach, where they will work on things like aunt hypertension medications and I'll take care of surgical issues, but we work as a team in the hospital.

Q. If they're an inpatient at the medical center, do they have a hospitalist?

A. In some cases, in some cases no. We have some family practice and internal medicine physicians who still round in the hospital. And so they will consult them. So they'll be involved in the care actively in the hospital. We have other primary care physicians who defer to the hospital lists, so the hospitalists would then get involved while the patient

is in the hospital to help coordinate care with us.

Q. Have you ever acted as a hospital list at Olathe medical center?

A. No.

Q. Have you ever been retained as an expert witness in giving opinions as to the care and treatment provided by physical medicine and rehabilitation physician?

MR. ARNTZ: Object to form of the question.

A. There was -- I don't know if it was directly -- there was one case where I was consulted to render an opinion about a retained wound vac sponge in a patient who was in the rehabilitation facility under the auspices of a physical medicine rehab doctor. I don't know whether that applies to what you're looking for.

Q. Sure. Did you render opinions about whether a physical medicine and rehabilitation physician fell below the applicable standard of care?

A. In that case I didn't and my opinion was they did not fall below.

Q. I'm sorry. Your opinion was that they did not fall below the standard of care?

A. Yes.

Q. But you were specifically retained to render an opinion about the acts of a PMR physician?

A. Because the wound vac had been ordered by the physical medicine physician while the patient was in a rehabilitation facility, and there was a retained sponge, they filed suit against the home health agency, the physical rehabilitation and rehab doctor. So I was retained --

Q. Were you retained by the plaintiff?

A. No. I was retained by the defense counsel.
Q. Okay. In November of 2019, did you hold any privileges at a hospital or facility to perform PMR services?
A. No.
Q. Between 2015 and 2019, did you take any CME courses that were dedicated to the practice of PMR services?
A. No.
Q. Before you signed your affidavit in this case on November 10th of 2020, did you review the prevailing standards of the practices for PMR physicians?
A. No.
Q. Did you research the generally accepted physicians in the PMR specialty?
A. Regarding which topic?
Q. Regarding rehabilitation and physical

medicine specialty. Did you look up any standard of care guidelines regarding PMR physicians?
A. Again, that's a hugely broad topic.
Q. Let me ask this way: What did you review,

if anything, in order to render your opinion that Dr. Flaviono fell below the standard of care other than the medical records?

A. So I reviewed both the package insert for Eliquis, I reviewed the prevailing articles out there on Eliquis and gastrointestinal hemorrhage. I reviewed medical school texts I have that discuss decreasing hemoglobin and looking for science of bleeding and then also just my own basic knowledge of patients who have a documented decrease in hemoglobin on a repetitive basis in terms of what would be expected from a physician. Not specifically M R physician, but any physician.

Q. Did you save in your job file the articles that you found regarding GI bleeds and Eliquis?

A. No. Those are hundreds and thousands. In this case, my -- what itches looking for was all the different things that could have possibly caused a gastrointestinal hem ran on the patient with Crohn's disease. Now that we have the autopsy, we already have the answer.

Q. What was the amendment that is stated on

that new autopsy report that you have and we don't have?

A. So there was a toxicology report, which

lists the apixaban levels within the patient's bloodstream at the time of his death, which indicates that he still had detectable levels in his bloodstream and then there was also -- prior to that, I did not have a complete listing of the pathologic forensic findings. I was missing a page.

Q. And then you were provided with at page in the amendment?

A. So I've got -- as far as I know, I have all the necessary -- or all the pages that are available for that report at this point.

Q. On your CV, I notice that you stated that you're a fellow of the American College of Surgeons; is that right?

A. I am.

Q. Okay. And you're a member of the Kansas chapter of the American College of Surgeons?

A. I am.

Q. You are still currently?

A. Yes.

Q. Okay. And are you familiar with -- let me ask you this: You've been a fellow of the American College of Surgeons since 2004; right?

A. Yes.

Q. Okay. Are you familiar with the statement on the physician acting as an expert witness that was sent out by the American College of Surgeons, it's dated April 1st, 2011?

A. Yes. Very familiar with it.

Q. And you're familiar with their statement that in order to act as an expert witness, as a general surgeon, that you must be actively involved in clinical practice of the specialty at the time of the alleged occurrence?

A. So in this case, because the specialty that's involved is basic general medicine, it doesn't have anything to do with specific physical medicine rehab. It's basic general medicine, in terms of a patient with a decreasing hemoglobin that's been documented on a blood thinner. That is why I felt that I was qualified to render this opinion, because this is not specific to any individual specialty within need sin. But it's just general medical knowledge.

Q. Do you believe that you are qualified to render an opinion as Totten tighter of care that was given it Mr. Neason while he was at Dignity rehab?

A. No. Only the portions where I made comments.

Q. And is it your testimony, then, that your opinions are limited to the GI bleed?

A.

MR. ARNTZ: I'll object to the form of the question.

A. Pending any new information, that is what I have rendered my opinions on; correct.

Q. When is the last time that you prescribed Eliquis for a patient?

A. I had to renew a prescription on a patient last week.

Q. When is the last time that you prescribed Eliquis for a patient as a new prescription as opposed to refilling it?

A. I don't prescribe it as a new intervention.

Q. And I believe you said that you have never spoken with Dr. Fish about this case?

A. The only way in which I spoke to him is it originally, you know, in the interest of full disclosure, I had known Dr. Fish for 25 years now, from the Army. And he mentioned to me when we were in

22 conversation that he referred an attorney to me to talk
23 about this particular case. So in terms of that, yes,
24 we have talked about it. But the specifics of it, no,
25 we have not discussed the specifics of the case.

1 Q. Do you know why Dr. Fish recommended that
2 you be contacted to act as an expert witness as opposed
3 to just him acting as an expert witness?
4 A. I'm not sure. I know he knows that I work
5 with a lot of patients with gastrointestinal hemorrhages
6 who are on blood thinners. Maybe that's why I referred
7 the patient or this case to me. I'm not quite sure. I
8 didn't delve into that.
9 Q. And Dr. Fish is a physical medicine and
10 rehabilitation physician; correct?
11 A. Yes.
12 Q. Olathe Medical Center has specific PMR
13 physicians; correct?
14 A. We have one on staff, yes.
15 Q. And you are not listed as one of the PMR
16 physicians; correct?
17 A. No. We require board certification for our
18 physicians and I would be lacking that in numerous ways.

Q. I think that's all I have for now. I may circle back. I'll go ahead and let Mr. Kelly go ahead and ask you some questions.

EXAMINATION

QUESTIONS BY MR. KELLY:

Q. Doctor, I represent Dr. Patel in this matter, and I'm going to be very brief. Are you board

certified in internal medicine?

A. No.

Q. Have you ever done an internship in internal medicine?

A. No.

Q. Have you ever done a residency in internal medicine?

A. No.

Q. And based upon your statement just a moment ago, because you're not board certified in internal medicine, you are not -- or have never been at Olathe on internal medicine physician; correct?

A. Correct.

Q. You said that you are actively involved with the care of your patients in the rehab part of the hospital. While you're actively involved, is there

still either a hospitalist or the patient's primary care physician also involved?

A. In some cases, yes. In other cases, no. It depends on the number of different issues that we are dealing with. To in some cases, where it's fairly straightforward, like in a trauma case, then I'll be working with the physical therapist and occupational therapist without necessarily the hospitalist os internal medicine folks. But in a lot of cases, yes, we

work as a team.

Q. That's all I have. Thank you.

EXAMINATION

QUESTIONS BY MS. WRENN:

Q. I have some follow-ups. Once again, my name is Dione Wrenn and I represent the Dignity select. So to confirm your earlier testimony, Olathe does not have an independent rehabilitation hospital; correct?

A. Correct.

Q. This services, I think you mentioned were brought in; is that correct?

A. No. They're a part of the facility, but we don't have a dedicated portion of the hospital that is

devoted solely to the care and treatment involved with rehabilitation.

Q. So the services that the -- let's say your therapist or others who are part that have rehabilitation process, they are employees of Olathe?

A. They are.

Q. And are they rehabilitation services classified as acute inpatient rehabilitative care?

A. Yes, they would be acute.

Q. And do you have any input in the policies and procedures used by Olathe for their rehabilitation services?

A. Only in the sense that I'm on the medical executive committee. So if there's changes to policies and procedures that involve the medical staff, then those will go to the med executive community and I sit on that as the president. But in terms of a lot of the nuts and bolts, no, I do have participation in that care.

Q. What do you mean by the nuts and bolts?

A. So if they want to get a new range of motion machine for therapy after a knee replacement, I would not be involved in purchasing that or how that

would be utilized.

Q. Have you been retained in a Nevada case to offer expert opinions on standard of care for an acute rehabilitation hospital.

A. The only one was that one sponge case. And it wasn't -- they did not -- actually, they did include that facility, but my opinion was limited to the wound vac itself.

Q. How about in Kansas?

A. No.

Q. And outside of a Dr. Flaviano and Patel, which staff members are you referencing in your opinion that on numerous occasions the staff at Dignity failed to provide timely testing for Jeffrey Neason's

gastrointestinal hemorrhage and failed to diagnose his bleed until?

A. That would be those physicians. Physicians are the only ones who are capable of actually doing those orders. The nursing staff, I don't have any knowledge at this point in time to render an opinion regarding the nursing staff. Standard of care.

Q. So does that change or alter how your

reference in paragraph 21 where you talk about the staff and doctors Patel and Flaviano?

A. That was who I was referring to at that time. The staff would only be how they assisted Dr. Flaviono and Patel in their care and assessment of the patients.

