

ALPHABETICAL INDEX TO PETITIONER'S APPENDIX

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2	Defendant NNRH's Motions in Limine	
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10	dba Northeastern Nevada Regional Hospital's	Vol. 5/PA. 899-1080
11	Motion for Partial Summary Judgment	
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13	Plaintiff's Third Amended Complaint	Vol. 3/PA. 446 - 529
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HALL PRANGLE & SCHOONVELD, LLC
1140 NORTH TOWN CENTER DRIVE, STE. 350
LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400
FACSIMILE: 702-384-6025

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 31st day of October 2022, I served a true and correct copy of the foregoing **PETITIONER’S APPENDIX TO THE PETITION FOR WRIT OF MANDAMUS** via USPS mail and/or E-Service Master List for the above referenced matter in the Nevada Supreme Court e-filing System in accordance with the electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules, to the following:

Sean Claggett, Esq.
Jennifer Morales, Esq.
Shirley Blazich, Esq.
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Email: jmorales@claggettlaw.com
Email: sblazich@claggettlaw.com
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Las Vegas, NV 89113

Honorable Kriston N. Hill
Elko County Courthouse
571 Idaho Street
Elko, Nevada 89801
Tel: 775.753.4601

HALL PRANGLE & SCHOONVELD, LLC
1140 NORTH TOWN CENTER DRIVE, STE. 350
LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400
FACSIMILE: 702-384-6025

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Tel: 702.792.5855
Fax: 702.796.5855
Email: rmcbride@mcbridehall.com
Email: crhueth@mcbridehall.com
Attorneys for Defendant Ruby Crest

Fax: 775.753.4611

EXHIBIT 14

4827-4619-5248.1

PA. 1

9.27.2018
NEN000006



Professional Document Retrieval

2450 W. Osborn Rd.,
Phoenix, AZ 85015
Ph. 602.322.0200
Fax. 602.258.4965

ProDox Order No: 458718-001

To: Lewis, Brisbois, Bisgaard & Smith
Attn: Maceo, Butler
6385 S Rainbow Boulevard Suite 600
Las Vegas, NV 89118

Patient Name: Douglas Schwartz
File Number: 38406-24
Case Name: v
Case Number:
Record Type: Paramedic
Records Obtained From: Elko County Ambulance
Records Attached: Paramedic

Order Online at www.prodox.net

CUSTODIAN OF RECORDS CERTIFICATION

0207

458718 1

I am over the age of 18 and the duly authorized custodian of records for:

Elko County Ambulance
540 Court Street Suite 101
Elko, NV 89801

I have the authority to certify the records pertaining to:

Records Of: Douglas Schwartz

Alias:

DOB: 06/02/1958

SSN:

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

A) CERTIFICATION OF RECORDS/MATERIALS:

The records provided to ProDox are true and complete copies of all records requested. No documents have been withheld in order to avoid their being copied. To the best of my knowledge, all such records were prepared or compiled by personnel of our office or given to personnel of ProDox to be copied in the ordinary course of business, at or near the time of the acts, conditions or events recorded.

Records/Items Produced:

Paramedic

Exceptions:

B) AFFIDAVIT OF NO RECORDS/MATERIALS, (and the following applies):

- A thorough search of our files, carried out under my direction using the specific information provided in your request revealed no documents, records, or other materials or images. It is to be understood that this does not mean that records do not exist under another spelling, name, or other classification.
All records as described in your request were destroyed/purged in accordance with our document retention policy. Records are maintained for ___ years.
All records named in your request were lost, stolen or damaged beyond repair.
Other

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

Custodian Name (Print)

Signature of Custodian of Records

Subscribed and sworn to before me this ___ Day of ___, 20___

Notary Public

My Commission Expires

I do not have a notary available to me, and I am outside of the ProDox service area.

(ProDox Office Use Only)

These documents have been prepared by a representative of ProDox and by signing below I declare the attached are true and complete copies of the documents provided by the Custodian.

ProDox Representative

Date

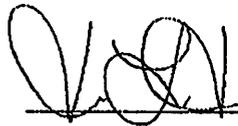
DECLARATION

I, Victoria Vanich, declarant, hereby say and declare as follows:

1. That the Declarant is the Custodian of Records of Elko Co. Ambulance
2. That on 28 day of June, 2018, the Declarant was served a Medical Records Request in connection with the above -entitled cause, calling for the production of records pertaining to: Douglas Schwartz.
3. That the Declarant has examined the original of those records and has made or has caused to be made a true and exact copy of them and that the reproduction of them attached hereto is true and complete.
4. That the original of those records was made a or near the time of the act, event, condition, opinion, diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of regularly conducted activity of the Declarant or Elko County Ambulance.

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

Executed on: 12 day of July, 2018.

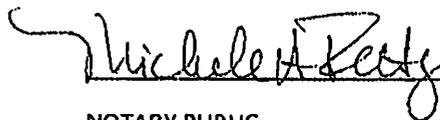


DECLARANT

STATE OF Nevada

COUNTY OF Elko

Subscribed and sworn to before me, a notary public in and for said county, this 12th day of July, 2018.



NOTARY PUBLIC

My commission expires: 8-11-18

Incident EA16-2256
Number:
EMS Unit 939
Call Sign:

Patient Name: Schwartz, Douglas

Patient 68ffb27070654b639ee678a
Care
Report
Number:

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

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

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

Past Medical History

Medication Allergies

Medication Allergies

No Known Drug Allergy

Medical History: CV - Primary
Hypertension

Assessment Exam

Incident #: EA16-2256

Patient Name: Schwartz, Douglas

Date 06/29/2018
Printed: 10:40

Incident EA16-2256
 Number:
 EMS Unit 939
 Call Sign:

Patient Name: Schwartz, Douglas

Patient 68ffb27070654b639ee678a
 Care
 Report
 Number:
 Initial Emergent
 Patient (Yellow)
 Acuity:

Provider's Acute
 Primary pain
 Impression: due to
 trauma

Patient Condition

Alcohol/Drug Use: None Reported
 Primary Symptom: Fracture of rib(s), sternum and thoracic spine

Activities

Medications

Time	Crew	Medication	Route	Dosage	Response	PTA
20:29:00	Anderson, Josh (17542)	Oxygen		4 Liters (l)	Improved	No
20:39:11	Rader, Darcie (911)	Fentanyl	Intravenous (IV)	100 Micrograms (mcg)	Improved	No
20:40:16	Rader, Darcie (911)	Ondansetron (Zofran)	Intravenous (IV)	4 Milligrams (mg)	Improved	No

Procedures

Time	Crew	Name	Location	Size of Equipment	Attempts	Response	Success
20:35:32	Rader, Darcie (911)	Establish Intravenous Access (IV)	Hand-Left	20	1	Unchanged	Yes

Vitals

Time	BP	Pulse	Resp	SpO2	Qual
20:30:52	156 / 92	74	16	90	
20:42:39	176 / 94	74	14	94	O2
20:47:32	167 / 89	72	14	94	

EKG

Time	Medical Device Event Type	ECG Cardiac Rhythm
20:32:39	ECG-Monitor	NSR - Normal Sinus Rhythm

Incident #: EA16-2256

Patient Name: Schwartz, Douglas

Date 06/29/2018
 Printed: 10:40

Incident EA16-2256
Number:
EMS Unit 939
Call Sign:

Patient Name: Schwartz, Douglas

Patient 68ffb27070654b639ee678a
Care
Report
Number:

Controlled Substances

Controlled Substance Medication Name	Controlled Substance Amount Administered	Controlled Substance Amount Units	Crew Initial #1 Licensure ID	Crew Initial #2 Licensure ID
Fentanyl	100	mcg	Rader, Darcie (911)	Anderson, Josh (17542)

Call Type/Location/Disposition

Call Type: Traffic/Transportation Incident (29)

Disposition: Patient Treated, Transported by this EMS Unit

Resp. Mode: Emergent (Immediate Response)

Transport Mode: Non-Emergent

Urgency: Immediate

Destination: Northeastern NV Regional Hospital
2001 Errecart Blvd
Elko, Nevada 89801

Response: 911 Response
Location: Street and highway
Incident Address: 450 Commercial St
City of Elko, NV
89801

Dest. Determ.: Closest Facility
Response Delay: None/No Delay

Patient Transport/Positioning

Patient Moved to Stretcher
Ambulance:
Patient Moved From Stretcher
Ambulance:

Response Times and Mileage

Unit 06/22/2016	Start Odom: 78181	To Dest: 2.9	Incident EA16-2256
Disp.: 20:16:56	Scene Odom: 0		Number:
Enroute: 06/22/2016	Dest. Odom: 2.9		Call Sign: 939
20:17:56			Veh. #: 104
At 06/22/2016			
Scene: 20:19:39			
At 06/22/2016			
Patient: 20:19:44			

Incident #: EA16-2256

Patient Name: Schwartz, Douglas

Date 06/29/2018
Printed: 10:40

Incident Number: EA16-2256
EMS Unit: 939
Call Sign:

Patient Name: Schwartz , Douglas

Patient Care Report Number: 68ffb27070654b639ee678a

Depart: 06/22/2016 20:41:58
Arrive: 06/22/2016 20:48:38
In: 06/22/2016 21:21:04
Service:

Unit Personnel

Crew Members

Crew Member ID	Crew Member Level	Crew Member Response Role
Rader, Darcie (911)	Paramedic	Driver-Response , Driver-Transport , CrewMemberResponseRole_PrimaryPatientCaregiverAtScene , CrewMemberResponseRole_OtherPatientCaregiverAtScene
Anderson, Josh (17542)	Advanced Emergency Medical Technician (AEMT)	Driver-Response , Driver-Transport , Primary Patient Caregiver , Secondary Patient Caregiver

Suspected EMS Exposure/Work Related Illness or Injury: No

Signatures

Incident #: EA16-2256

Patient Name: Schwartz , Douglas

Date: 06/29/2018
Printed: 10:40

Incident EA16-2256
Number:
EMS Unit 939
Call Sign:

Patient Name: Schwartz , Douglas

Patient 68ffb27070654b639ee678a
Care
Report
Number:

Type of Person Signing: Patient Representative

Signature Reason: Claim Submission Authorization/HIPAA

Type Of Patient Representative: Wife

Signature Status: Signed



Date/Time of Signature: 06/22/2016 21:09:14

Signature Last Name: schwartz

Signature First Name: diane

Language: English

Paragraph Text:

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by ECAS now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered. By signing below, I the signer acknowledge that Elko County Ambulance Service (ECAS) provided a copy of its Notice of Privacy Practices to myself with instructions to provide the Notice to the patient. I attest that I am one of the following:

- Patient's legal guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the patient
- Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

Type of Person Signing: EMS Crew Member

Signature Reason: Crew Signature , Controlled Substance Waste Witness

Type Of Patient Representative:

Incident 50107

<https://www.imagetrendelite.com/Elite/Organizationelkocounty/Agen...>

Incident Number: EA16-2256
EMS Unit: 939
Call Sign:

Patient Name: Schwartz, Douglas

Patient Care Report Number: 68ffb27070654b639ee678a

Incident #: EA16-2256

Patient Name: Schwartz, Douglas

Date: 06/29/2018
Printed: 10:40

ELKO COUNTY AMBULANCE (ELKO)

PO BOX 398379
SAN FRANCISCO, CA 94139
(800)811-4045
Federal Tax ID: 88-6000039

Patient Name: DOUGLAS SCHWARTZ

Insurance: BLUE CROSS - NEVADA
ANTHEM BC/BS

DOUGLAS SCHWARTZ
736 WESTCOTT DR
SPRING CREEK, NV 89815

Patient Number: EA16-2256

Call Number: EA16-2256

Date Of Call: 06/22/2016

Call Time:

Caller:

From Location: SCENE CALL

To Location: NORTHEAST NEVADA REGION HOSP

Reason(s) R41.82

For R52

Transport V03.10XA

<u>DESCRIPTION OF CHARGES</u>	<u>HCPC</u>	<u>QUANTITY</u>	<u>UNIT PRICE</u>	<u>AMOUNT</u>
BASE RATE - ALS1 E	A0427	1.0	1118.00	1118.00
LOADED MILES - GROUND	A0425	3.0	34.00	102.00
OXYGEN	A0422	1.0	52.00	52.00
IV SUPPLIES - ADULT	A0398	1.0	68.00	68.00