Q. But you're not offering any opinions with respect to just the staff and the standard?

A. At this point in time, I'm not.

Q. Have you reviewed the policies and procedures for the rehabilitation services that are provided at Olathe?

A. Unfortunately, yes. That -- we've had to sift through those in terms of the by-laws committee and we've had to view them, that's probably been a decade since I looked at those, though?

Q. And you didn't look at them back in 2019?

A. I did not.

MS. WRENN: That's all I have.

MS. GORDON: I don't have anything else, thanks.

EXAMINATION

QUESTIONS BY MR. ARNTZ:

Q. Doctor, I'm going to ask like two questions. How would you -- if you could, for the court, explain what you see as the issues in this case as it relates to malpractice?

A. So the basis of this -- of the case, as I read the information and the facts of the case, is that this patient Mr. Neason was admitted to the facility on a blood thinner. His hemoglobin was documented to decrease over the course of a number of days in precipitous fashion while on a blood thinner. Despite this decrease, the blood thinner was continued up until the afternoon prior to the patient transferring emergently to St. Rose Dominican, where he expired basically from ex sang which nation. Even though the death certificate says this is a result of complications from colon cancer, it was by bleeding, which was exacerbated by the Eliquis. So the crux of this case has nothing to do with the specs of any specialty. This is basic medicine that we learn in third year of medical

school S patient whose hemoglobin is decreasing over time in a demonstrable fashion, you have an obligation to try to determine and correct whatever the cause of

that is. And that should span every discipline, even if you're a psychiatrist, if you're treating a patient in the hospital and you have knowledge that that patient's hemoglobin is decreasing to an dangerous level, you have an obligation, if you don't know what test to order, at least to get the patient referred to someone who does or at least to a facility who can take care of the patient.

Q. So would you say that it's not so much knowing exactly how to treat the patient, but knowing that drop of hemoglobin is indicative of a problem?

A. Correct. I mean, there are certain basic things, though that after single one of us learned in medical school. We all learned about stool black checking for colon bleeding. We all learned when hemoglobin decrease, far enough, a patient dies. It doesn't have to be 0, that's just part of everybody's medical training. And the fact that blood thinners in our society, which are highly prevalent, I think numerous specialties would have the ability to identify and opine about the effects of a blood thinner whose patient's hemoglobin is decreasing.

Q. And is that standard of care that would be

applicable to a physician treating a patient with these

different issues? Is that standard of care different from a physiatrist to a general surgeon to an internist?

A. No. We all have the same basic medical knowledge. These are not -- this is not oh, I know we talked about this numb husband sometimes. I do not contend to be a million medicine rehab specialist. I do have medical knowledge from my training and since then. I have specialized I did not look at this case check collect with the expectation that a physical medicine rehab physician would meet the same standard that I would as a general surgeon. I looked at this case as would the physicians in this case meet the standard for any treating physician in a facility, where they have this information available, to them.

Q. Okay. That's all I have.

MS. GORDON:

Q. I have a follow-up. Taking that statement that you just made, doctor, about knowledge of a physician regarding a patient's hemoglobin result, you would agree with me, then, that that physician is only as good as the time that he receives those results, does that make sense?

MR. ARNTZ: Object to form.

A. If I can rephrase what I think you're

asking is that is the physician dependent on getting those results from staff and that was where the earlier query about the Dignity hospital staff and their potential roll in this case, and that's why I said I'm not ready to render an opinion, because obviously, there could be some situation where the physician may have an opinion that they were not notified in a timely fashion. That is not documented in any of the documents I have available. So I do agree that if you don't get the information, if it's not available to you, then it's hard to act on that information.

Q. That's fair. And I wasn't referring to staff. I was referring to the time that the lab results are actually available. You would agree with me then, that a physician is not expected to take action on test results that are not yet available to him or her.

A. Yes, I think that -- I would agree with that. That seems like a common sense statements, yes.

Q. And taking your general knowledge of medicine, at what point did Mr. Neason's hemoglobin results mandate that Dr. Flaviono do something that he did not do?

A. 1120.

MR. ARNTZ: Let me --

MS. GORDON: I'm sorry. 1112.

MR. ARNTZ: Let me object to the question. This does seem like it's going more into his basic opinions and not qualifications. But if you can explain the next us, Katie, going down this line.

MS. GORDON: Sure, I don't plan ongoing down this line too very much. I'm just wondering based on the general nature of your medical background, what result or multiple results are you referring to with Mr. Neason's hemoglobin that mandated that Dr. Flaviono do something that he did not do.

A. I'm sorry. I was waiting to make sure there were no other objections.

So I'm outlining, on 111119, the hemoglobin had been noted to decrease from 1124 to 928. At that point, the intervention that at minimum should have been done would be a stool guaiac. And then to monitor the patient's hemoglobin as was suggested by Dr. Patel. On 1113, the hemoglobin at that point, the patient should have had the Eliquis stopped immediately, not waiting for a new result later on in the day and the patient

should have been transferred for evaluation for the source of blood loss.

Q. And that 7.0 result obviously would have had to have been available to the physicians in order to act on it; correct?

A. Correct. But it obviously was available, because they ordered a repeat of that result. And got that and that was documented at 12:20. So they -- and they said they were going to repeat it, so they had that result available at the 7.0 prior to ordering the repeat.

Q. So is 7.0 your cutoff time for them needing to transfer Mr. Neason?

A. At that point in time, I would say that the patient, it was mandate that had the patient be transferred for evaluation for the source of their blood loss.

Q. Okay. That's all I have. Thank you.

MR. ARNTZ: I don't have anything else. Anybody else.

MS. GORDON: Can we get a rough of this, please, because we have to file some supplemental

briefings with the court.

EXHIBIT 16

OPP
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DISTRICT COURT

CLARK COUNTY, NEVADA

ARLIS NEASON, as Heir of the Estate of JEFFREY NEASON, Plaintiff, vs. DIGNITY SELECT NEVADA, LLC, a foreign limited-liability company; CASIANO R. FLAVIANO, MD; SUSHIL R. PATEL, MD; DOES I through X; and ROE BUSINESS ENTITIES I through X; inclusive, Defendants.	CASE NO.: A-20-824585-C DEPT. NO.: XXIX **OPPOSITION TO DEFENDANT DIGNITY SELECT NEVADA, LLC (1) MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT AND (2) JOINDER IN DEFENDANT FLAVIANO' MOTION TO DISMISS**

COMES NOW, Plaintiff, Arlis Neason, as Heir of the Estate of Jeffrey Neason (hereafter, "Plaintiff"), by and through her attorneys of record, GGRM Law Firm and Arntz Associates, hereby files her Opposition to Defendant Dignity Select Nevada, LLC Motion to

Dismiss Plaintiff's First Amended Complaint and its Joinder in Defendant Flaviano's Motion to Dismiss.

This Opposition is made and based upon the attached Memorandum of Points and Authorities, all papers and pleadings on file herein, and any oral argument permitted.

Dated this 29th day of July, 2021.

GGRM LAW FIRM

/s/ Breen Arntz

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Defendant Dignity Select Nevada, LLC (hereafter, "Defendant") filed a Motion to Dismiss Plaintiff's First Amended Complaint and a Joinder in Defendant Flaviano's Motion to Dismiss.

Defendant argues that the expert affidavit used in Plaintiff's Complaint and First Amended Complaint fails fulfill the requirements of NRS 41A.071. Defendant states that Plaintiff's Complaint includes an Affidavit from Dr. Davoren, who is based in Kansas, and does not practice in the area of physical medicine and rehabilitation. Interestingly enough, Defendant additionally argues that Plaintiff's Complaint fails to point out who was responsible for certain aspects of the treatment that ultimately led to the death of Plaintiff's son. Defendant makes this argument without acknowledging the lack of said information in the decedent's medical records, and the fact that this issue would be cleared up quite quickly through some initial discovery.

Defendant accurately states the standard for a motion to dismiss. Defendant takes issue with the fact that the expert affidavit provided by Dr. Davoren identifies that his experience involved general surgery, but that it does not mention significant experience in physical medicine and rehabilitation. According to Defendant, because Dr. Flaviano is not a general surgeon, than Dr. Davoren's opinion shouldn't matter. Defendant supports this argument by citing NRS 41A.071 and NRS 50.275. Additionally, Defendant cites to *Carnes v. Wairimu,* 2011 Nev. Unpub. LEXIS 504, at *7.

Defendant then pivots and claims that Plaintiff failed to state a claim against Dr. Flaviano for Negligent Hiring, Retention, and Supervision. As Defendant tries to explain, Dr. Flaviano did not owe a duty of care to his patients or the Plaintiff since Dr. Flaviano is not responsible for the hiring of employees at the medical facility where the decedent passed. Finally, Defendant concludes stating that Plaintiff is not entitled to punitive damages.

II. LEGAL ARGUMENT

A. Dr. Davoren's Affidavit Complies with NRS 41A.071

Dr. Davoren's affidavit complies with NRS 41A.071, which requires that a medical malpractice action must be filed with "an affidavit, supporting the allegations contained in the action." Zohar v. Zbiegien, 334 P.3d 402, 405 (Nev. 2014). As discussed in the original opposition to this motion, the purpose of the expert affidavit requirement in NRS 41A.071 is "to lower costs, reduce frivolous lawsuits, and ensure that medical malpractice actions are filed in good faith based upon competent expert medical opinion." Szydel v. Markman, 121 Nev. 453 (2005). The affidavit requirement "is intended primarily to foreclose frivolous medical malpractice suits at the pleading stage, *not to block meritorious suits on narrow technical grounds*."

NRS 41A does not, however, define the level of detail required to adequately "support" a plaintiff's allegations. Zohar, 334 P.3d at 405. The Nevada Supreme Court held that "reason and public policy dictate that courts should read the complaint and plaintiff's NRS 41A.071 expert affidavit together when determining whether the expert affidavit meets the requirements of NRS 41A.071." *Id*. NRS 41A.071's affidavit requirement is a preliminary procedural rule subject to the notice-pleading standard, and thus, it must be "liberally construe[d]…in a manner that tis consistent with our NRCP 12 jurisprudence." *Id.*

B. Dr. Davoren Practices Medicine, The Only Area of Medicine Needed to Qualify Him to Testify In This Action

Dr. Davoren is qualified to render opinions regarding the medical issues presented in the subject case. He artfully describes the area of medicine necessary for this review in his deposition as follows:

> Q. Let me ask this way. What did you review, if anything, in order to render your opinion that Dr. Flaviano fell below the standard of care other than the medical records?

> A. So I reviewed both the package insert for Eliquis, I reviewed the prevailing articles out there on Eliquis and gastrointestinal hemorrhage, I reviewed medical school texts I have that discuss decreasing hemoglobin and looking for signs (sic) of bleeding and then also just my own basic knowledge of patients who have a documented decrease in hemoglobin on a repetitive basis in terms of what would be expected from a physician. Not specifically a PMR physician, but any physician. ….. In this case, my – what [I'm] looking for was all the different things that could have possibly caused a gastrointestinal hem ran on the patient with Crohn's disease (Deposition of Dr. Davoren, pg. 19 ln. 4 thru pg. 20 ln. 25, a true and correct copy attached hereto as Exhibit 1).

The Legislature has not provided an explanation or guidance for courts to resolve disputes over whether an affiant practices in an area that is "substantially similar to the type of practice engaged in at the time of the alleged malpractice." Borger v. Dist. Ct., 102 P.3d 600, 605 (Nev. 2004). Nevada turned to Connecticut law that held, "[t]he threshold question of admissibility is governed by the scope of the witness' knowledge and not the artificial classification of the witness by title." *Id.* Thus, NRS 41A "allows medical experts to testify in medical malpractice cases where their present or former practice reasonably relates to that engaged in by the defendant at the time of the alleged professional negligence." *Id.* In Borger, a gastroenterologist was qualified to opine as to the medical malpractice of a general surgeon. In Zohar, an emergency physician was qualified to testify as to the malpractice of nurses in the emergency department. Zohar, 334 P.3d at 407 (both Summerlin Hospital and Dr. Zbiegien are parties in this case).

In Borger, the defendant surgeon moved to dismiss the plaintiff's claims against him because the affidavit submitted was executed by a gastroenterologist and not a surgeon. The Nevada Supreme Court found that the affidavit by the gastroenterologist was sufficient, explaining:

> Although [NRS 41A.071] does not allow unrestricted use of medical expert witnesses who testify based upon acquired knowledge outside the witness' area of present or former practice and prohibits testimony based upon knowledge solely obtained for the purpose of litigation, the legislation allows medical experts to testify in medical malpractice cases where their present or former practice ***reasonably relates*** to that engaged in by the defendant at the time of the alleged professional negligence.

…

> [T]he statute does not require that the affiant practice in the same area of medicine as the defendant; rather it requires that the affiant practice in an area "substantially similar" to that in which the defendant engaged, giving rise to the malpractice action.

Borger, 102 P.3d at 605 (emphasis added).

Similarly, in Zohar, the physician's affidavit submitted in support of the plaintiffs' medical negligence complaint did not specifically name all of the nurses and physicians who had violated the standard of care. 334 P.3d at 404. For that reason, the trial court dismissed the complaint for failure to comply with NRS 41A.071—a decision the Nevada Supreme Court reversed. The Nevada Supreme Court noted that the legislative history of NRS 41A.071 demonstrated that the statute was enacted to deter baseless medical malpractice litigation, and that it should be interpreted "to ensure that our courts are dismissing only frivolous cases, further, the purposes of our notice-pleading standard, and comport with the Nevada Rules of Civil Procedure. *Id*. at 405-06. The Court emphasized:

> The NRS § 41A.071 affidavit requirement is a preliminary procedural rule subject to the notice-pleading standard, and thus, it must be liberally construed in a manner that is consistent with our NRCP 12 jurisprudence.

Id. at 406.

Finally, the Supreme Court's decision in Baxter v. Dignity Health, 357 P.3d 927 (2015), again emphasized the fact that NRS 41A.071 must be liberally construed "because NRS § 41A.071 governs the threshold requirements for initial pleadings in medical malpractice cases, not the ultimate trial of such matters." The clear implication is that the threshold requirements are less stringent than the requirements for establishing a violation of the standard of care at trial.

We turn once again to the state of Connecticut that the Nevada Supreme Court relied on for further clarification. In Marshall v. Yale Podiatry Group, 496 A.2d 529 (1985), the court considered the question of whether an expert in one area of medicine can testify in a case involving allegations of against an expert in a different area of medicine where the foundation for the opinion is in the **general area of medicine**.

It turned to the court's discussion in another similar case, Fitzmaurice v. Flynn, 167 Conn. 609, 359A.2d 887 (1975).

> [T]he court found that the trial court erred in excluding the plaintiff's expert, a practicing surgeon specializing in breast cancer surgery, from testifying as to the proper medical standards of practice among obstetrician-gynecologists pertaining to breast examinations. In that case, the testimony was "that breast lump examinations are performed in exactly the same manner by obstetrician-gynecologists and surgeons; and that these two specialties are identical with respect to breast lump examination and diagnosis." Id. 615
>
> …
>
> **The threshold question of admissibility is governed by the scope of the witness' knowledge and not the artificial classification of the witness by title. Id. 618 (emphasis added.)**

Marshall, 459 A.2d at 531.

Again, in the *Marshall* case specifically relied upon by the Nevada Supreme Court in *Borger* when discussing qualified experts for purposes of NRS 41A.071, *Marshall* approvingly addressed another case, Katsetos v. Nolan, that held:

> Our appellate courts have had occasion to address this issue since that case. In Katsetos v. Nolan, 170 Conn. 637, 646-47, 368 A.2d 172 (1976), the court held that **where the evidence presented at trial showed that the treatment in question falls within the field of all medical specialties and the minimum standard of care was common to all specialties, the plaintiff's medical experts were competent to testify as to the applicable standard of care, although not specialists in the same field as the defendants**."

Marshall, 459 A.2d at 531.

While Katsetos was not specifically in the context of the pre-suit expert affidavit, the pre-suit expert requirements are **not** more stringent than the expert requirements during *trial*, but rather, the NRS 41A.071 pre-suit expert requirement is to be more liberally construed. As Marshall recognized, "The decisions allowing and excluding expert testimony in this area generally focus on the expert's familiarity with the school of medicine and the procedures involved." *Id*. at 532.

Dr. Davoren essentially made the same point during his deposition when counsel asked a line of questioning designed to preclude him from testifying because of some artificial, not legal, standard created by a board of certification. The question and answer were as follows:

> Q. Okay. Are you familiar with the statement in the physician acting as an expert witness that was sent out by the American College of Surgeons, it's dated April 1st, 2011.
>
> A. Yes. Very Familiar with it.
>
> Q. And you're familiar with their statement that in order to act as an expert witness, as a general surgeon, that you must be actively involved in clinical practice of the specialty at the time of the alleged occurrence.
>
> A. So in this case, because t**he specialty that's involved is basic general medicine, it doesn't have anything to do with specific physical medicine rehab**. **It's basic general medicine, in terms of a patient with a decreasing hemoglobin that's been documented on a blood thinner**. That is why I felt that I was qualified to render this opinion, because this is not specific to any individual specialty within medicine. But it's just general medicine knowledge. (Davoren depo pg. 22 ln. 2 thru ln. 20).

When specifically asked about the malpractice issue in this case, Dr. Davoren explained:

> Q. … How would you - - for the court, explain what you see as the issues in this case as it relates to malpractice?
>
> A. So the basis of this - - of the case, as I read the information and facts of the case, is that this patient Mr. Neason was admitted to the facility on a blood thinner. His hemoglobin was documented to decrease over the course of a number of days in precipitous fashion while on blood thinner. Despite this decrease, the blood thinner was continued up until the afternoon prior to the patient transferring emergently to St. Rose Dominican, where he expired … it was by bleeding, which was exacerbated by the Eliquis. So the crux of this case has nothing to do with the spec of any specialty. This is basic medicine that we learn in third year of medical school [that a] patient whose hemoglobin is decreasing over time in a demonstrable fashion, you have an obligation to try and determine and correct whatever the cause of that is. And that should be every discipline …

> … And the fact that blood thinners in our society, which are highly prevalent, I think numerous specialties would have the ability to identify and opine about the effects of a blood thinner whose hemoglobin is decreasing …

Id. at p.30-31.

In addition, Dr. Davoren also testified: he is president of the medical staff at Olathe Medical Center, chief of surgery, employed as a physician, and maintains clinical hours where he treats patients, operates or is in the GI lab doing colonoscopies or upper endoscopies (*id*. at p. 9-10); that his hospital has rehabilitative services and that he is actively involved in their care (*id*. at p.10-11); that he is part of the group process assessing whether a patient should receive rehabilitative services (*id*. at p.11); that a part of the treatment he interacts with the staff regularly in directing orders for the patient in their treatment (*id*. at p.12); that he has referred patients to physical medicine rehabilitation ("PMR") specialists (*id*. at p.14); that he creates and devises treatment plans for patients on whom he does surgery (*id*. at p.13); and, among other things, that he has been previously retained as an expert to render an opinion about the acts of a PMR physician by the defense counsel in the case (*Id*. at p.18-19).