Total 6.68
Total Charges 1346.68

<u>DESCRIPTION OF PAYMENT</u>	<u>RECEIPT</u>	<u>PAYMENT DATE</u>	<u>AMOUNT</u>
PATIENT PAYMENT		01/09/2017	268.00
COMMERCIAL INSURANCE PAYMENT - BLUE CROSS - NV		12/08/2016	1078.68

Total Credits 1346.68

PLEASE PAY THIS AMOUNT => \$0.00

^DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT^

Patient Name: SCHWARTZ, DOUGLAS
Patient Number: EA16-2256

Call Number: EA16-2256
Current Date: 07/02/2018

Amount Due: \$0.00

Amount
Enclosed \$ _____

ELKO COUNTY AMBULANCE (ELKO) PO BOX 398379 SAN FRANCISCO, CA 94139-8379

ECA 0010

ELKO COUNTY AMBULANCE (ELKO)

PO BOX 398379
 SAN FRANCISCO, CA 94139
 (800)811-4045
 Federal Tax ID: 88-6000039

Patient Name: DOUGLAS SCHWARTZ

Patient Number: EA16-2256

Insurance: BLUE CROSS - NEVADA
 ANTHEM BC/BS

Call Number: EA16-2256

Date Of Call: 06/22/2016

Call Time:

Caller:

From Location: SCENE CALL

To Location: NORTHEAST NEVADA REGION HOSP

DOUGLAS SCHWARTZ
 736 WESTCOTT DR
 SPRING CREEK, NV 89815

Reason(s) R41.82

For R52

Transport V03.10XA

<u>DESCRIPTION OF CHARGES</u>	<u>HCPC</u>	<u>QUANTITY</u>	<u>UNIT PRICE</u>	<u>AMOUNT</u>
BASE RATE - ALS1 E	A0427	1.0	1118.00	1118.00
LOADED MILES - GROUND	A0425	3.0	34.00	102.00
OXYGEN	A0422	1.0	52.00	52.00
IV SUPPLIES - ADULT	A0398	1.0	68.00	68.00

Total 6.68
 Total Charges 1346.68

<u>DESCRIPTION OF PAYMENT</u>	<u>RECEIPT</u>	<u>PAYMENT DATE</u>	<u>AMOUNT</u>
PATIENT PAYMENT		01/09/2017	288.00
COMMERCIAL INSURANCE PAYMENT - BLUE CROSS - NV		12/08/2016	1078.68

Total Credits 1346.68

PLEASE PAY THIS AMOUNT => \$0.00

 ^DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT^

Patient Name: SCHWARTZ, DOUGLAS
 Patient Number: EA16-2256

Call Number: EA16-2256
 Current Date: 05/01/2018

Amount Due: \$0.00

Amount
 Enclosed \$ _____

ELKO COUNTY AMBULANCE (ELKO) PO BOX 398379 SAN FRANCISCO, CA 94139-8379

ECA 0011

Anthem
Blue Cross Blue Shield of Indiana

0000000000

When Blue Cross and Blue Shield of Indiana merge, the new company will be called Anthem. The new company will be a public company and will be listed on the New York Stock Exchange. The new company will be a member of the Blue Cross and Blue Shield of Indiana system. The new company will be a member of the Blue Cross and Blue Shield of Indiana system.

ELFD COUNTY AMBULANCE
PROVIDER ID NO: 62213133

12/25/14
CHECK NUMBER: 001562997

3 of 4

PLEASE GO TO WWW.CASH.ORG/SOLUTIONS/EMERGENCY FOR ENROLLING INFO
ELECTRONIC FUND TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVISE (ERA).

STATUTORY INTEREST DUE ON CLAIMS

IMPORTANT NOTE: YOU ARE NOT PERMITTED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ABOUT INDIVIDUALS THAT YOU ARE NOT CURRENTLY TREATING. THIS APPLIES TO PROTECTED HEALTH INFORMATION ACCESSIBLE BY ANY ANTHEM ONLINE TOOL, OR SENT IN ANY OTHER MEDIUM INCLUDING MAIL, EMAIL, FAX, OR OTHER ELECTRONIC TRANSMISSION.

ED LUMENS NSA PPO

SERVICE DATE(S)	SERVICE CODE(S)	PCS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLAN CODE(S)	WHAT WE WILL PAY
11/16/2016	41427	41	1,106.00	1,106.00	0.00	0.00	0.00	0.00	0.00		0.00		1,106.00
11/16/2016	41425	41	286.00	286.00	0.00	0.00	0.00	0.00	0.00		0.00		286.00
TOTAL:			1,392.00	1,392.00	0.00	0.00	0.00	0.00	0.00		0.00		1,392.00
INTEREST PAID													1.00
TOTAL NET PAID													1,393.00

TOTAL APPROVED AMOUNT: 1,391.00

TOTAL INTEREST: 1.00

TOTAL NET AMOUNT DUE: ED LUMENS NSA PPO: 1,391.00

PPG

SERVICE DATE(S)	SERVICE CODE(S)	PCS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLAN CODE(S)	WHAT WE WILL PAY
06/22/2016	41427	41	1,238.00	1,238.00	0.00	0.00	297.00	0.00	0.00		297.00	107 2	941.00
06/22/2016	41425	41	102.00	102.00	0.00	0.00	26.00	0.00	0.00		26.00	107 2	76.00
TOTAL:			1,340.00	1,340.00	0.00	0.00	268.00	0.00	0.00		323.00		1,017.00
INTEREST PAID													6.00
TOTAL NET PAID													1,023.00

INSURED'S NAME: SCHWARTZ, DOUGLAS R	PHYSICIAN ID: 441051556	PATIENT NAME: SCHWARTZ, DOUGLAS R	INSURANCE CALL: 1-855-856-1158
PATIENT ACCOUNT#: 6416-72664	CLAIM NUMBER: 28163501243	RECEIVED DATE: 10/13/2016	
SERVICE PROVIDER NAME: ELFD COUNTY AMBULANCE	SERVICE PROVIDER ID: 62213133	RELATIONSHIP TO INSURED: HALE DAUGHTER	
NETWORK: EA NETWORK			

Transaction 4 Summary

General

Lockbox Number: 138378
Lockbox Name: Elko County
Lockbox Site: SF
Batch Number: 1

Transaction Type: Regular
Transaction Total: \$268.00
Deposit Account Number: 8046040684
Sequence Number: 4

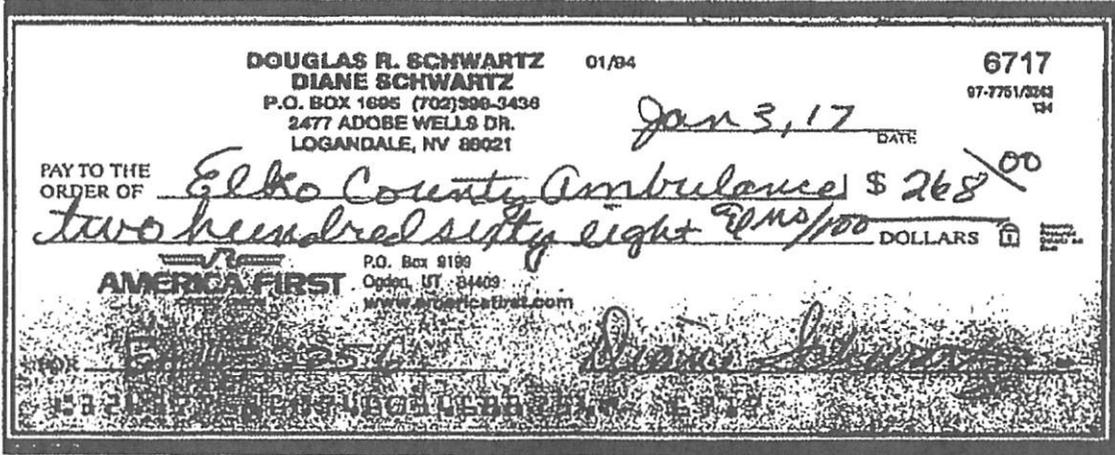
Check(s)

Deposit Date: 01/09/2017
Check Number: 6717
Check RTN: 324377616

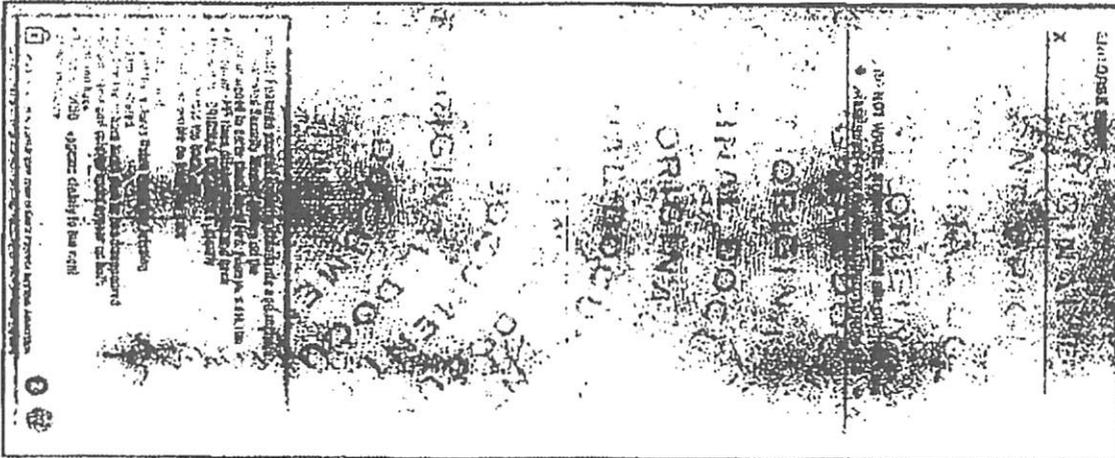
Check Amount: \$268.00
Check Account Number: 7

Invoice(s)

Check 1



Back Image



Deposition of
DAVID JAMES GARVEY, M.D.

SCHWARTZ, et al. v. GARVEY, M.D., et al.

Case No. CV-C-17-439

June 25, 2019

CONDENSED TRANSCRIPT AND KEY WORD INDEX

TURNER REPORTING & CAPTIONING SERVICES, INC.
7500 W. Lake Mead Blvd., Ste. 9246
Las Vegas, NV 89128
(702) 242-9263

1 IN THE FOURTH JUDICIAL DISTRICT COURT OF THE
2 STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO
3
4 DIANE SCHWARTZ, individual)
and as Special Administrator)
5 of the Estate of DOUGLAS R.)
SCHWARTZ, deceased,)
6)
Plaintiff,)
7) Case No. CV-C-17-439
vs.) Dept. No. 1
8)
DAVID GARVEY, M.D., an)
9 individual; BARRY BARTLETT, an)
individual (Formerly)
10 Identified as BARRY RN); CRUM,)
STEFANKO & JONES LTD., dba)
11 Ruby Crest Emergency Medicine;)
PHC-ELKO INC. dba NORTHEASTERN)
12 NEVADA REGIONAL HOSPITAL, a)
domestic corporation duly)
13 authorized to conduct business)
in the State of Nevada; REACH)
14 AIR MEDICAL SERVICES, L.L.C.;)
DOES I through X; ROE BUSINESS)
15 ENTITIES XI through XX,)
inclusive,)
16)
Defendants.)
17 _____)
18)
19 DEPOSITION OF DAVID JAMES GARVEY, M.D.
20 Taken on Tuesday, June 25, 2019
21 At 10:17 a.m.
22 At 6385 South Rainbow Boulevard, Suite 600
23 Las Vegas, Nevada
24 Reported By:
Vicki Chelst Turner, CCR 375, RMR, CRR, CRC
25

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1 APPEARANCES:
2 For the Plaintiff: JENNIFER MORALES, ESQ.
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7 Suite 600
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8
9 For Defendant PHC-Elko, JENNIFER RIES-BUNTAIN, ESQ.
Inc. dba Northeastern HALL PRANGLE & SCHOOVELD, LLC
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and for its individually 36 South State Street
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18
19 Also Present: ELLEN HARMON, ESQ.
JAMES WATT, ESQ.
LEXI EPLEY, Law Clerk
20 DANIEL BRADY, Law Clerk
CASEY XAVIER, Law Clerk
21 ANDREW JONES, Videographer
22
23
24
25

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1 THE VIDEOGRAPHER: This begins the videotaped
2 deposition of David Garvey, M.D. Today's date is
3 June 25, 2019. The time is 10:17 a.m. We are at
4 6385 South Rainbow Boulevard in Las Vegas, Nevada
5 89118, for the matter entitled Diane Schwartz, et al.,
6 versus David Garvey, M.D., et al., Case No.
7 CV-C-17-439, being heard in the Fourth Judicial
8 District Court of the State of Nevada in and for the
9 County of Elko.
10 I'm the videographer, Andrew Jones. The
11 court reporter is Vicki Turner with Turner Reporting
12 Services.
13 Will counsel please identify yourselves and
14 affiliations, and then the reporter will administer
15 the oath.
16 MS. MORALES: Jennifer Morales on behalf of the
17 plaintiff, Diane Schwartz and the estate.
18 MS. MONTET: Jordan Montet on behalf of Ruby
19 Crest Emergency Medicine.
20 MR. BURTON: James Burton on behalf of REACH Air
21 Medical. I also have with me in-house counsel Ellen
22 Harmon and J.C. Watt.
23 MR. WEAVER: Go ahead, Jenn.
24 MS. RIES-BUNTAIN: Jennifer Ries-Buntain on
25 behalf of Northeastern Nevada Regional Hospital.