Dr. Davoren is more than qualified to testify as to the standard of care required by all defendants in the subject case. It would be an absurd result to deny him the ability to present an affidavit under NRS 41A.071. An affidavit is a preliminary procedure and must be construed liberally—as opposed to the strict testifying requirements for trial. Dr. Davoren is qualified to testify as to the standard of care of Dr. Flaviano and Dr. Patel, a nurse or other healthcare providers because the malpractice issue in this case involve areas of medicine a general surgeon is trained in. The practices are therefore substantially similar under Nevada law as shown in Borger and the case upon which it relies, Marshall, when it comes to treating patients with the issues attendant to Jeffrey here. The mere fact that the malpractice occurred at a physical rehabilitation facility does not lead one to the conclusion that only a physiatrist can testify regarding the propriety of the care Jeffrey received.

Other Defendants relied primarily on Carnes v. Wairimu, 2011 Nev.Unpub. LEXIS 504 for its statement that the 'expert must be qualified to perform or render the medical procedure or

treatment being challenged as negligent.' Supplement at 7:13-14. Carnes relies upon Staccato v. Valley Hospital, 123 Nev. 526, 170 P.3d 503 (2007) concerning the qualification of an expert at the trial stage. In Staccato, the primary issue was "whether a physician is qualified to testify as to the proper standard of care in a malpractice action against a nurse when the allegedly negligent act implicates the physician's realm of expertise." *Id*. at 527, 170 P.3d at 504. In resolving this question, the Supreme Court "noted that, **in Nevada, expert qualification does not hinge on the specialty or license of the medical caregiver but, instead, turns on "whether the proposed witness's special knowledge, skill, experience, training, or education will assist the jury."** *Id*. at 531, 170 P.3d at 506; see NRS 50.275.

Thus, it held that "a physician or other medical provider is not automatically disqualified from testifying against a defendant who specializes in a different area of medicine or who practices in a different medical discipline." *Id*. at 531-32, 170 P.3d at 506-07. Consequently, the Supreme Court "**emphasized that 'the proper measure for evaluating whether a witness can testify as an expert is whether that witness possesses the skill, knowledge, or experience necessary to perform or render the medical procedure or treatment being challenged as negligent,** and whether that witness's opinion will assist the jury.'" *Id*. at 527, 170 P.3d at 504. Because the emergency room physician in Staccato was qualified to administer injections—the medical procedure or treatment at issue—the Court reversed the lower court, concluding that the physician was qualified as an expert and could offer standard-of-care testimony in relation to the nurse." *Id*. at 533, 170 P.3d at 508.

This case is like Borger, the cases discussed above from *Marshall*, and *Staccato*, in that Dr. Davoren is more than qualified and competent in the treatment being challenged as negligent here, and his training, practice, experience, skill in the negligent area is substantially similar to allow for him to provide the NRS 41A.071 affidavit as an expert witness.

C. The Court should consider Dr. Fish's Statement

As this court is aware from other pleadings and the argument of counsel, plaintiff had this matter reviewed by a physiatrist named Dr. David Fish from UCLA. His report is

attached hereto and reflects virtually the same opinion as those offered by Dr. Davoren. This is because the opinions in the subject case are based on basic medicine, not medicine or standards of care that are unique to physiatrists. Further, it was Dr. Fish who recommended Dr. Davoren to also review the case.

D. <u>Plaintiff's Second Cause of Action Should Not Be Dismissed, Instead Plaintiff Should be Allowed to Conduct Meaningful Discovery on all Potential Claims</u>

The mere fact that this mistake was made means that Defendant's employees may have not been trained properly. Negligent hiring is a direct claim against the employer and not a derivative claim as argued by the Defendant.

Defendant Dignity Select moves for dismissal of Plaintiff's claim for negligent hiring, training, and supervision. Defendant's position is that Plaintiff's claims are on the threadbare allegations, state no facts and entirely lacking in underlying support.

Plaintiff acknowledges that the filed amended complaint in this matter may lack excruciating details. However, the Court should not dismiss Plaintiff's claims, but should instead allow Plaintiff the opportunity to conduct meaningful discovery on all potential claims which is wholly and completely consistent with NRCP 8 with respect to the "notice pleading standard."

Defendant filed the instant motion and is asking this court to dismiss Plaintiff's claims prior to the disclosure of any potentially relevant documents and before either party has had an opportunity to conduct anything remotely resembling discovery.

In *Estate of Lee v. J.B. Hunt Transp., Inc.,* 308 F. Supp 2d 310 (S.D.N.Y. 2004), the Court was asked to consider a motion to dismiss *after* the parties have had an opportunity to conduct discovery on all claims. Unlike Lee, Defendants are attempting to deny Plaintiff the

opportunity to conduct meaningful discovery on all potential claims. Plaintiff intends to conduct discovery on her claim for negligent hiring, training and supervision hiring. Additionally, Defendant's Motion to Dismiss Plaintiff's Second Cause of Action is inappropriate pursuant to NRCP 12(b)(5).

E. Plantiff Stipulates to Dismissal of the Punitive Damage Claim Without Prejudice

Plaintiff is willing to stipulate that at present the facts should be built upon to justify a punitive damage claim. Accordingly, plaintiff is willing to have that cause of action dismissed without prejudice so that it might be added later should this court determine that it is appropriate.

III. CONCLUSION

Based on the foregoing, Plaintiff respectfully requests that Defendant's Motion to Dismiss Plaintiff's First Amended Complaint, be denied.

Dated this 29th day of July, 2021.

GGRM LAW FIRM

/s/ Breen Arntz

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of GGRM LAW FIRM, and that on the 29th day of July, 2021, I caused the foregoing document entitled **OPPOSITION TO DEFENDANT DIGNITY SELECT NEVADA MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT** to be served upon those persons designated by the parties in the E-service Master List for the above-referenced matter in the Eighth Judicial Court E-filing System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules, to wit:

/s/

An Employee of GGRM LAW FIRM

David E. Fish, MD, MPH

PHYSICAL MEDICINE AND REHABILITATION
PAIN MEDICINE
ELECTRODIAGNOSTIC MEDICINE

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Medical Records Review and Report

DATE OF EVALUATION: 9 / 21 / 2020

RE: Jeffrey Neason DOB: 9 / 29 / 82 Date of Death: 11/13/19 Age: 37 yrs

To Whom This May Concern:

I was asked to evaluate the medical records of Jeffrey Neason. I am currently a full-time faculty member at UCLA Medical Center. My position is Director of Physiatry and Interventional Pain Management at the UCLA Spine Center. I am board certified in Physiatry and Pain Management. I have also provided my CV.

MEDICAL and BILLING RECORDS REVIEWED

Death Certificate: 11/13/19. Cause: Complications of Colon Cancer
Community Ambulance 11/13/19: Dignity Rehab Hospital to St. Rose Siena Hospital
Comprehensive Cancer Centers of Nevada
Case Preparation Report, Embalmer Phuong Le 11/20/19
Clark Country Coroner/Medical Examiner Report 11/13/19 3:20pm
Dignity Health Rehab Hospital
Genesis Medical Group
Henderson Fire Department Prehospital Care Report Summary
Henderson Police Department Incident Report
Jackson Physical Therapy
Pueblo Medical Imaging
St Rose Hospital

Timeline:

4/5/19: Genesis medical Group: Cough, congestion, and post-nasal drip. Ordered: Sulfasalazine, Prednisone, OT cough, nebulizer

8/26/19: Genesis Medical Group: Limp when walking, neck and right shoulder pain after 7/30/19 MVA. Meds: Sulfasalazine, folic acid, Flagyl, KCl, prednisone, Vit D3

10/7/19: Genesis Medical Group: Upper back pain due to accident July 2019. Bilateral chest pain that started on 9/14 after mopping the floor. EKG reviewed. Pain muscular in nature. PT

10/21/19: Jackson PT: Therapy: Cervical, thoracic, lumbar spine, 7/30/19 MVA

10/30/19: Genesis Medical Group: Swelling and pain left neck and chest. Meds: Sulfasalazine, folic acide, Flagyl, KCL, prednisone, Vit D3, Eliquis 5mg. Ultrasound with left IJ DVT. Start Eliquis, refer to Heme Onc. CXR negative.

10/30/19: Comprehensive Cancer Center: Reason for visit: Blood clot in neck. 7/30/19 was in MVA
Medications:
Eliquis 5mg 2 tabs twice daily (Started 10/30/19)
Sulfasalazine 500mg twice daily
Prednisone 5mg 1 tab daily
Folic Acid 1mg 1 tab daily
KCL 20%
Vit D
Claritin
Metronodazole 500mg
Allergies: Zithromax

10/31/19: Comprehensive Cancer Centers of Nevada, Ratnasabapathy, MD. Newly diagnosed left jugular DVT. Swelling and redness in neck, UC with nearly occlusive thrombus in the left internal jugular vein. Hx Chron's disease, Bowel Obstruction. Meds: Sulfasalazine, Prednisone, Potassium, Eliquis. Continue Eliquis loading dose. Neck and chest CT.

11/3/19: Henderson Police Department Incident Report. Son has blood clot and on blood thinner, now has balance and vision probs. Male is only 78 lbs/special needs.

11/3/19: Henderson Fire Dept Prehospital Care Report Summary

Narrative History Text:

S: PATIENT HAS A CC OF WEAKNESS X 2 DAYS. PATIENT STATES THE WEAKNESS STARTED YESTERDAY AT 0300. HE STATES HE WAS WALKING AROUND WHEN HE BEGAN TO FEEL WEAK. PATIENT ALSO HAS A COMPLAINT OF NO APPETITE, LOSS OF COORDINATION, AND CHILLS. PATIENT STATES HE DID NOT FALL, AND DOES NOT REMEMBER ANY ABNORMAL EVENTS LEADING UP TO THIS EVENT. PATIENTS MOTHER STATES PATIENT HAD BLOOD CLOT THAT SWELLED ON HIS LEFT SIDE OF HIS NECK. MOTHER STATES HE WENT TO A CLINIC ON WEDNESDAY AND WAS PRESCRIBED ELIQUIS. PATIENT STATES THE SWELLING HAS GONE DOWN BUT HE FEELS WEAK SINCE THE START OF HIS NEW MEDICATION. PATIENT DENIED DENIED CHEST PAIN, SOB, LOC, SYNCOPE, ABDOMINAL PAIN, N/V/D, CHANGES IN URINARY OUTPUT OR BOWEL MVTS,
TRAUMA OR FALLS, ILLEGAL DRUGS, ALCOHOL INTAKE, OTHER CHANGES IN BASELINE MEDS OR DIAGNOSIS. SI OR HI

BP 121/82 9:15

11/3/19-11/8/19: St. Rose Hospital
37 year old male, hx of Crohn's Disease and Johanson-Blizzard Syndrome presents with parents for chest and back pain s/p MVA. Troponin > 7in ER, peaked to 9. Cardiology consulted, Non STEMI, Echo normal, offered left heart catherization, parents opted to treat conservatively

11/3/19: Nurse noted stroke-like symptoms with vision distortion. Neurology consult did not feels he was appropriate for TPA. Imaging negative for acute stroke. MRI offered, mother declined given claustrophobia.

Developed hypoxia, tachycardia. CXR with multifocal pneumonia, started on IV Rocephin. Parents refused azithromycin stating it worsens diarrhea.
Continued Eliquis given left neck DVT. Reduced to 5mg bid after completing 10mg BID loading.
Followed acute MI protocol, started on ASA and Lipitor. Metoprolol started, changed to Cardizem.
Continued prednisone.

Imaging St. Rose Hospital Visit
11/3/19 Echo:

SUMMARY:

1. Left ventricle: The cavity size is normal. Wall thickness is normal. Systolic function is normal. The estimated ejection fraction is 50-55%. Wall motion is normal; there are no regional wall motion abnormalities. The study is not technically sufficient to allow evaluation of LV diastolic function.
2. Left atrium: The atrium is mildly dilated.
3. Aortic valve: Thickening, consistent with sclerosis. There is mild regurgitation.

11/3/19: Xray chest

FINDINGS:
Lungs are clear without focal opacity or edema. Heart size and mediastinal contour normal. No pleural effusion or pneumothorax. No acute bony abnormality.

11/3/19: CT angio:

IMPRESSION:

No pulmonary embolism.

No consolidation, edema, nodule, mass or effusion.

Soft tissue masslike appearance in the limited visualized left lower neck and a few small lymph nodes in the mediastinum. This could be due to distended thrombosed left internal jugular vein though a lymph node or mass or mass lesions of other etiology cannot be excluded.

Very limited visualized upper abdomen raises possibility for retroperitoneal lymphadenopathy and splenomegaly. Clinical correlation with history of malignancy, lymphoma and further evaluation of the neck and abdomen may be considered.

11/4/19: CT cerebral perfusion w/contrast
Normal
11/4/19 CT Angio Head and Neck

IMPRESSION: Unremarkable CT angiogram of the head and neck.

11/4/19: CT head:

IMPRESSION:

1. Abnormal low attenuation edema involving the cortical and subcortical white matter of both occipital lobes, left greater than right, suspicious for acute ischemia/infarction. This can be seen in posterior reversible encephalopathy syndrome upper (PRES). Recommend further evaluation with MRI brain with and without contrast.
2. No acute intracranial hemorrhage.

11/6/19: CXR:
Interval development of bibasilar airspace disease concerning for multilobar pneumonia
11/7/19 CXR:
Stable multifocal pneumonia

Discharge Medications:
Atorvastatin 10mg
ASA 81 mg
Eliquis 5mg BID
Diltiazem 30mg

Prednisone 20
Sulfasalazine 500mg
KCL 3.75mL once daily
Folic Acid 1mg once daily
Claritin 5mg daily
Levalbuterol nebulizer
Ceftriazone 1gram daily
Lactobacillus
Discharge to Rehabilitation Facility 11/8/19
Vitals: 46.5, HR 105, RR 17, BP 100/63. SpO2 100%

Dignity Health Rehab Hospital 11/8/19-11/13/19
11/8/19: Flaviano, MD.
CC: Encephalopathy. H&P: Symptoms of vision distortion. Parent's refusing Axithromycin stating it worsens his diarrhea. Started on Eliquis and continued, reduced to 5mg BID. Remains on prednisone for Crohn's. With decline in function, requires 24 hr supervision.
Meds:
Tylenol 650mg
Alum, Mag Hydroxide 15ml Oral
Eliquis 5mg BID
Aspirin 81mg oral
Lipitor 10mg
Dulcolax 10mg
Rocephin 1G IV
Clonidine 0.1 q6h PRN
Diltiazem 30mg q6h
Colace 100mg BID
Pepcid 20mg BID
Floranex 1 tab TID
Folic Acid 1mg once daily
Neurontin 100mg nightly
Robitussin PRN
Hydralazine 25mg po Q6hrs
Hydroxyzine 25mg 4x daily PRN
Lactulose PRN
Levalbuterol nebulizer q4hs prn
Claritin 10mg qday
Milk of Magnesia 30ml Oral PRN
Zofran 4mg q8hrs PRN
Percocet 5/325 q4hrs PRN
Miralax PRN
Potassium Chloride 10mEg Oral Qday
Prednisone 20mg twice daily
Senna nightly PRN
Fleet enema PRN
Sulfasalazine 500mg twice daily
Trazodone 25mg nightly PRN
Vit D 1,000 units once a day

BP 114/92 **Hemoglobin/Hematocrit 11.4/32.8 11/8/19**
Plan: Therapies 3hrs/day, 5 days/week. 24hr physiatry supervision, 24 hr nursing.
"Patient's labile blood pressure, 122/76 to 119/79, places patient at risk for stroke, renal complications, and MI"

11/10/19: **H/H 9.8/28.1** (No progress note identified in records)

11/11/19: Flaviano, MD. 12.33pm Progress Note BP 111/72. Some loose stools due to Chrons. On Eliquis. "Monitor CBC"

11/11/19. Consult note Internal Medicine Patel 3:02 pm (Consult ordered 11/8/19, 19:57). "Current Hemoglobin noted to be low and patient cannot confirm if he has noticed blood in the stools." Plan: Continue ASA, Statin. Monitor HGB while on Eliquis; monitor for GI bleed."

11/12/19 0358: **H/H 7.0/20.1**
11/12/19 1220: **H/H 6.8/19.6**
11/12/19. Progress note Internal Medicine Patel: Diarrhea better. "Pt believes he still may be darker but not sure" Anemia, exacerbated by OAC. "Repeating HBG; if still low will d/c Eliquis; monitor for GI bleed; check iron studies."

11/12/19: Progress Note: Flaviano, MD 4:27 pm. BP 105/77. Team conference. "WBC elevated on steroids. Monitoring HGB. Stop Apizxaban."

11/12/19: Speech: "I am really tired today"

11/12/19 3:40pm: Sweety RN: Spoke with Dr. Patel to relate Stat hemoglobin 6.8. Given orders to discontinue Eliquis and Aspirin, repeat labs ordered to tomorrow AM. No other orders at this time.

11/12/19: Cunanan, RN 8:30pm: Eliquis and Aspirin discontinued. "Arlis mentioned brought son'/pt's clothes home to launder, noticed dark, black stool residue on pants.

11/13/19 0559: **H/H 4.5/13.3**

1/13/19 10:54 am. Nursing note, Murray RN: Pt found on floor in bathroom with black tarry stool. Patient reported he feels like passing out so he sat on the floor. BP 80/50, tachycardiac with HR 127.

11/13/19: 10:56am: Nursing note Cruz, RN: "Pt picked up by ambulance via Gurnee. Appears to be awake, pale looking."

11/13/19: Flaviano, MD Progress Note 11:53am
Team conference. Black Tarry stools, drop in BP. Transferred acutely to ER. BP 100/62

DC Summary 11/13/19: "Preceding events led to patient's decline in function. Acute physical therapy and occupational therapy failed to return patient back to prior level of function." "Drop in HGB monitored as gross bleed monitored. On 11/13/19 patient had black tarry stools and drop in blood pressure. He was transferred acutely to the ER.":Monitor CBC. Drop in NGB monitored as gross bleeding monitored, On 11/13/19 patient had black tarry stools and drop in blood pressure. He was transferred acutely to the ER"

Labs:
Hemoglobin/Hematocrit:

11/8/19:	11.4/32.9
11/10/19:	**9.8/28.1**
11/12/19 0358:	**7.0/20.1**
11/12/19 1220:	**6.8/19.6**
11/13/19 0559:	**4.5/13.3**

Vitals:
BP
11/9/19: 108-119/70-83
11/10/19: 98-108/60-70
11/11/19: 105-128/66-72
11/12/19:101-105/55-77
11/13/19: 98-106/62-63

Community Ambulance 11/13/19: Dignity Rehab Hospital to St. Rose Siena Hospital

Narrative History Text:

U/A REPORT AND PAPERWORK GIVEN BY RN. PER RN THE PT HAD A SYNCOPAL EPISODE IN THE RESTROOM. THEIR INITIAL BP SHOWED 82/52 WITH A HEART RATE OF 127. THE PT IS AT THE REHAB FACILITY FOR HAVING STROKE LIKE SYMPTOMS AND DEVELOPING PNEUMONIA WHILE HE WAS IN THE HOSPITAL. HE THEN WAS SENT TO THE REHAB FACILITY. THE PT IS BEING SENT TO ST. ROSE SIENA ER FOR HIGHER LEVEL OF CARE.