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1 MR. WEAVER: And Keith Weaver for Dr. Garvey.
 2 Thereupon--
 3 DAVID JAMES GARVEY, M.D.,
 4 was called as a witness by the Plaintiff and, having
 5 been first duly sworn, testified as follows:
 6 EXAMINATION
 7 BY MS. MORALES:
 8 Q Can you please state your full name for the
 9 record.
 10 A **David James Garvey.**
 11 Q Dr. Garvey, how many times have you had your
 12 deposition taken prior to today?
 13 A **For any case?**
 14 Q Yes.
 15 A **Probably eight to ten.**
 16 Q Okay. And when is the last time that you
 17 had your deposition taken?
 18 A **Ten -- eight to ten years ago. Ten years**
 19 **ago probably.**
 20 Q Okay. I'm going to go over -- I'm sure your
 21 counsel went over with you, but I'm going to go over a
 22 few admonitions and procedure of having your
 23 deposition taken.
 24 If you have any -- if you have any
 25 questions, please feel free to ask. Okay?

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1 A **Uh-huh.**
 2 Q You understand that today the court reporter
 3 is taking down everything that is said in a
 4 question-answer format.
 5 A **Yes.**
 6 Q Okay. And because she is doing that, it's
 7 important to make sure we have a clear transcript. So
 8 I'm going to ask that you answer "yes" or "no" instead
 9 of "uh-huh" or "hu-uh."
 10 Do you understand that?
 11 A **Yes.**
 12 Q Okay. Along the same lines, sometimes as a
 13 deposition goes forward, you get a little bit more
 14 relaxed, and people tend to nod their head. I'll ask
 15 that you make -- make sure that you make verbal
 16 responses in addition to just nodding your head.
 17 Okay?
 18 A **Yes.**
 19 Q As you can see, we have a room full of
 20 people, attorneys, and they have the opportunity to
 21 make objections. However, unless your attorney
 22 instructs you not to answer, I'm going to ask that you
 23 answer the question. Okay?
 24 A **Yes.**
 25 Q After your deposition is taken, you have an

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1 opportunity to review your deposition transcript and
 2 make any changes. However, any substantive changes --
 3 for example, a yes to a no answer -- can be brought up
 4 at the time of trial, which could affect your
 5 credibility.
 6 Do you understand that?
 7 A **Yes.**
 8 Q We never want you to guess, but we are
 9 entitled to your best estimate.
 10 Do you understand the difference between an
 11 estimate and a guess?
 12 A **Yes.**
 13 Q Okay. Today if you need for any reason to
 14 take a break, just let us know, and we'll do that.
 15 However, if there is a question pending, I will ask
 16 that you answer the question before you take a break.
 17 Okay?
 18 A **Okay.**
 19 Q And I may have forgot something. I'm sure I
 20 did. But if I -- I did, I'll caution you as we move
 21 along. Okay?
 22 A **Okay.**
 23 Q You just testified that you've had your
 24 deposition taken eight to ten times.
 25 Have any of those times that you had your

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1 deposition taken were in regard to where you have been
 2 named as a defendant?
 3 A **No.**
 4 Q Have you ever been -- besides this case,
 5 have you ever been a defendant in a medical
 6 malpractice suit?
 7 A **No.**
 8 Q Can you give me a brief synopsis of your
 9 educational history.
 10 A **Bachelor's degree, Miami University, Oxford,**
 11 **Ohio. Master's degree, University of Buffalo,**
 12 **New York. And Ph.D., anatomy, University of**
 13 **California, Berkeley. And M.D. degree, Wright State**
 14 **University, Dayton, Ohio.**
 15 Q Okay. And when did you earn your M.D.?
 16 A **Graduated in 1984.**
 17 Q And are you board certified?
 18 A **I was board certified for the last 30 years,**
 19 **but recently did not recertify. Within the past six**
 20 **months, I was supposed to recertify.**
 21 Q Okay. And why didn't you recertify?
 22 A **Because I'm preparing to retire.**
 23 Q Okay. And when are you planning to retire?
 24 A **Maybe August.**
 25 Q Congratulations.

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1 **A Thank you.**
 2 MR. WEAVER: Does your wife know?
 3 MS. MORALES: I keep having --
 4 MR. WEAVER: You don't have to answer. You're
 5 under oath. You don't have to answer.
 6 MS. MORALES: I keep having more kids, so I'm
 7 never going to retire, as Claggett reminds me.
 8 Q Okay. So you're retiring in August.
 9 Where have you -- who have you been employed
 10 by in the last five years?
 11 **A Employed? Huntsville Hospital is my only**
 12 **employment.**
 13 Q Okay. And where is Huntsville Hospital?
 14 **A Huntsville, Alabama.**
 15 Q Okay. And what's your position there?
 16 **A Currently I'm an emergency physician there.**
 17 **Previously I was a medical director there.**
 18 Q And how many beds does that hospital have?
 19 **A Well over a thousand. Level I trauma**
 20 **center.**
 21 Q And how long have you worked there?
 22 **A Previously I worked there for 12 years, and**
 23 **now I just went back part time less than a year.**
 24 **Probably last eight months.**
 25 Q How long did you hold the position,

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1 administrative position?
 2 **A A little over ten years.**
 3 Q And how much -- how much time did you put
 4 into the administrative position there?
 5 **A Most of my time. Probably 75 percent of my**
 6 **time was administrative.**
 7 Q Did you have any other employments during
 8 this five-year period of time?
 9 **A No employments. I think everything else was**
 10 **independent contractor.**
 11 Q Okay. And tell me, working at the
 12 Northeastern Nevada Regional Hospital, were you
 13 employed by anyone there?
 14 **A No.**
 15 Q Okay. What was your position -- sorry.
 16 MR. WEAVER: I was just going to object it calls
 17 for a legal conclusion. I think he's interpreting to
 18 mean employee versus independent contractor.
 19 Go ahead.
 20 Q (BY MS. MORALES) What was your position
 21 there?
 22 **A An emergency physician.**
 23 Q Were you associated or employed by any
 24 groups?
 25 **A Not employed, no.**

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1 Q Do you have any affiliation with Ruby Crest?
 2 **A I work as an independent contractor with**
 3 **Ruby Crest.**
 4 Q Does Ruby Crest pay you any type of salary?
 5 **A Not a salary. I get paid an hourly based on**
 6 **the hours worked.**
 7 Q And how much do you make per hour from Ruby
 8 Crest?
 9 MR. WEAVER: Don't answer that question.
 10 That's an invasion of his privacy. You can
 11 ask him how he gets paid, but not how much.
 12 I'm instructing him not to answer.
 13 MS. MORALES: I'm going to reserve my right on
 14 that.
 15 Q So you are -- you make an hourly salary from
 16 Ruby Crest; is that correct?
 17 **A Yes.**
 18 Q And are you paid every two weeks?
 19 **A I think I'm paid every two weeks after my**
 20 **shifts are worked. And I'm only part time, so it**
 21 **depends how much of a gap there is between my work.**
 22 Q Do they -- does Ruby Crest give you some
 23 type of schedule?
 24 **A I give them days that I'm available. And if**
 25 **they need me during those days, they will schedule me.**

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1 Q And on average, how many days do you give
 2 them a month that you can work?
 3 **A I probably give them 20, but usually work**
 4 **five.**
 5 Q And has that been pretty consistent over the
 6 last three years?
 7 **A That's been pretty consistent over the last**
 8 **eight years.**
 9 Q Is that how long you've been working with
 10 Ruby Crest?
 11 **A Yes.**
 12 Q Besides paying you hourly, does Ruby Crest
 13 provide any type of benefits to you?
 14 **A No, they do not.**
 15 Q Does Ruby Crest provide any policies or
 16 procedures to you that you're to follow while working
 17 in an emergency room at Northeastern Regional
 18 Hospital?
 19 **A Not that I'm aware of, no.**
 20 Q And from the time that you've worked with
 21 Ruby Crest, have they held any type of meetings
 22 pertaining to safety or patient care?
 23 **A Ruby --**
 24 MS. MONTET: Objection. Lacks foundation.
 25 THE WITNESS: Am I supposed to answer?

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1 MR. WEAVER: Go ahead.
 2 THE WITNESS: No meeting -- we have departmental
 3 meetings, but not particularly Ruby Crest meetings,
 4 no.
 5 Q (BY MS. MORALES) Do you know for Ruby Crest
 6 who -- how many doctors own that company?
 7 A Yes. Three.
 8 Q And do you know those physicians?
 9 A Yes.
 10 Q Who are they?
 11 A Robert Stefanko, Dan Jones, and Donald Crum.
 12 Q And how do you know -- how do you know them?
 13 A I know them mainly through Dan Jones. I
 14 hired him to work for me in Huntsville Hospital at --
 15 when he completed his residency. And I met the other
 16 two when I started working with Dan at Northeastern
 17 Nevada.
 18 Q Do you know how many physicians work for
 19 this group?
 20 A I can estimate. One, two, three, four --
 21 MR. WEAVER: Don't think out loud. Just give her
 22 the answer.
 23 THE WITNESS: About eight.
 24 Q (BY MS. MORALES) And besides Northeastern
 25 Nevada Regional Hospital, does -- to your knowledge,

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1 does Ruby Crest provide services to other facilities?
 2 A Not to my knowledge.
 3 Q So, to your knowledge, it's just with --
 4 their work is just with Northeastern?
 5 A Yes.
 6 Q In the past three years, what type of
 7 meetings, if any, have you attended with the
 8 physicians of Ruby Crest?
 9 MS. MONTET: Objection. Foundation.
 10 THE WITNESS: Official meetings, none.
 11 Q (BY MS. MORALES) Has any of the physicians
 12 ever contacted you regarding any care that you
 13 provided to a patient --
 14 MR. WEAVER: Object as to form.
 15 Go ahead.
 16 Q (BY MS. MORALES) -- while working at
 17 Northeastern Nevada Regional Hospital?
 18 A Not that -- not that I remember, no.
 19 Q When you agreed to work with Ruby Crest, did
 20 they provide you any type of policies, procedures, or
 21 protocols that you were to follow as an emergency room
 22 doctor working for Ruby Crest?
 23 MS. MONTET: Objection. Form. Foundation.
 24 THE WITNESS: Other than the hospital policies, I
 25 don't remember anything specific from Ruby Crest.