I FOUND THE PT IN BED AT THE FACILITY. THE PT IS A/O X4. THE PT IS PALE AND DRY. THE PT DENIES ANY PAIN OR DISCOMFORT. THE PT DENIES CP, SOB, N/V/D, OR DIAPHORESIS. PER ANOTHER RN THE PT WAS BEING ASSISTED IN THE RESTROOM WHEN HE WAS FEELING FAINT. HE WAS HELPED TO HIS KNEE SO HE WOULDN'T FALL TO THE FLOOR. THE PT NEVER HAD A LOSS OF CONSCIOUSNESS. THE PT WAS ASSISTED BACK INTO BED PTA OF EMS. WE PLACED THE GURNEY NEXT TO THE BED AND LIFTED THE PT OVER TO THE GURNEY. PT SECURED TO THE GURNEY WITH SHOULDER STRAPS AND LAP BELTS. V/S OBTAINED. 3 LEAD AND 12 LEAD OBTAINED. THE MONITOR SHOWED SINUS TACHYCARDIA. WE TOOK THE PT DOWN TO THE AMBULANCE AND LOADED HIM INTO THE BACK. I GAVE A TELEMETRY REPORT TO ST. ROSE SIENA ER. I CONTINUED TO MONITOR THE PT DURING THE VERY SHORT TRANSPORT ACROSS THE PARKING LOT TO THE AMBULANCE ENTRANCE AT THE ER. NO CHANGES IN PT CONDITION NOTED. THE PT ATTEMPTED TO SING THE EPCR A FEW TIMES, BUT WAS UNABLE TO COMPLETE A SIGNATURE. PT TRANSFERRED TO ER BED A11. REPORT AND PAPERWORK GIVEN TO RN.

Death Certificate: 11/13/19. Cause: “Complications of Colon Cancer”

Clark County Coroner/Medical Examiner Report 11/13/19 3:20pm: Location and date of incident: 7/30/19 Silverado Ranch Boulevard and War Horse Way

MEDICAL IMAGING

8/26/19: Xray C spine Pueblo Medical Imaging

IMPRESSION:
1. Reversal of the normal cervical lordosis which can be seen in setting of muscle spasm or patient positioning.
2. No acute osseus abnormality of the cervical spine.

8/26/19: Xray Right Hip Pueblo Medical Imaging

IMPRESSION:
No evidence of fracture or dislocation.

8/26/19: Xray right shoulder Pueblo Medical Imagin

IMPRESSION:
No evidence of fracture or dislocation.

10/30/19: US Soft Tissue, Pueblo Medical Imaging
DVT left internal jugular vein

10/30/19: Chest Xray, Pueblo Medical Imaging
Unremarkable

COMMENTARY AND MEDICAL DECISION MAKING:

I am evaluating the medical records of Jeffrey Neason for evaluation purposes only. All records sent to me are reviewed for the purpose of a medical decision based upon the events and records outlined above. The opinions of this report are within a reasonable degree of medical probability and are based upon my review and examination of the evidence in the medical records provided to me. All of my opinions have been rendered with a reasonable degree of medical probability but are preliminary to the extent that there is relevant information that I have not yet had the opportunity to review.

My opinions in regards to Jeffrey Neason are based upon my clinical experience as an active treating Physiatrist who specializes and is boarded in Physiatry, Pain Medicine, and Electrodiagnostic Medicine. I am currently on staff at the UCLA School of Medicine in the UCLA Spine Center and the UCLA Medical Center. I am involved with resident and fellowship training of physicians at UCLA and must maintain updated and clinically relevant evidence-based guidelines for treatment of patients that fall within the standards of care. Based upon my review of the records available to me, I would make the following opinions to a reasonable degree of medical probability based on events and medical evidence:

Based on my review of medical records above, medical staff at Dignity Hospital Rehabilitation Center did not meet standard of care on 11/10/10, 11/11/19, 11/12/19, and 11/13/19, and this directly led to the subsequent events on 11/13/19, and unfortunately, Jeffrey's Neason's death.

1) **Failure to adequately identify that Jeffrey Neason had a number of concurrent risk factors placing him at HIGH RISK for a GI bleed:**
    a. hx of Chron's disease
    b. oral steroids (increase risk of ulcers and GI bleed)
    c. aspirin (increases risk of GI bleed)
    d. Eliquis is an anticoagulant, thus increasing the risk of bleeding

    - Each of these factors individually increase risks of a GI bleed, and in combination would increase risk even more. Despite this, the Rehabilitation Facility PM&R physician and Internal Medicine Physician did not recognize Jeffrey Neason's presentation and clear evidence from laboratory data as a potentially life-threatening situation.

2) **Failure to identify and act upon laboratory evidence indicating an active bleed**
    - Labs on 11/10/19 shows a drop in hemoglobin to 9.8 from 11.4 on 11/8/19, and hematocrit of 28.1 from 32.9. Particularly for this patient who is on an antiplatelet agent (ASA), anticoagulation (Eliquis), chronic steroids, and Chron's disease, this drop of almost 2 points

hemoglobin at the very least should have warranted a recheck of labs, and if they remained low, an immediate workup should have been initiated on 11/10/19

3) **Failure to redraw labs in a timely manner, even after potential for GI bleed was recognized**
   - Labs were not drawn again until two days later, on 11/12/19. For a drop in hemoglobin and hematocrit in a patient with these risk factors, close follow-up and trending of labs would be standard of care.

4) **Failure to immediately stop any agents contributing to a potential bleed in a timely manner**
   - With these risk factors and a decrease in hemoglobin and hematocrit, one immediate step would also be to stop any medications contributing to the bleed, including Eliquis and ASA. These were not stopped until 11/12/19

5) **Significant delay in Internal Medicine Consultation**
   - Records indicate that although order was placed on 11/8/19 at 7:57 pm for Internal Medicine Consultation, this consultation did not happen until 11/11/19, and note was not signed until 11/11/19 at 3:02pm.

6) **Failure to provide reasonable testing and/or workup to evaluate for a GI bleed**
   - Despite a clear downward trend in labs, and several notes indicating that this was concern, no Guaic Test or FOBT (Fecal Occult Blood Test) was performed, which would have been easy ways to determine if was any blood in Mr. Neason's stool. Instead, providers relied on asking the patient, who just had an MI and possible stroke, and did not remember if he had any darker stools or not.

7) **Failure to recognize a critical lab value and immediately transfer to acute care on 11/12/19**
   - Repeat labs on 11/12/19 showed a significant drop in hemoglobin and hematocrit, to 7.0 and 20.1. This reflected greater than 4 point drop in hemoglobin, and over 8 point drop in hematocrit, clearly indicating an acute and significant loss of blood. This lab was reported at 4am on 11/12/19. Combined with the prior results from 10/10/19, it is clear that Mr. Neason at this time had a significant bleed. Standard of care at this time, with this result, would be to immediately transfer Mr. Neason to the emergency room for further emergent workup and treatment, including possible transfusion.
   - A STAT hemoglobin result of 6.8 was relayed to the internal medicine consultation physician at 3:40 pm on 11/12/19. Rather than immediate transfer to ER, orders were given only to stop Eliquis and Aspirin, and repeat labs again the next morning. No other orders were given – no further workup was done to evaluate for an acute GI bleed.

8) **Failure to recognize even more urgent critical lab value and immediately transfer to acute care on 11/13/19**
   - Labs from 5:59 am on 11/13/19 showed an even more critical hemoglobin of 4.5, with a continued precipitous and life-threatening trend downward. It was not until 10:54 am, 5 hours after this urgently critical lab was reported, and 23 hours after the critical 6.8 result, that patient was eventually transferred to the ER.

The medical and professional opinions expressed within this report are unique and specific to the factual circumstances of this individual case and therefore may not apply to other cases or factual scenarios.

David E. Fish, MD, MPH
Chief, Division of Interventional Pain Physiatry
Professor, UCLA Department of Orthopaedic Surgery
Physical Medicine and Rehabilitation, The UCLA Spine Center
Electrodiagnostic Medicine, Pain Medicine, Sports Medicine
UCLA School of Medicine

EXHIBIT 17

ELECTRONICALLY SERVED
9/9/2021 5:23 PM

Electronically Filed
09/09/2021 5:23 PM
CLERK OF THE COURT

NODR

DISTRICT COURT
CLARK COUNTY, NEVADA

ARLIS NEASON, et. al., v. CASIANO FLAVIANO, M.D., et. al.,	Case No.: A-20-824585-C Department 1

NOTICE OF DEPARTMENT REASSIGNMENT

PLEASE TAKE NOTICE that Pursuant to Administrative Order 21-06; the above-entitled action was reassigned to Honorable Judge Bita Yeager, in District Court Department 1.

Please update your records and incorporate the correct department in your filings.

Furthermore, please take notice the previously scheduled hearings may have been re-scheduled. **Please log into the Odyssey online portal at least a week before your hearing to keep up-to-date information on your case as hearings may have been re-scheduled.** A Notice of Change of Hearing should be filed by the Department if that occurs.

https://www.clarkcountycourts.us/Anonymous/default.aspx

If you have an upcoming hearing with Dept. 1, the Bluejeans login information that will be used is below. Please login at least 15 minutes before your hearing and check in with the Court Clerk, so that they are aware of your presence.

Dated this 9th day of September, 2021

Bita Yeager

04A 6F5 FEEC 6181
Bita Yeager
District Court Judge

BLUEJEANS INSTRUCTIONS:
Meeting URL: https://bluejeans.com/234538947
Meeting ID: 234 538 947

Want to dial in from a phone?
Dial one of the following numbers:
+1.408.419.1715 (United States(San Jose))
+1.408.915.6290 (United States(San Jose))
Enter the meeting ID followed by #

Bita Yeager
Eighth Judicial
District Court
Clark County,
Nevada
Department I

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Arlis Neason, Plaintiff(s) vs. Casiano Flaviano, M.D., Defendant(s)	CASE NO: A-20-824585-C DEPT. NO. Department 1

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Notice of Department Reassignment was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 9/9/2021

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Kellie Piet	kpiet@mcbridehall.com
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Breen Arntz	breenarntz@me.com
Breen Arntz	breen@breen.com
Gianna Mosley	gmosley@ggrmlawfirm.com
Ryan Loosvelt	rloosvelt@ggrmlawfirm.com
Lauren Smith	lsmith@mcbridehall.com

EXHIBIT 18

ELECTRONICALLY SERVED
10/11/2021 3:07 PM

Electronically Filed
10/11/2021 3:07 PM
CLERK OF THE COURT

ORDR
DILLON G. COIL, ESQ.
Nevada Bar No. 11541
RYAN LOOSVELT, ESQ.
Nevada Bar No. 8550
GGRM LAW FIRM
2770 S. Maryland Pkwy., Ste. 100
Las Vegas, NV 89109
Phone: 702. 384.1616 Fax: 702.384.2990
Email: dcoil@ggrmlawfirm.com
Attorneys for Plaintiff

DISTRICT COURT

CLARK COUNTY, NEVADA

ARLIS NEASON, as Heir of the Estate of JEFFREY NEASON, Plaintiff, vs. DIGNITY SELECT NEVADA, LLC, a foreign limited-liability company; CASIANO R. FLAVIANO, MD; SUSHIL R. PATEL, MD; DOES I through X; and ROE BUSINESS ENTITIES I through X; inclusive, Defendants.	CASE NO.: A-20-824585-C DEPT. NO.: I **ORDER DENYING IN PART DEFENDANT FLAVIANO'S MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT, DEFENDANT PATEL'S JOINDER, AND DEFENDANT DIGNITY SELECT'S MOTION TO DISMISS AND JOINDER, AND, GRANTING IN PART DEFENDANT DIGNITY SELECT'S MOTION TO DISMISS WITHOUT PREJUDICE**

This matter came on for hearing on September 23, 2021, at 9:00 a.m. Ryan A. Loosvelt of GGRM Law Firm appeared for Plaintiff ARLIS NEASON, as Heir of the Estate of JEFFREY NEASON ("Plaintiff"), Katherine Gordon of Lewis Brisbois Bisgaard & Smith LLP appeared for CASIANO R. FLAVIANO, MD ("Flaviano"), Sean M. Kelly of McBride Hall appeared for Defendant SUSHIL R. PATEL, MD ("Patel"), and Dione C. Wrenn of Gordon Rees Scully Mansukhani, LLP appeared for Defendant DIGNITY SELECT NEVADA, LLC ("Dignity Select").

Case Number: A-20-824585-C

This Court, having considered the pleadings and papers on file, heard oral argument, and for other good cause appearing, hereby ORDERS as follows:

Plaintiff filed a First Amended Complaint on January 14, 2021 against Defendants Dignity Select, Dr. Flaviano, and Dr. Patel, attaching an NRS 41A.071 Affidavit of Dr. Michael Davoren, asserting claims styled as Medical Negligence/Malpractice and Negligent Hiring, Retention, Supervision against Defendants, that also alleged punitive damage relief.

Defendant Flaviano filed a January 20, 2021 Motion to Dismiss Plaintiff's First Amended Complaint and Defendant Patel filed a January 25, 2021 Joinder to Motion. Plaintiff filed an Opposition, Defendant Flaviano filed a Reply, and Defendant Patel filed a Joinder to Reply.

The pending Flaviano Motion and Patel Joinder was initially heard February 23, 2021. On March 8, 2021, the Court entered an order Granting in Part and Deferring in Part the Flaviano Motion and Patel Joinder. Specifically, the Court's March 8, 2021 Order:

- Granted Flaviano's Motion to Dismiss and Patel's Joinder as to the negligent hiring, retention and supervision claim against them, without prejudice;
- Granted Flaviano's Motion to Dismiss and Patel's Joinder as to the request for punitive damages against them, without prejudice; and,
- Deferred the Flaviano Motion to Dismiss and Patel Joinder as to Plaintiff's claims for medical malpractice for Defendants to conduct limited discovery related to the issue of whether Plaintiff's proposed expert, Michael Davoren, M.D. fulfills the requirements of N.R.S. 41A.071, directing the parties to use their best efforts to complete the discovery and file supplements to the Motion, Joinder, and Opposition.

Defendant Dignity Select filed an April 5, 2021 Limited Joinder to Defendant Flaviano's Motion and an April 30, 2021 Motion to Dismiss Plaintiff's First Amended Complaint.

Dr. Davoren's deposition was taken with all Defendants present. Defendant Flaviano then filed a May 28, 2021 Supplemental Memorandum of Points and Authorities in support of its Motion to Dismiss, Defendant Patel filed a Joinder, and Plaintiff filed a Supplemental Opposition. Defendant Dignity Select also filed a Joinder in Defendant Flaviano's Supplement.

Plaintiff filed an Opposition to Dignity Select's Motion to Dismiss and Defendant Dignity Select filed a Reply.

The pending matters were heard September 23, 2021. All three Defendants argued Dr. Davoren's affidavit is insufficient under NRS 41A.071, which Plaintiff opposed.

NRS 41A.071 provides that an affidavit of medical expert must be submitted with an action for professional negligence "by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged professional negligence." "[T]he expert affidavit requirements of NRS 41A.071 are designed to account for the abolition of the screening panels and to ensure that parties file malpractice cases in good faith, i.e., to prevent the filing of frivolous lawsuits." *Borger v. District Court*, 120 Nev. 1021, 1026, 102 P.3d 600, 604 (2004).

"The Legislature has not provided an explanation or guidance for courts to resolve disputes over whether an affiant practices in an area that is 'substantially similar to the type of practice engaged in at the time of the alleged malpractice.'" *Borger*, 120 Nev. at 1027. "However, in addressing a similarly worded testimonial requirement, the Connecticut Appellate Court has held that 'the threshold question of admissibility is governed by the scope of the witness' knowledge and not the artificial classification of the witness by title.'" *Id*. at 1027-1028. "[T]he Connecticut view provides a partial framework for our interpretation of NRS 41A.071." *Id*. at 1028.

"The legislation allows medical experts to testify in medical malpractice cases where their present or former practice reasonably relates to that engaged in by the defendant at the time of the alleged professional negligence." *Id*. "[T]he statute does not require that the affiant practice in the same area of medicine as the defendant; rather, it requires that the

affiant practice in an area 'substantially similar' to that in which the defendant engaged, giving rise to the malpractice action." *Id*. "[B]ecause NRS 41A.071 governs the threshold requirements for initial pleadings in medical malpractice cases, not the ultimate trial of such matters, we must liberally construe this procedural rule of pleading in a manner that is consistent with our NRCP 12 jurisprudence." *Id*.

The Court finds the Plaintiff's medical expert affidavit by Dr. Davoren is sufficient and meets the standards of NRS 41A.071.

In addition, Defendant Dignity Select argued Plaintiff has not alleged sufficient facts at this stage under Rule 12(b)(5) to state a claim for negligent hiring, retention and supervision or as to the punitive damage relief, which Plaintiff argues, among other things, if dismissed, should be without prejudice.

The Court finds sufficient facts are not currently alleged as to Plaintiff's claims for negligent hiring, retention and supervision or as to the punitive damage relief against Dignity Select and dismisses the claim and relief without prejudice to bringing them later in the case.

IT IS THEREFORE HEREBY ORDERED, ADJUDGED AND DECREED that Defendant Casiano R. Flaviano, M.D.'s Motion to Dismiss and Supplement, Defendant Sushil R. Patel, M.D.'s Joinders, Defendant Dignity Select Nevada, LLC's Motion to Dismiss and Joinder, as they pertain to dismissal of Plaintiff's medical negligence/malpractice claims for the alleged insufficiency of the affidavit under NRS 41A.071 are **DENIED** and such claims allowed to proceed against the Defendants.

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IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Defendant Dignity Select Nevada, LLC's Motion to Dismiss and Joinder as they pertain to dismissal of Plaintiff's negligent hiring, retention and supervision claim and as to the punitive damage relief against it is **GRANTED WITHOUT PREJUDICE** as to both issues.

IT IS SO ORDERED.

DATED this 11th day of October, 2021.