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1 Q (BY MS. MORALES) Do you still work for Ruby
 2 Crest?
 3 A Yes.
 4 Q After this lawsuit was filed, did you have
 5 any discussions with anyone from Ruby Crest regarding
 6 this case?
 7 MS. MONTET: Objection. Form.
 8 THE WITNESS: Probably Dan Jones just to let him
 9 know that the case was filed. But no real discussion
 10 with him. He's the medical director.
 11 Q (BY MS. MORALES) Were you asked to provide
 12 any synopsis or summary of the medical care and
 13 treatment by Mr. Jones that you provided to
 14 Mr. Schwartz?
 15 A No.
 16 Q Are you currently working approximately five
 17 days a month for Ruby Crest?
 18 A I'm working less now. Up until about April,
 19 I was working -- probably averaging five days a month.
 20 Q And where do you currently reside?
 21 A Charleston, South Carolina.
 22 Q And have you resided in Charleston, North
 23 Carolina, since the time you began working for Ruby
 24 Crest?
 25 A No. Only the last year and a half maybe.

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1 MR. WEAVER: I think you said --
 2 THE WITNESS: Year and a half to two years.
 3 MR. WEAVER: Sorry. I think you said North
 4 Carolina. It's South Carolina.
 5 MS. MORALES: South Carolina. I just went to
 6 North Carolina.
 7 Q Okay. So -- so the last year and a half
 8 you've worked -- or you've lived in South Carolina?
 9 A Yes.
 10 Q And prior to that last year and a half,
 11 where did you reside?
 12 A Huntsville, Alabama.
 13 Q So in June of 2016, were you living in
 14 Huntsville, Alabama?
 15 A Yes.
 16 Q And in June of 2016, how much of your time
 17 was dedicated to working at Huntsville Hospital?
 18 A Zero.
 19 Q You had already stopped working there?
 20 A Yes.
 21 Q Okay. What other positions, if any, did you
 22 hold in June of 2016?
 23 A Sort of a part-time consulting position.
 24 Q And when you say "part-time consulting
 25 position," who was that for?

Page 17

1 **A Hospital Physician Advisors. HPA.**
 2 Q And when you say part time, how many hours
 3 were you working?
 4 **A It's based on the jobs that they have. So**
 5 **it might be once every four months I'll do a one- or**
 6 **two-week consulting job. Sometimes once or twice a**
 7 **month for six months. It depends on the job that they**
 8 **have.**
 9 Q And as a consultant, what were you -- what
 10 were your duties? What were you doing?
 11 **A Evaluating emergency department operations.**
 12 **Helping struggling emergency departments better**
 13 **improve their operations.**
 14 Q And was that for a specific area?
 15 **A No. Anywhere in the country.**
 16 Q And was it limited to a certain size
 17 hospital?
 18 **A No.**
 19 Q Did you consult for any facilities in
 20 Nevada?
 21 **A No.**
 22 Q So in June of 2016, do you know if -- if you
 23 had any assignments at that time for consulting?
 24 **A I don't know if I did or not. I may have**
 25 **had either one in Tupelo, Mississippi, or Brooklyn,**

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1 **New York. I was working on them around that time,**
 2 **so -- but I -- I would have to look back in my...**
 3 Q And in those -- in that consulting position,
 4 did you help the facilities put together clinical
 5 pathways and protocols?
 6 **A Sometimes.**
 7 Q When you would work in Elko at Northeastern
 8 Nevada Regional Hospital, did you have -- have a
 9 residence in Elko or where would you stay?
 10 **A I shared an apartment, yes.**
 11 Q And who did you share that apartment with?
 12 **A Dr. Crum and his nephew. His name is also**
 13 **Dr. Crum.**
 14 Q Okay. Is it fair to say that besides
 15 working for Mr. Jones, that you're also personal
 16 friends with him?
 17 **A Yes.**
 18 Q And how often would you estimate that you
 19 speak to Mr. Crum each month?
 20 **A Mr. Crum?**
 21 Q I'm sorry, Mr. Jones.
 22 **A I -- not necessarily monthly. I sometimes**
 23 **see him if our shifts overlap in Elko. We did**
 24 **vacation once together for a week I think in December**
 25 **or January.**

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1 MR. WEAVER: She just asked you how often you
 2 talk to him per month.
 3 Q (BY MS. MORALES) December or January of
 4 this last year?
 5 **A Yes.**
 6 Q And who went on that vacation?
 7 **A His wife, my wife, and us. The two of us.**
 8 Q And where did you guys vacation?
 9 **A Death Valley.**
 10 Q And how long was that vacation?
 11 **A Five to seven days maybe.**
 12 Q Is that the only vacation that you've gone
 13 on with that couple?
 14 **A Yes.**
 15 Q Do you guys double date frequently?
 16 **A No. Never.**
 17 Q What about Dr. Crum? You share or rent an
 18 apartment. How often do you talk to Dr. Crum each
 19 month?
 20 **A Only when our shifts overlap. And that's**
 21 **rare. I may see him once or twice a month.**
 22 Q Do you socialize with him outside of work?
 23 **A No.**
 24 Q What about Stef- -- Stefanko?
 25 **A Stefanko.**

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1 Q Stefanko.
 2 **A The same with Crum. Only when our shifts**
 3 **overlap and don't socialize.**
 4 Q So Dr. Jones is the director of the group?
 5 **A Yes.**
 6 Q What's the -- what positions do the other
 7 two hold, if you know?
 8 **A They were the owners of the group before**
 9 **they brought Jones into the group. But Jones lives in**
 10 **Elko, so he was asked to be the medical director since**
 11 **he's there more than the other two.**
 12 Q And all -- are all three of them emergency
 13 room physicians?
 14 **A Yes.**
 15 Q Are they all board certified?
 16 **A Yes.**
 17 Q How long have you been working out of
 18 Northeastern Nevada Regional Hospital?
 19 **A About eight -- eight years.**
 20 Q Did you work with any other groups besides
 21 Ruby Crest?
 22 MR. WEAVER: At that hospital?
 23 Q (BY MS. MORALES) At that hospital.
 24 **A No.**
 25 Q Have you held any administrative positions

Page 21

1 at Northeastern Nevada Regional Hospital?
 2 **A No.**
 3 Q Do you know who the COO was of Northeastern
 4 Nevada Regional Hospital in June of 2016?
 5 **A No.**
 6 Q What about the CEO?
 7 **A I -- I don't remember right now.**
 8 Q When you go in to work your five days a
 9 month at Northeastern, is it five consecutive days?
 10 **A Yes.**
 11 Q And what hours were you working in June of
 12 2016?
 13 **A I usually worked the night shift. It's**
 14 **6:00 p.m. to 7:00 a.m.**
 15 Q When you worked at Ruby Crest in June of
 16 2016, how many -- how many beds were available in the
 17 ER during that period of time?
 18 **A Sixteen.**
 19 Q And was there only one emergency room
 20 physician on at a time?
 21 **A Yes.**
 22 Q Was there a certain number of nurses that
 23 would work in the emergency room in June of 2016 when
 24 you worked --
 25 MS. RIES-BUNTAIN: Object to foundation. Sorry,

Page 22

1 Jenn.
 2 MS. MORALES: That's okay.
 3 Q -- 6:00 p.m. to 7:00 a.m.?
 4 Do you know how many nurses worked with you?
 5 **A No, I -- I don't really know how many, but**
 6 **they usually have a set number per -- covering per**
 7 **number of beds. So I -- again, if I had to guess,**
 8 **it's probably four nurses.**
 9 Q Okay. And is that a guess, or is that more
 10 of an estimate of what the average was?
 11 **A That's an estimate.**
 12 Q And do you have an understanding of what
 13 level trauma center Northeastern Hospital is?
 14 **A No. I don't know if it is even a trauma**
 15 **center. But it's not a I or a II. I know that.**
 16 Q Prior to working out of Northeastern Nevada
 17 Regional Hospital, were you provided any policies,
 18 procedures, or protocols that you were to follow as an
 19 emergency room physician?
 20 MR. WEAVER: It's been asked and answered, but
 21 you can go ahead.
 22 MS. RIES-BUNTAIN: Objection. Form.
 23 THE WITNESS: Do I answer?
 24 MR. WEAVER: Go ahead.
 25 THE WITNESS: I'm sure I -- I received the bylaws

Page 23

1 and rules and regulations of the hospital and
 2 everything when I started my employment there and
 3 credentials.
 4 Q (BY MS. MORALES) Well, that's a little
 5 different.
 6 Did -- did you -- what I'm asking is a
 7 little more specific as far as clinical pathways or
 8 policies and procedures regarding medical care and
 9 treatment that you would be rendering to patients in
 10 the emergency room at Northeastern Hospital.
 11 **A There are certain clinical pathways that are**
 12 **posted for various illnesses and that -- that**
 13 **occasionally get updated and -- and distributed.**
 14 Q Did you receive those at the time that you
 15 began working at Northeastern Nevada Regional
 16 Hospital?
 17 **A I'm not sure when I received them, but I**
 18 **know that there are certain clinical pathways that are**
 19 **posted every once in a while.**
 20 Q And when you say "posted," where are they
 21 posted?
 22 **A Either in the physician room or in the**
 23 **hallway with the nurses where -- or where the**
 24 **physicians were stationed so they can be seen.**
 25 Q Are they posted just like as a piece of

Page 24

1 paper or --
 2 **A Usually, yes.**
 3 Q Have you -- besides those pieces of paper
 4 that are posted, do you -- have you been asked to
 5 review any kind of binders that are policies and
 6 procedures that the hospital wants the physicians
 7 holding privileges to follow?
 8 MS. RIES-BUNTAIN: Objection. Form.
 9 THE WITNESS: Again, when I first started, I'm
 10 sure that I read through the policies and procedures
 11 of the hospital.
 12 Q (BY MS. MORALES) Well, and -- and I think
 13 we're talking about two different things. So there's
 14 the bylaws; right? And the rules and regulations for
 15 working as a physician. But I'm talking about actual
 16 policies and procedures pertaining to medical care of
 17 patients.
 18 **A I don't recall if there's anything specific**
 19 **called policies and procedures other than what -- like**
 20 **rules and regulations and guidelines.**
 21 Q And when you say "guidelines," what
 22 guidelines were you provided?
 23 **A Again, I don't know anything specific that**
 24 **I -- that I can think of, but -- other than, again,**
 25 **what's posted, care plans and sepsis protocols and**

Page 25

1 **things like that.**
 2 Q Since you've worked at the hospital for the
 3 last eight years, have you been asked to attend any
 4 type of educational meetings pertaining to clinical
 5 pathways, policies and procedures pertaining to
 6 medical care?
 7 **A By the hospital?**
 8 Q By the hospital.
 9 **A By the hospital, no.**
 10 Q Have you ever had your privileges -- have
 11 you ever had your privileges suspended?
 12 **A No.**
 13 Q Or terminated at any facility?
 14 **A No.**
 15 Q What about your medical license? Have you
 16 ever had any reprimands?
 17 **A No.**
 18 Q When you work in the emergency room at
 19 Northeastern Nevada Regional Hospital, do you wear a
 20 white coat?
 21 **A No.**
 22 Q What do you wear?
 23 **A Scrubs.**
 24 Q And does the scrubs have any identifying
 25 information on it?

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1 **A It has my name and "Emergency Medicine," I**
 2 **think, on it.**
 3 Q Does your -- it just says "Emergency
 4 Medicine"?
 5 **A Yes.**
 6 Q Is there any identifying -- identification
 7 of Ruby Crest or the hospital?
 8 **A No.**
 9 Q And when you introduce yourself to patients,
 10 do you say -- well, what do you say when you're
 11 introducing yourself to somebody?
 12 **A Usually give them my name. "I'm**
 13 **Dr. Garvey."**
 14 Q Okay. So you don't say, "I'm Dr. Garvey,
 15 and I work with Ruby Crest" or --
 16 **A No.**
 17 Q Just "Dr. Garvey."
 18 **A Yes.**
 19 Q Have -- have you had any meetings with
 20 anyone at the hospital following the incident with
 21 Dr. Schwartz -- I mean Mr. Schwartz?
 22 **A No.**
 23 Q When you work in the emergency room -- and I
 24 believe you said your hours -- do the nurses also work
 25 the 6:00 p.m. to 7:00 a.m.?

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1 **A No. Slightly different shift.**
 2 Q Is it 7:00 to 7:00?
 3 **A They -- usually 7:00 to 7:00, and then there**
 4 **are overlapping shifts, like a 1:00 to 1:00, and**
 5 **I'm -- I'm not exactly sure what their schedule is,**
 6 **but they -- they -- their shifts are sort of based on**
 7 **the patient volume.**
 8 Q In preparation for your deposition today,
 9 did you review any documents?
 10 **A Yes.**
 11 Q What did you review?
 12 **A The hospital chart, the medical record from**
 13 **my -- mine. The physician and the nurses. EMS**
 14 **records, REACH and Elko County.**
 15 Q So the hospital chart from Northeastern
 16 Nevada Regional Hospital.
 17 **A Yes.**
 18 Q Correct?
 19 The EMS records from Elko Ambulance -- I
 20 don't know what it's called.
 21 **A Elko County --**
 22 Q Elko County.
 23 **A -- EMS.**
 24 Q Okay. REACH Air? Did you say REACH Air?
 25 **A REACH Air.**

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1 Q Anything else?
 2 **A The hospital record. The medical record,**
 3 **yes.**
 4 Q Did you review any deposition transcripts?
 5 **A No. Not in preparation.**
 6 Q Did you review any discovery responses?
 7 **A No.**
 8 Q Did you meet with your attorney prior to
 9 your deposition today?
 10 **A Yes, I have.**
 11 Q Approximately how long did you meet with
 12 him?
 13 **A A couple times. Couple -- few hours each**
 14 **time.**
 15 Q Besides your attorney, have you talked with
 16 anyone else regarding having your deposition taken
 17 today?
 18 **A No.**
 19 Q Did anyone from the hospital reach out to
 20 you prior to having your deposition taken?
 21 **A No.**
 22 Q Without review of the medical records, did
 23 you have an independent recollection of this incident?
 24 **A Yes.**
 25 Q When you reviewed the medical records, do

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1 you believe that there was anything inaccurate or
 2 incorrect in -- in any of the records you reviewed?
 3 **A Not inaccurate or incorrect, but the record**
 4 **was retrospective and charted after the fact, so some**
 5 **of the timetables were a little off. But overall, it**
 6 **was a pretty good reflection of the case.**
 7 Q And when you say the timetables were a
 8 little off, was that -- was that during the intubation
 9 procedure?
 10 **A All through. You know, some -- you know,**
 11 **some of the -- some of the times are computer**
 12 **generated. They don't necessarily reflect the actual**
 13 **times that things were done.**
 14 **So when you look at the timetable, an order**
 15 **could be timed at a certain time, but it was really**
 16 **done before or after that.**
 17 Q Was there one specific order or document
 18 that really stuck out in your mind as being incorrect?
 19 **A No, not -- not necessarily.**
 20 Q Prior to taking care of Mr. Schwartz, had
 21 you worked with REACH Air before?
 22 **A Yes.**
 23 Q Could you estimate how many times?
 24 **A Multiple times.**
 25 Q Had you -- prior to this day on June 26,

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1 2016, had you worked with Barry Bartlett?
 2 **A Yes.**
 3 Q How many times do you estimate that you've
 4 worked with him?
 5 **A Again, several times.**
 6 Q And when you say several, is that more than
 7 five times? Less than five times?
 8 **A More than five times.**
 9 Q More than ten times?
 10 **A Probably.**
 11 Q Do you think it's more than 15?
 12 **A Oh, I don't know the exact number. But**
 13 **it -- I've worked with almost everyone at REACH Air**
 14 **for -- several times. A lot -- a lot of times. I**
 15 **don't know the individual, but, you know, the crews.**
 16 Q Did you know Mr. Bartlett personally?
 17 **A No.**
 18 **When you say "personally," I'm taking it you**
 19 **mean socially?**
 20 Q Right. Outside of --
 21 **A No.**
 22 Q -- the work context.
 23 Had you ever talked to him prior to June of
 24 2016 about his education, training, and experience?
 25 **A Have I talked to him about it? No, I**

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1 **haven't talked to him about it.**
 2 Q Have you ever had any meetings or discussed
 3 this case with anyone from REACH Air?
 4 **A Possibly one quick telephone conversation**
 5 **when the case was filed, either making them aware of**
 6 **the case being filed or them making me aware of the**
 7 **case being filed. I don't remember which one it was.**
 8 Q And who did you speak with?
 9 **A I don't recall who I spoke with. Someone --**
 10 MR. BURTON: I'm going to object. To the extent
 11 any of those conversations happened with in-house
 12 counsel at REACH, I'm going to instruct you not to
 13 answer.
 14 Otherwise, you can -- as far as the
 15 substance.
 16 MS. MORALES: Based on what? That's -- that's
 17 not his attorney, so based on --
 18 MR. BURTON: No. So -- so Dr. Garvey has a dual
 19 role, as has been disclosed in discovery. And to the
 20 extent he reached out to REACH Air in his role with
 21 REACH, it's governed by the attorney-client privilege,
 22 and I'm instructing him not to answer.
 23 Q (BY MS. MORALES) Can you tell me what your
 24 dual role is with REACH Air?
 25 **A I was the medical director for REACH Air.**

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1 Q And how long did you hold that position?
 2 **A Well, it started with Summit Air --**
 3 MR. WEAVER: She just asked how long.
 4 THE WITNESS: With REACH Air, I can't -- can't
 5 remember when REACH Air started from Summit. But
 6 maybe with REACH Air, for two years.
 7 Q (BY MS. MORALES) Okay. So let's --
 8 let's -- from the time -- let's start with the
 9 eight-year time period when you're in Elko.
 10 In that eight years, did you -- you
 11 mentioned Summit.
 12 Was there any other companies that
 13 contracted for ambulance flight?
 14 **A Well, there were other companies, but --**
 15 Q That you worked with. I'm sorry.
 16 **A No.**
 17 Q It wasn't a good question.
 18 **A Started working with Summit Air a couple**
 19 **years after I started working at Elko. And then**
 20 **Summit became REACH. They merged or whatever they did**
 21 **do --**
 22 Q Okay.
 23 **A -- and --**
 24 Q So let's back up to Summit.
 25 When would you estimate that you began

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1 working at -- with Summit?

2 **A Probably four years prior to REACH.**

3 Q So what year would you estimate?

4 **A Maybe 2012 maybe. I'd have to look at my**

5 **CV.**

6 Q And who -- do you recall who -- well, strike

7 that.

8 Did you see some kind of advertisement for a

9 position, or did someone reach out to you and ask you

10 to -- to fill a position that they had?

11 **A They -- they approached me to be their**

12 **medical director.**

13 Q And -- and do you recall who approached you?

14 **A What's his last name? Jeff. Whoever the**

15 **manager of REACH -- or Summit Air was at the time. It**

16 **was Jeff Antonichelly.**

17 Q Was Summit already in existence at the time

18 that they asked you to --

19 **A Yes.**

20 Q -- hold this position? Okay.

21 MR. WEAVER: Let her ask her whole question

22 before you answer.

23 Q (BY MS. MORALES) Did they have someone step

24 down from medical director or was it a new company?

25 **A I don't recall the situation.**

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1 Q Okay. What were you asked to do? What were

2 your job duties? What were you asked to do as a

3 medical director?

4 **A Training and education and supervision.**

5 Q And how -- how were you paid for that

6 position?

7 **A A monthly stipend.**

8 Q Was it a set amount every month?

9 **A Yes.**

10 Q And that was with Summit; right?

11 **A Both.**

12 Q Okay. And I just want to make sure we're

13 clear, so then I'll ask the next question when it was

14 REACH Air.

15 But when it was Summit, what was your

16 monthly stipend?

17 MR. WEAVER: Don't -- don't answer that question.

18 It's an invasion of your privacy.

19 MS. MORALES: Well, I don't think it is.

20 MR. WEAVER: Well, I do, and I'm --

21 MS. MORALES: So --

22 MR. WEAVER: -- instructing him not to answer.

23 THE WITNESS: Well, I don't remember anyway.

24 MR. WEAVER: Don't -- don't -- be quiet. So if I

25 instruct you not to answer, don't answer.

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1 MS. MORALES: Okay. And what's your objection

2 based on?

3 MR. WEAVER: My objection is it's an invasion of

4 his privacy to ask how much money he makes. It's no

5 more relevant than how much you make.

6 MS. MORALES: Well, no, it's absolutely relevant

7 when --

8 MR. WEAVER: How -- how is it relevant?

9 MS. MORALES: When he's holding two positions,

10 one as an ER doctor and one as a medical director of

11 the flight crew that -- or the flight company.

12 MR. WEAVER: How is the amount relevant?

13 MS. MORALES: It is the amount -- it is relevant

14 as far as --

15 MR. WEAVER: How? How is the amount relevant?

16 MS. MORALES: It is.

17 MR. WEAVER: Well, you can say that it's

18 relevant, but I'm asking you how is the amount -- how

19 much he made relevant?

20 MS. MORALES: It's relevant to his position

21 working as an ER doctor. I mean, I don't have to

22 argue it out with you right now.

23 MR. WEAVER: Well --

24 MS. MORALES: But I --

25 MR. WEAVER: -- you have to --

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1 MS. MORALES: That's fine. I'll -- I'll reserve

2 my right.

3 MR. WEAVER: Okay.

4 MS. MORALES: I'll reserve my right to take it in

5 front of the judge.

6 MR. WEAVER: Okay. Just let me say what I was

7 going to say, if you might.

8 Whether he had two positions might be

9 relevant. I'm asking you if you can state how the

10 amount he made is relevant.

11 MS. MORALES: Yeah, I think it is relevant, and

12 especially if that amount fluctuates at all according

13 to how many flights in or out.

14 MR. WEAVER: Well -- well, ask him that, then.

15 MS. MORALES: Okay. But I still think the amount

16 is relevant.

17 MR. WEAVER: I'm instructing you not to answer.

18 MS. MORALES: And I'm going to reserve my right.

19 MR. BURTON: So the -- any amounts paid by REACH,

20 I join the objection.

21 MR. WEAVER: You -- just so we're clear, you

22 can -- you can ask him how he's paid or the -- the

23 circumstances of him being paid. All I'm objecting to

24 is you asking him the monetary amount he's paid.

25 MS. MORALES: Okay. Well, I still want to

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1 reserve my right.
 2 MR. WEAVER: Fair enough.
 3 Q (BY MS. MORALES) So you were paid every
 4 month by Summit?
 5 A Yes.
 6 Q Is that right?
 7 And was that -- was that payment -- was that
 8 payment a set amount every month?
 9 A Yes.
 10 Q Okay. And did that vary at all as far as
 11 the number of transports out of the hospital?
 12 A No.
 13 Q How much time did you spend as -- well, from
 14 2012 to -- how long did you work for Summit? Because
 15 I want to make sure that we're clear, Summit and then
 16 REACH Air.
 17 A **Roughly four years till REACH Air took it --**
 18 **took it over. And I think it's probably two years**
 19 **prior to 2016.**
 20 Q So -- I thought you said 2012.
 21 So is it 2012 to 2014?
 22 A **2012 to 2014.**
 23 Q Okay.
 24 A **Four years. Or --**
 25 Q Two years.