Dated this 11th day of October, 2021

Bita Yeager

DISTRICT COURT JUDGE
5DA 1FE 34DC 6BAB
Bita Yeager
District Court Judge

Respectfully submitted by
GGRM LAW FIRM
Dated this 11th of October, 2021

/s/ *Ryan Loosvelt*

RYAN LOOSVELT, ESQ.
Nevada Bar No. 8550
2770 S. Maryland Pkwy., Ste. 100
Las Vegas, NV 89109
Attorneys for Plaintiff

Approved as to Form and Content by
McBRIDE HALL
Dated this 11th day of October, 2021

/s/ *Sean M. Kelly*

SEAN M. KELLY, ESQ.
Nevada Bar No. 10102
8329 W. Sunset Road, Ste. 260
Las Vegs, NV 89113
Attorneys for Defendant Sushi Patel,MD

Approved as to Form and Content by
LEWIS BRISBOIS BISGAARD & SMIITH LLP
Dated this 11th day of October, 2021

/s/ *Katherine J. Gordon*

KATHERINE J. GORDON
Nevada Bar No. 5813
LEWIS BRISBOIS BISGAARD
& SMITH LLP
6385 S. Rainbow Boulevard,
Suite 600
Las Vegas, NV 89118
Tel. 702.893.3383
Attorneys for Defendant Casiano Flaviano, M.D.

Approved as to Form and Content by
GORDON REES SCULLY MANSUKHANI LLP
Dated this 11th day of October , 2021

/s/ *Dione C. Wrenn*

DIONE C. WRENN, ESQ.
Nevada Bar No. 13285
300 South 4th Street, Suite 1550
Las Vegas, Nevada 89101
Attorneys for Defendant,
Dignity Select Nevada, LLC

CERTIFICATE OF SERVICE

I hereby certify that I am an employee of GGRM LAW FIRM, and that on the 11th day of October, 2021, I caused the foregoing document entitled **ORDER DENYING IN PART DEFENDANT FLAVIANO'S MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT, DEFENDANT PATEL'S JOINDER, AND DEFENDANT DIGNITY SELECT'S MOTION TO DISMISS AND JOINDER, AND, GRANTING IN PART DEFENDANT DIGNITY SELECT'S MOTION TO DISMISS WITHOUT PREJUDICE** to be served upon those persons designated by the parties in the E-service Master List for the above-referenced matter in the Eighth Judicial Court E-filing System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules.

/s/ *Rebeca Guardado*

An Employee of GGRM LAW FIRM

Rebeca Guardado

From: Gordon, Katherine <Katherine.Gordon@lewisbrisbois.com>
Sent: Monday, October 11, 2021 8:23 AM
To: Ryan Loosvelt; Dione Wrenn; smkelly@mcbridehall.com
Cc: Dillon Coil; Gianna Mosley
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

You may use my e-signature on behalf of Dr. Flaviano.
Thanks-
Katie

LEWIS BRISBOIS

Katherine J. Gordon
Partner
Katherine.Gordon@lewisbrisbois.com

T: 702.693.4336 F: 702.893.3789

6385 South Rainbow Blvd., Suite 600, Las Vegas, NV 89118 | **LewisBrisbois.com**

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Monday, October 11, 2021 8:20 AM
To: Dione Wrenn <dwrenn@grsm.com>; Gordon, Katherine <Katherine.Gordon@lewisbrisbois.com>; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: [EXT] RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

All, the court will require all parties re-confirm consent to the attached revised order by Dignity Select that corrects it name, including a response by Dignity Select. Please respond today if possible. Thank you,

Ryan Loosvelt
GGRM Law Firm

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Wednesday, October 6, 2021 6:03 PM
To: Dione Wrenn <dwrenn@grsm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Thanks. These are acceptable to Plaintiff correcting yours and your client's name.

From: Dione Wrenn <dwrenn@grsm.com>
Sent: Wednesday, October 6, 2021 4:37 PM
To: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Hi Ryan –

The attached has my redlines.

DIONE C. WRENN, ESQ. | Senior Counsel

300 South Fourth Street, Suite 1550
Las Vegas, NV 89101
D: 702-577-9304 | dwrenn@grsm.com

www.grsm.com
vCard | Bio

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Wednesday, October 6, 2021 3:58 PM
To: Katherine.Gordon@lewisbrisbois.com; Dione Wrenn <dwrenn@grsm.com>; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Counsel, following up on the proposed order for comment or approval by tomorrow. Thank you,

Ryan Loosvelt

From: Ryan Loosvelt
Sent: Tuesday, October 5, 2021 2:25 PM
To: Katherine.Gordon@lewisbrisbois.com; dwrenn@grsm.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Counsel, attached is a draft proposed order on the MTDs and Joinders. Please provide comments or approval to affix your e-signatures.

Thank you,

GGRM LAW FIRM INJURY ATTORNEYS

Ryan Loosvelt
Attorney
O: 702.384.1616 | F: 702.384.2990 | www.ggrmlawfirm.com
2770 S. Maryland Pkwy., Ste. 100 Las Vegas, NV 89109

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Rebeca Guardado

From: Sean M. Kelly <smkelly@mcbridehall.com>
Sent: Monday, October 11, 2021 8:28 AM
To: Ryan Loosvelt; Dione Wrenn; Katherine.Gordon@lewisbrisbois.com
Cc: Dillon Coil; Gianna Mosley
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

You can use my e-signature.

Thank you,

Sean M. Kelly, Esq.
smkelly@mcbridehall.com | www.mcbridehall.com

8329 West Sunset Road
Suite 260
Las Vegas, Nevada 89113
Telephone: (702) 792-5855
Facsimile: (702) 796-5855

MCBRIDE HALL
ATTORNEYS AT LAW

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Monday, October 11, 2021 8:20 AM
To: Dione Wrenn <dwrenn@grsm.com>; Katherine.Gordon@lewisbrisbois.com; Sean M. Kelly <smkelly@mcbridehall.com>
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

All, the court will require all parties re-confirm consent to the attached revised order by Dignity Select that corrects it name, including a response by Dignity Select. Please respond today if possible. Thank you,

Ryan Loosvelt
GGRM Law Firm

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Wednesday, October 6, 2021 6:03 PM
To: Dione Wrenn <dwrenn@grsm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Thanks. These are acceptable to Plaintiff correcting yours and your client's name.

From: Dione Wrenn <dwrenn@grsm.com>
Sent: Wednesday, October 6, 2021 4:37 PM
To: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Hi Ryan –

The attached has my redlines.

DIONE C. WRENN, ESQ. | Senior Counsel

300 South Fourth Street, Suite 1550
Las Vegas, NV 89101
D: 702-577-9304 | dwrenn@grsm.com

www.grsm.com
vCard | Bio

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Wednesday, October 6, 2021 3:58 PM
To: Katherine.Gordon@lewisbrisbois.com; Dione Wrenn <dwrenn@grsm.com>; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Counsel, following up on the proposed order for comment or approval by tomorrow. Thank you,

Ryan Loosvelt

From: Ryan Loosvelt
Sent: Tuesday, October 5, 2021 2:25 PM
To: Katherine.Gordon@lewisbrisbois.com; dwrenn@grsm.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Counsel, attached is a draft proposed order on the MTDs and Joinders. Please provide comments or approval to affix your e-signatures.

Thank you,

GGRM LAW FIRM INJURY ATTORNEYS

Ryan Loosvelt
Attorney
O: 702.384.1616 | F: 702.384.2990 | www.ggrmlawfirm.com
2770 S. Maryland Pkwy., Ste. 100 Las Vegas, NV 89109

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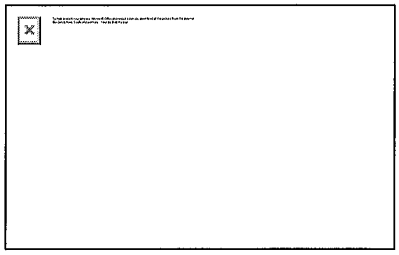
Rebeca Guardado

From: Dione Wrenn <dwrenn@grsm.com>
Sent: Monday, October 11, 2021 8:35 AM
To: Ryan Loosvelt; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil; Gianna Mosley
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

You may file with my e-signature.



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From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Monday, October 11, 2021 8:20 AM
To: Dione Wrenn <dwrenn@grsm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

All, the court will require all parties re-confirm consent to the attached revised order by Dignity Select that corrects it name, including a response by Dignity Select. Please respond today if possible. Thank you,

Ryan Loosvelt
GGRM Law Firm

From: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>
Sent: Wednesday, October 6, 2021 6:03 PM
To: Dione Wrenn <dwrenn@grsm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Thanks. These are acceptable to Plaintiff correcting yours and your client's name.

From: Dione Wrenn <dwrenn@grsm.com>
Sent: Wednesday, October 6, 2021 4:37 PM
To: Ryan Loosvelt <rloosvelt@ggrmlawfirm.com>; Katherine.Gordon@lewisbrisbois.com; smkelly@mcbridehall.com
Cc: Dillon Coil <dcoil@ggrmlawfirm.com>; Gianna Mosley <gmosley@ggrmlawfirm.com>
Subject: RE: Neason v. Flaviano, Patel, Dignity Health re: proposed order

Hi Ryan –

The attached has my redlines.

DIONE C. WRENN, ESQ. | Senior Counsel

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Las Vegas, NV 89101
D: 702-577-9304 | dwrenn@grsm.com

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Thank you,

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Attorney
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2770 S. Maryland Pkwy., Ste. 100 Las Vegas, NV 89109

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Arlis Neason, Plaintiff(s) vs. Casiano Flaviano, M.D., Defendant(s)	CASE NO: A-20-824585-C DEPT. NO. Department 1

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Denying Motion was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 10/11/2021

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