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1 A **2014 -- okay. Yeah, maybe two years before**
 2 **REACH. The whole time is five -- maybe five years for**
 3 **both. And I don't know where the -- where it crosses**
 4 **over.**
 5 Q Okay. So from the time that you worked as a
 6 medical director for Summit, how much time did you
 7 spend in that position each month on average?
 8 A **For Summit, probably five to ten hours a**
 9 **month.**
 10 Q And what did you spend those five to ten
 11 hours a month doing?
 12 A **Meetings. Crew meetings once a month. And**
 13 **just reviewing cases and some education. A few**
 14 **lectures.**
 15 Q And when you say education, what type of
 16 education would you provide and to whom?
 17 A **Recurrent education for the flight crews,**
 18 **the nurses and the -- and the paramedics.**
 19 Q And where was that training held?
 20 A **Either in Elko or Reno.**
 21 Q Was it held at the hospital or was it -- did
 22 you ever hold that training at Northeastern Nevada
 23 Regional?
 24 A No.
 25 Q And did you -- for Summit, did you create

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1 policies, procedures, and protocols to follow?
 2 A **Did I create? No.**
 3 Q Do you know if Summit had its own policies,
 4 procedures, and protocols?
 5 A **Yes, they did.**
 6 Q And the amount, since I'm not entitled,
 7 according to your counsel, to know how much that is,
 8 was it -- did that amount change over the time period
 9 that you worked for Summit? Like, did you ever get a
 10 raise?
 11 A **No. I don't think so, no.**
 12 Q And was that amount the same regardless if
 13 you worked five hours or ten hours or 20 hours?
 14 A Yes.
 15 Q Did Summit provide you any type of benefits
 16 or additional compensation besides your stipend every
 17 month?
 18 A No.
 19 Q Okay. Was there -- do you know why the
 20 company -- since you're a medical director, do you
 21 have knowledge as far as the reason the medical
 22 company -- or the company switched over to REACH Air?
 23 A **No. I don't know the business reasons, no.**
 24 Q Was it the same -- some of the same people
 25 who owned Summit now own REACH Air?

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1 A **I don't think any of the Summit people are**
 2 **left, no. So --**
 3 Q Okay.
 4 A **-- it's a whole new administration.**
 5 Q When REACH Air took over, did someone
 6 specifically contact you to ask you to be the medical
 7 director for REACH Air?
 8 A Yes.
 9 Q And do you recall who that was?
 10 A **No, I really do not.**
 11 MR. WEAVER: Jenn, are you -- whenever it's
 12 convenient, can we take a break, if you're moving into
 13 a new area?
 14 MS. MORALES: Yeah, that's fine.
 15 MR. WEAVER: Now?
 16 MS. MORALES: Yes.
 17 THE VIDEOGRAPHER: We are off the record,
 18 11:19 a.m.
 19 (Recess taken.)
 20 THE VIDEOGRAPHER: We are back on the record,
 21 approximately 11:40 a.m.
 22 Q (BY MS. MORALES) You understand, Doctor,
 23 you're still under oath?
 24 A Yes.
 25 Q Okay. I think we left off just as -- with

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1 you becoming medical director of REACH Air.
 2 **A Okay.**
 3 Q And I had asked if you knew who approached
 4 you for that, and you didn't recall.
 5 Do you know who the owners were of REACH Air
 6 at the time that you were asked to be medical
 7 director?
 8 **A No, I do not.**
 9 Q At the time that you were asked to be a
 10 medical director for REACH Air, did you negotiate a
 11 different pay structure?
 12 **A No, I did not negotiate anything.**
 13 Q Were you offered a different pay structure?
 14 **A I received the same pay structure as -- the**
 15 **Summit structure continued.**
 16 Q And that -- that payment that you would get
 17 from -- well, that, I guess -- strike that.
 18 When you started getting payment from REACH
 19 Air, it was the same amount that you used to get at
 20 Summit?
 21 **A Yes.**
 22 Q Did that ever increase?
 23 **A No.**
 24 Q Did you receive a payment like once a month?
 25 Twice a month?

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1 **A Once a month.**
 2 Q Was it the same time or period of time every
 3 month?
 4 **A I think it was.**
 5 Q Do you know when you would receive payment
 6 every month?
 7 **A No. I don't remember.**
 8 Q And when REACH Air took over or you started
 9 working for REACH Air, did your duties change at all
 10 as a medical director?
 11 **A Slightly.**
 12 Q And how did they change?
 13 **A Had more responsibilities.**
 14 Q And when you say more responsibilities, what
 15 additional responsibilities did you have?
 16 **A More educational duties. More on-call**
 17 **duties.**
 18 Q More education -- more educational duties,
 19 what do you mean by that?
 20 **A They had a much more structured educational**
 21 **program for the crews. More robust than Summit.**
 22 Q When you -- when you say it was more robust
 23 and there was more education, how -- how much more
 24 education?
 25 **A Significant. They had biannual practical**

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1 **training sessions with all the crew members. They had**
 2 **monthly refresher educational requirements for each of**
 3 **the crew members.**
 4 Q And who -- who at REACH Air would you work
 5 with to set up the trainings?
 6 **A REACH Air has -- had -- has or had an**
 7 **educational person that would go base to base and help**
 8 **with the education. They usually use someone at the**
 9 **base who was also responsible for education.**
 10 Q Okay. And who was that person when you
 11 started working at REACH Air?
 12 **A Again, I -- I don't remember the names. I**
 13 **don't remember the name.**
 14 Q Was it just one person that you would work
 15 with?
 16 **A No. There were several. And sometimes**
 17 **based on their availability to be at our base.**
 18 Q Where -- where did REACH Air offer services?
 19 **A The -- the flight --**
 20 Q Yes.
 21 **A -- program?**
 22 **Oh, several states in the west. Nevada,**
 23 **California, Oregon, Montana. Probably several other**
 24 **places that I...**
 25 Q As medical director, were you involved in

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1 the training, education, or did any of your other
 2 duties apply to those other states or just Nevada?
 3 **A Not my education duties. Just -- just my --**
 4 **my Nevada bases.**
 5 Q So I just want to make sure I'm clear
 6 because that probably wasn't a good question.
 7 As a medical director, were you overseeing
 8 REACH Air -- REACH Air's flight program for more than
 9 just the state of Nevada?
 10 **A No. I was an assistant or a regional**
 11 **director just for the two bases in Nevada.**
 12 Q And where were those bases?
 13 **A Reno and Elko.**
 14 Q And do you know how many planes that they
 15 had between Reno and Elko for transport?
 16 **A Not exactly. But at least one -- usually**
 17 **one plane for each of the bases.**
 18 Q Did -- how would it work? Would the
 19 hospitals actually contract with REACH Air for
 20 services?
 21 MR. WEAVER: Object as to form.
 22 THE WITNESS: I don't think the hospital
 23 contracted --
 24 MR. WEAVER: I objected as --
 25 THE WITNESS: Oh, I didn't hear you.

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1 MR. WEAVER: That's okay.
 2 THE WITNESS: Sorry.
 3 MS. RIES-BUNTAIN: The audio cut out. I didn't
 4 hear it either.
 5 MR. WEAVER: Sorry, Jenn. My objection is to
 6 form. So the -- sorry, Jenn. Both Jenns, I'm sorry.
 7 So the -- the question that Jenn Morales
 8 asked Dr. Garvey is if he knew how it worked and if
 9 the hospitals contracted with REACH Air. And the
 10 doctor's answer was he doesn't know.
 11 MS. RIES-BUNTAIN: Perfect. That was -- my
 12 objection was foundation. Thank you.
 13 Q (BY MS. MORALES) So as a medical director,
 14 you didn't have any knowledge as far as if there was a
 15 contract in place between REACH Air and, for instance,
 16 Northeastern Nevada Regional Hospital?
 17 A **No, I did not. No.**
 18 Q And is your answer the same for any
 19 facilities out of Reno?
 20 A **The same.**
 21 Q Do you know if REACH Air in the time --
 22 well, strike that.
 23 Are you currently medical director for REACH
 24 Air?
 25 A **No.**

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1 Q When did that end?
 2 A **Oh, I don't remember exactly. Probably a**
 3 **year or so, a little over a year ago. Maybe a year**
 4 **and a half.**
 5 Q And why did you stop being the medical
 6 director for REACH Air?
 7 A **I think the main reason is they were**
 8 **consolidating programs, and there would be more --**
 9 **they needed someone more local that -- I, you know,**
 10 **live in South Carolina and fly back and forth, and**
 11 **they needed someone for -- they were -- they were**
 12 **going to have multiple bases, and someone would have**
 13 **to be more local to be able to visit the bases more**
 14 **often.**
 15 Q Did Northeastern Nevada Regional Hospital
 16 purchase its own plane?
 17 A **I don't know what the business aspects of**
 18 **the -- helicopter, but not plane.**
 19 Q Okay. And do you know when they purchased
 20 that helicopter?
 21 A **No, I do not.**
 22 Q When you were a medical director in June of
 23 2016, do you know if REACH Air transported patients
 24 from multiple facilities out of Reno?
 25 A **Out of Reno?**

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1 Q Yeah.
 2 A **Usually the transports were into Reno,**
 3 **but -- so I -- I don't know if they were transporting**
 4 **from multiple facilities outside -- from Reno out.**
 5 **I -- I don't know.**
 6 Q Okay. So the knowledge that you had was
 7 that -- that there would be transporting from Elko to
 8 Reno; is that correct?
 9 A **Elko to Reno to Boise to Las Vegas to Salt**
 10 **Lake City, yes.**
 11 Q Okay. And when you say that when REACH Air
 12 took over, that your duties increased, how much time
 13 were you spending per month for your duties with REACH
 14 Air?
 15 A **Oh, 20 to 30 hours per month.**
 16 Q And were you required to keep any kind of
 17 time sheet to provide to REACH Air for the time that
 18 you were actually putting in?
 19 A **At some point in time, we were. I don't**
 20 **know if that -- how that -- if that continued. I**
 21 **don't know what the time frame of that was. We**
 22 **submitted our hours monthly, yes.**
 23 Q So that wasn't always the case when you
 24 started with REACH Air?
 25 A **I don't think it was always the case. I**

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1 **don't -- I don't remember what triggered that, but**
 2 **yes.**
 3 Q And do you know approximately -- can you
 4 estimate when that started?
 5 A **No.**
 6 Q And who would you submit that time to?
 7 A **To the corporate office at -- the medical**
 8 **director at -- in Santa Rosa.**
 9 Q When there was training provided of the
 10 REACH Air staff, did it ever take place at
 11 Northeastern Nevada Regional Hospital?
 12 A **No.**
 13 MR. WEAVER: Asked and answered, but go ahead.
 14 THE WITNESS: No.
 15 Q (BY MS. MORALES) Does REACH Air actually
 16 have like an office out of Elko?
 17 A **They have two hangars.**
 18 MS. RIES-BUNTAIN: **Objection. Foundation.**
 19 Q (BY MS. MORALES) I'm sorry?
 20 A **They have two hangars at the airport.**
 21 Q So if educational training was being
 22 provided to the staff, was space rented for that?
 23 A **No. Education was usually at the airport,**
 24 **either the hangar or at the FSO there at the -- the**
 25 **airport facility.**

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1 Q In your position as the medical director for
 2 REACH Air, on or around June of 2016, were you to keep
 3 track of how many transports were being sent out of
 4 Elko?
 5 A No.
 6 Q Was anyone in charge of that?
 7 A I'm sure someone was in charge of it, but...
 8 MR. WEAVER: You've answered.
 9 Q (BY MS. MORALES) Did you -- were you part
 10 of the management that would make the decision of how
 11 much these air flights would cost?
 12 A No.
 13 Q Did you have knowledge as a medical director
 14 how much it cost?
 15 A No.
 16 Q Did REACH Air have ground transportation or
 17 was it only flight?
 18 A Only flight.
 19 Q Do you know if Ruby Crest would receive any
 20 type of compensation for the number of transports out
 21 of -- recommended by ER doctors out of the hospital
 22 for Northeastern?
 23 MS. MONTET: Objection. Form. Foundation.
 24 THE WITNESS: To my knowledge, they did not
 25 receive any compensation.

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1 Q (BY MS. MORALES) And I assume that the
 2 owners of Ruby Crest that we spoke of earlier knew
 3 that you were medical director for REACH Air during
 4 your position there; correct?
 5 MS. MONTET: Objection. Speculation. Form.
 6 MR. BURTON: Same objection. Also lacks
 7 foundation.
 8 Q (BY MS. MORALES) Is that correct?
 9 A Yes, they were aware that I was the medical
 10 director.
 11 Q Did you ever have any meetings with your
 12 partners or -- not partners, but with the owners of
 13 Ruby Crest regarding the usage of REACH Air --
 14 A No.
 15 Q -- for transport?
 16 A No.
 17 Q During your time that you worked out of
 18 Northeastern Nevada Regional Hospital as an emergency
 19 physician, including June of 2016, has -- besides
 20 Summit and REACH Air, have there been any other flight
 21 companies that have been utilized for transport?
 22 A Oh, yes.
 23 Q And what companies are those?
 24 A American Medflight was one of the others.
 25 Q And was that -- was American Medflight

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1 offering services in June of 2016?
 2 A I think they were.
 3 Q How was it determined as an emergency room
 4 doctor what flight company would be used to transport
 5 a patient out?
 6 A It depends. Patient preference. Patient
 7 could have a contract or insurance with a particular
 8 flight program. Or the -- the quickest, most
 9 available, whoever could get the plane or the
 10 helicopter there the quickest.
 11 Q And when you say quickest, I assume that's
 12 only for emergent cases; correct?
 13 A Almost all our transport are emergent cases.
 14 Q At -- in your position as an emergency room
 15 doctor at Northeastern Regional Hospital, have you
 16 ever transported a patient by ground -- ground
 17 transport?
 18 A Never.
 19 Q And why is that?
 20 A It's too -- too long of a transport.
 21 There's no company that will take an ambulance out for
 22 more than, you know, a day.
 23 Q In your position as medical director for
 24 REACH Air, did you ever research or determine what
 25 companies out of Elko would be available to transport

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1 a patient by ambulance to the University of Utah or
 2 Reno?
 3 A Have I ever? Yes.
 4 Q And do you recall when that was?
 5 A Usually in the wintertime, if -- if crews --
 6 if the airplanes or helicopters cannot fly and we have
 7 an urgent -- emergent patient to get to either Salt
 8 Lake or Reno. But usually when the helicopters and
 9 planes can't fly, the ground transportation can't go
 10 either.
 11 Q And so what company is available to do that
 12 out of Elko?
 13 A Really none. But we can try to get Elko
 14 County EMS to do it if they can get a crew together.
 15 But never able to do it.
 16 Q And the drive to Salt Lake is about three --
 17 three-and-a-half hours; is that right?
 18 A It would be about three-and-a-half to four
 19 hours to get to the hospital.
 20 Q And to your knowledge, what's the time
 21 period to get to Reno?
 22 A A little longer. Four, four and a half.
 23 Q Have you ever successfully transferred a
 24 patient by ground in those situations where the
 25 weather hasn't allowed flight?

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1 **A I've never transported a patient by ground.**
 2 **To my knowledge, no one has.**
 3 Q Is there only one ambulance company out of
 4 Elko?
 5 **A Yes.**
 6 Q And that's Elko County, you said?
 7 **A (Witness nods head.)**
 8 MR. WEAVER: Yes?
 9 THE WITNESS: Yes. Sorry. I shook my head.
 10 MR. WEAVER: That's all right.
 11 Q (BY MS. MORALES) In your position as a
 12 medical director for REACH Air, did you ever put
 13 together any policies, procedures, or protocols for
 14 the crew of REACH Air?
 15 **A Personally, no.**
 16 Q Are there, to your knowledge, any kind of
 17 materials provided to the staff, employees of REACH
 18 Air pertaining to policies, procedures, and -- and/or
 19 clinical pathways?
 20 MR. WEAVER: Hold on one second.
 21 Could you read me that back?
 22 I'm not saying it's bad. I just --
 23 MS. MORALES: It might be.
 24 (Question read.)
 25 MR. WEAVER: Did you understand the question?

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1 THE WITNESS: Yes.
 2 MR. WEAVER: Go ahead.
 3 THE WITNESS: Yes, there are.
 4 Q (BY MS. MORALES) And as medical director
 5 for REACH Air, did those -- do you know if those
 6 things -- those materials existed in June of 2016?
 7 **A Yes, they did.**
 8 Q Did you have any duty to -- even if you
 9 didn't put them together, to review them for accuracy
 10 or amendments or revisions?
 11 **A Yes.**
 12 Q Was there any specific policies, procedures,
 13 and protocols pertaining to intubations?
 14 **A Yes.**
 15 Q And those intubation procedures existed in
 16 June of 2016?
 17 **A Yes.**
 18 MR. WEAVER: You mean policies and procedures?
 19 MS. MORALES: Yes.
 20 MR. BURTON: You're being specific as to REACH;
 21 correct?
 22 MS. MORALES: Yes.
 23 Q (BY MS. MORALES) Did the policies and
 24 procedures that REACH provided to its employees
 25 regarding intubation mandate how intubations are to be

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1 performed?
 2 MR. WEAVER: Object as to form.
 3 MR. BURTON: Join.
 4 MR. WEAVER: Go ahead.
 5 THE WITNESS: I don't know about the word
 6 "mandate," but --
 7 MR. WEAVER: Well, if you don't understand the
 8 question as she phrased it, just tell her to rephrase
 9 it.
 10 THE WITNESS: Explain "mandate."
 11 Q (BY MS. MORALES) Well, did it provide
 12 guidelines or procedure that had to be followed for
 13 intubations?
 14 **A There were guidelines, yes.**
 15 Q Okay. Did it show -- was it specific as to
 16 how an intubation is to take place or be performed?
 17 **A Pretty much.**
 18 Q And did those -- to your knowledge, the
 19 policies and procedures set forth when REACH Air
 20 employees or crew are to perform intubations?
 21 **A Would you repeat that?**
 22 Q Yeah. When -- is there anything specific,
 23 to your knowledge, in those policies and procedures
 24 that REACH Air has for intubations as to when its
 25 employees are to intubate a patient?

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1 MR. WEAVER: Object as to form, but go ahead.
 2 MR. BURTON: Join.
 3 THE WITNESS: Pretty much there are indications
 4 on when a patient needs to be intubated in those
 5 policies and procedures.
 6 Q (BY MS. MORALES) And are those policies and
 7 procedures that are set forth by REACH Air for their
 8 employees, are they specific to occur only during the
 9 flight or does it indicate that -- something else?
 10 **A Not necessarily just during the flight.**
 11 MS. HARMON: Could you repeat that, please, that
 12 whole -- the question and answer, please?
 13 MR. BURTON: Yes.
 14 (Record read.)
 15 Q (BY MS. MORALES) Okay. So those policies
 16 and procedures are specific for the employees to
 17 follow during the flight path; correct?
 18 MR. WEAVER: Well, object.
 19 MR. BURTON: Object. Asked and answered.
 20 MR. WEAVER: It misstates his -- are you asking
 21 him if it's only during flight?
 22 MS. MORALES: Yes.
 23 MR. WEAVER: Because that's not what he said.
 24 MS. MORALES: Yes.
 25 MR. WEAVER: Is that what you're asking him,

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1 though?

2 MS. MORALES: Yes.

3 THE WITNESS: Yeah, that's not what I said.

4 Q (BY MS. MORALES) Okay. When are they to

5 apply?

6 **A Whenever they're indicated, and hopefully**

7 **not during the flight.**

8 Q Okay.

9 **A If someone --**

10 MR. WEAVER: You've answered. Let her ask her

11 next question.

12 Q (BY MS. MORALES) What is the chain of

13 command for the REACH Air crew?

14 MR. BURTON: Object to the form of the question.

15 It's vague and ambiguous.

16 MR. WEAVER: Join.

17 Q (BY MS. MORALES) As medical director, you

18 have an understanding of what the chain of command is

19 for the flight crew; correct?

20 MR. BURTON: Objection. Lacks foundation.

21 THE WITNESS: Not -- not really. I don't know

22 what the -- how -- what they actually have as chain of

23 command, no.

24 Q (BY MS. MORALES) During -- during a flight

25 to transport a patient, how many employees on average

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1 are on a plane?

2 **A Usually a flight nurse, a flight paramedic,**

3 **and the pilot.**

4 Q You testified earlier that your job duties

5 increased when you began working for REACH Air to 20

6 to 30 hours per week.

7 Besides -- can you explain to me what --

8 specifically what was different that was increasing

9 the time that you were having to spend in that

10 capacity?

11 MR. WEAVER: It's asked and answered, but go

12 ahead.

13 MR. BURTON: I was going to assert the same

14 objection, but go ahead.

15 THE WITNESS: I had on-call duties to -- if any

16 of the flight crews pretty much for the entire

17 organization had any questions inflight, had any

18 concerns, et cetera, I was on call to answer those

19 through their central EMS Flight Guard. And I had

20 more educational duties. They had biannual practical

21 sessions that I attended. They usually lasted three

22 or four days. And then that -- that was pretty much

23 it. And then some of the -- the crew meetings once a

24 month.

25 Q (BY MS. MORALES) Did you have specific days

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1 that you were on call for REACH Air?

2 **A Yes. Every four to six weeks for one week.**

3 **Usually about every six weeks.**

4 Q And would -- that one week that you would be

5 on call for REACH Air, did you schedule that to be the

6 same period of time that you were working for Ruby

7 Crest in the ER?

8 **A No. I tried to schedule separate from that.**

9 Q And that on-call shift, was it 24 hours a

10 day?

11 **A Yes.**

12 Q And on average, per week, what would you

13 estimate how many calls you would get?

14 **A Maybe three or four per week at the most.**

15 Q And what kind of questions were you dealing

16 with or handling while on call?

17 **A It varied. Questions, concerns of the**

18 **flight crew. Transporting a patient. Certain**

19 **physicians that may or may not want something done**

20 **prior to transport. Pretty much any kind of**

21 **questions. Certain medication questions that they may**

22 **not carry or -- or substitutions, anything like that.**

23 Q And how long did your average telephone call

24 last?

25 **A A couple minutes.**

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1 Q Of -- if you had to break it down, of the 20

2 to 30 hours that you would spend per month while

3 working as medical director for REACH Air, how many of

4 those hours per month were spent dealing with

5 educational duties?

6 **A On average, ten.**

7 Q You mentioned the crew meetings.

8 How long that would occur -- I'm sorry. Did

9 you say once a month?

10 **A Once a month, and only when I was working**

11 **usually. So I tried to -- initially tried to schedule**

12 **the meetings while I was in Elko.**

13 Q Okay. And how -- is that with all of the

14 REACH crew that worked out of both bases?

15 **A Yes. I only attended a couple of the**

16 **Nevada -- or the Reno meetings, and that was usually**

17 **during the time of the annual -- or biannual**

18 **educational sessions. Or a special trip there.**

19 Q So you didn't -- you didn't regularly attend

20 these meetings every month?

21 **A No, not regularly.**

22 Q Why would you just do it biannually? Was

23 there a reason?

24 **A That's when REACH had their practical**

25 **training sessions. They lasted for -- all the -- all**

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1 **the crew members were expected to attend. Oftentimes**
 2 **the Reno crew would come to Elko. Sometimes the Elko**
 3 **crew would go to Reno.**
 4 Q Okay. And we'll get back there, but I don't
 5 want to get off base there.
 6 So ten hours per week doing education. The
 7 crew meetings were every month --
 8 **A Per month, not per week.**
 9 Q I'm sorry?
 10 **A You said ten hours per week.**
 11 Q Oh, per week in education?
 12 **A Ten hours per month.**
 13 Q Oh, per month. Sorry.
 14 The crew meetings that you attended weren't
 15 every month, so where was the rest of your time spent
 16 that you worked for -- as medical director of REACH
 17 Air?
 18 **A I'm considering the on-call times, too, if**
 19 **you stretch them out.**
 20 Q And did you have some type of schedule of
 21 the time that you were provided for the times that you
 22 were going to be on call for REACH Air?
 23 **A Yes. We had an on-call schedule.**
 24 Q And was that provided to you like every
 25 month?

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1 **A Pretty much. It just -- it rotated through**
 2 **all the medical -- regional medical directors.**
 3 Q Who was your direct supervisor?
 4 **A The medical director at -- at REACH in -- in**
 5 **Santa Rosa. I'm blanking on his name.**
 6 Q You can't remember his name?
 7 **A Right now, I cannot.**
 8 Q Okay. If during your deposition, because
 9 we'll be here a while, if it -- I'm bad with names
 10 too, but if it comes across your mind, please --
 11 **A I -- I know him, and I can't --**
 12 Q Yeah. Just answer the question that's posed
 13 to you, and then say, "By the way, that's the name of
 14 the medical director." Okay? Or supervisor.
 15 How long -- so you said biannually you would
 16 go to these crew meetings that were the practicals.
 17 How long -- how long was that training
 18 session, the practicals?
 19 **A All day.**
 20 Q And what did that consist of?
 21 **A Case scenarios. Different medical trauma.**
 22 **Mostly involving critical care procedures,**
 23 **intubations, lines. Anything that the crew had to do.**
 24 **It was a hands-on situation.**
 25 Q And after -- was there any type of written

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1 test that was administered to the -- the staff?
 2 **A They had a monthly, yeah, continuing**
 3 **education sort of refresher test that they -- I think**
 4 **all the bases did.**
 5 Q Besides yourself going out for these
 6 practicals, was there any other physicians or --
 7 **A No other physicians --**
 8 Q -- trainers --
 9 MR. WEAVER: Just let her ask the whole question
 10 before you answer.
 11 THE WITNESS: No other physicians.
 12 Q (BY MS. MORALES) Who else would help train?
 13 **A Again, REACH had a education person that**
 14 **covered several bases, and then there -- each of the**
 15 **bases usually had someone designated as the education**
 16 **supervisor or whatever for the base.**
 17 Q Since you have been medical director for
 18 REACH Air, approximately how many transfers do you
 19 estimate that you've sent out to one of the
 20 neighboring states?
 21 MR. BURTON: Object to the form.
 22 THE WITNESS: Boy, sometimes three or four --
 23 MR. WEAVER: Give her the answer. Don't think
 24 out loud. Just give her the answer.
 25 THE WITNESS: Sometimes three to four a day.

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1 Q (BY MS. MORALES) And was that same average
 2 true in June of 2016?
 3 **A Yes. That wasn't an average, though.**
 4 **Sometimes three to four a day.**
 5 Q So if you had to estimate, would you think
 6 that you've sent out several hundred patients by
 7 transport since you've been medical director?
 8 **A Ten a week, hundreds, yes.**
 9 Q How do you make a determination when you're
 10 going to transfer a patient what facility you're going
 11 to transfer them to?
 12 MR. BURTON: Objection. Asked and answered.
 13 MS. MORALES: I don't think I have.
 14 THE WITNESS: Usually the most appropriate.
 15 Sometime patient preference. You usually ask them
 16 their preference, Salt Lake City or Reno, and then
 17 find an appropriate facility at one of those two that
 18 will accept the transfer.
 19 Q (BY MS. MORALES) Does the hospital have any
 20 protocols, policies, or procedures as to when it
 21 should be recommended to transfer a patient out?
 22 MS. RIES-BUNTAIN: Objection. Foundation.
 23 THE WITNESS: Not that I'm aware of, no.
 24 Q (BY MS. MORALES) As medical director, did
 25 you attend any type of -- any type of meetings

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1 regarding this case?
 2 **A No.**
 3 Q As medical director for REACH Air, did
 4 you -- did you have any type of administrative
 5 meetings regularly at REACH Air?
 6 **A Yes.**
 7 Q And how often was that?
 8 **A It would be annually maybe.**
 9 Q And where were those held?
 10 **A Santa Rosa.**
 11 Q And who -- who was invited or who was
 12 normally in attendance at those meetings?
 13 **A Usually all the regional directors.**
 14 Q And do you know if there's any minutes that
 15 are kept during those meetings?
 16 **A I don't know if there are or not.**
 17 Q And if you were to estimate how many people
 18 attend those meetings, what would be your best
 19 estimate?
 20 **A Eight to ten.**
 21 Q And what's discussed at the annual meetings?
 22 MR. BURTON: I'm going to object. To the extent
 23 any attorneys are present in those meetings and
 24 there's attorney-client privileged communications,
 25 don't disclose those. Otherwise you can answer.

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1 THE WITNESS: Usually reviewing policies and
 2 procedures and any new medications, any new changes in
 3 care, update.
 4 Q (BY MS. MORALES) And how long would those
 5 meetings normally last?
 6 **A Usually a couple days, if I remember right.**
 7 Q And do you know when the last time you
 8 attended an annual meeting?
 9 **A No. I haven't been with them for the last**
 10 **couple years, so probably -- probably around 2016.**
 11 Q When you would get your schedule every
 12 month, was that sent to you by email or how would you
 13 get your on-call schedule from REACH?
 14 **A Email.**
 15 Q And did you keep any of those schedules?
 16 **A No.**
 17 Q Did you ever keep track of -- yourself of
 18 the number of patients that you would send out on air
 19 transport?
 20 **A No.**
 21 Q When you would attend the annual meetings,
 22 is the number of patients sent out on air -- by air
 23 transport one of the subject areas?
 24 **A I don't recall.**
 25 Q The other -- to your knowledge, the other

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1 regional directors for REACH Air, are they -- do they
 2 also hold positions as emergency room physicians?
 3 **A To my knowledge, all of them do.**
 4 Q So, to your knowledge, you don't know of any
 5 other type of physician that's a regional director?
 6 **A No, I don't. I think they're all emergency**
 7 **physicians.**
 8 Q Are there any regional directors that work
 9 out of the University of Utah Hospital?
 10 **A No.**
 11 Q Did you -- when you became a -- a medical
 12 director for REACH Air, did you actually sign any type
 13 of contract?
 14 **A Yes, I think I did.**
 15 Q And do you know the period of time that
 16 contract was valid?
 17 **A No. I don't remember.**
 18 Q Do you know during your position as medical
 19 director if you signed more than one contract?
 20 **A I don't recall.**
 21 Q And you actually stepped down from the
 22 position as medical director?
 23 MR. WEAVER: Asked and answered.
 24 Go ahead.
 25 MR. BURTON: Join.

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1 THE WITNESS: Yes. Because I wouldn't have had
 2 enough time to visit all the bases.
 3 Q (BY MS. MORALES) Do you know the person who
 4 took over your position?
 5 **A No, I do not.**
 6 Q Since you still are working out of the
 7 hospital as a ER doctor, what companies are used
 8 currently to transport patients?
 9 **A I think American Medflight is still there,**
 10 **REACH, and then the hospital has a helicopter that's**
 11 **based there.**
 12 Q Are most of the -- the transports out now by
 13 the helicopter that's owned by the hospital?
 14 **A I don't know if it's most or not.**
 15 Q As an ER doctor, when you have to transport
 16 a patient now, how do you make the determination of
 17 how that transport is going to take place?
 18 **A Probably the same reason I gave you before.**
 19 **It's patient preference, their insurance policies,**
 20 **and/or the -- the one that's quickest -- the most**
 21 **available and most appropriate for whatever the**
 22 **transport is. Helicopter transport is often the most**
 23 **appropriate for some of the patients.**
 24 Q And why is that?
 25 **A Oh, just long -- helicopter to Reno in the**

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1 **winter is not preferable. It's quicker to take a**
 2 **fixed wing and more comfortable for the patient and a**
 3 **little bit more room.**
 4 MS. MORALES: Okay. So I was given a little note
 5 that I have five minutes about three minutes ago, so I
 6 think it's probably a good place to take a lunch.
 7 MR. WEAVER: Sure.
 8 MS. MORALES: And then come back and we'll
 9 actually talk about the case.
 10 MR. WEAVER: An hour?
 11 THE VIDEOGRAPHER: We are off the record at
 12 12:36 p.m.
 13 (Whereupon, at 12:36 p.m. a lunch
 14 recess was taken, proceedings resuming
 15 at 2:00 p.m.)
 16 THE VIDEOGRAPHER: We are back on the record,
 17 two o'clock p.m.
 18 Q (BY MS. MORALES) You understand that you're
 19 still under oath; correct?
 20 **A Yes, I do.**
 21 Q Holding a position as a medical director at
 22 REACH Air and working out of the emergency room
 23 department, did you have to sign any kind of forms
 24 with the hospital acknowledging that you work for
 25 both?

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1 **A Not that I remember.**
 2 Q Okay. Have you had any meetings with
 3 administration disclosing that you held both
 4 positions?
 5 **A No.**
 6 Q To your knowledge, were they aware?
 7 **A Yes.**
 8 Q Okay. So we're here to talk about Douglas
 9 Schwartz, the medical care and treatment received by
 10 Douglas Schwartz in June of 2016.
 11 And I believe you testified earlier that you
 12 have an independent recollection of Mr. Schwartz; is
 13 that correct?
 14 **A Yes.**
 15 Q Okay. So as I go through the records --
 16 luckily there's not a whole lot of them, but as I go
 17 through the records, I'm going to just ask you if you
 18 have independent recollections outside of that period
 19 of time that you were treating him. Okay?
 20 **A Okay.**
 21 Q All right. So Mr. Schwartz was transferred
 22 by ambulance on June 22, 2016, to Northeastern Nevada
 23 Regional Hospital.
 24 Is that your understanding?
 25 **A Yes.**

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1 Q Okay. And you have the records. I gave you
 2 the records, and we'll -- we'll mark that as the first
 3 exhibit, and then I'll just reference a page.
 4 So the first exhibit will be the
 5 Northeastern Nevada Regional Hospital records.
 6 (Plaintiff's Exhibit 1 marked for
 7 identification.)
 8 Q (BY MS. MORALES) And now I'm looking --
 9 because the first couple of pages were cover sheets,
 10 so I'm on page 3, Bates stamp 3.
 11 MR. WEAVER: At the bottom.
 12 THE WITNESS: Okay.
 13 Q (BY MS. MORALES) Okay. So up on the left
 14 corner, it says 20:51.
 15 And that is military time for 8:51 p.m.; is
 16 that correct?
 17 **A I can't --**
 18 MR. WEAVER: So Dr. Schwartz is having an eye
 19 issue, so he's having a --
 20 THE WITNESS: Dr. Garvey.
 21 MR. WEAVER: Dr. Garvey. Sorry.
 22 He's having an eye issue, so he's having a
 23 little trouble reading, so...
 24 THE WITNESS: I have to get close. I'm sorry.
 25 I'm having surgery next week.

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1 MS. MORALES: That's okay.
 2 THE WITNESS: Yeah, 20:51. Okay.
 3 Q (BY MS. MORALES) Okay. So that would have
 4 been the time that he arrived and was admitted to the
 5 emergency --
 6 **A Yes.**
 7 Q -- room; is that correct?
 8 **A Yes.**
 9 Q At the time that a patient such as
 10 Mr. Schwartz is presenting to the ER under the
 11 circumstances of -- of a car crash or being hit by a
 12 car, is it -- is it -- do you acquire information
 13 prior to their arrival to the hospital?
 14 **A I usually do, yes.**
 15 Q In this specific case, do you know if you
 16 got any information en route?
 17 **A I don't know if I did, but I almost always**
 18 **do.**
 19 Q Okay. Is that -- tell me what the -- how
 20 that information is conveyed.
 21 **A Usually by radio. EMS will call, giving us**
 22 **an ETA, an arrival time that they're bringing in, and**
 23 **tell us vital signs and sort of the general**
 24 **description of what -- what happened.**
 25 Q Okay. And is that -- while a patient is

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1 en route, is that -- do you document that anywhere
 2 within the medical chart as far as information that's
 3 received by EMS?
 4 **A No, not in the medical record. We will**
 5 **make -- sometimes make notes next to the radio, but**
 6 **that's about it.**
 7 Q Okay. And you don't have an independent
 8 recollection of exactly what was conveyed; correct?
 9 **A No.**
 10 Q Okay. So on this first page, page 3, at
 11 21:15, there are some notations there. And I realize
 12 that you have -- you're having an eye issue, so --
 13 **A No, I can see them.**
 14 Q Okay. So it has "d/jg," and then, slash,
 15 "j/kp."
 16 Are these notes that you're writing, or is
 17 this a history that's obtained by somebody else?
 18 **A That's the history as obtained by me, but it**
 19 **is transcribed by the scribe.**
 20 Q Okay. And where do you get the information
 21 to include in what's listed under HPI?
 22 **A From the patient or from EMS.**
 23 Q Okay. And HPI means History of Present
 24 Illness.
 25 **A Yes.**

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1 Q Is that fair?
 2 So this -- this notation indicates that the
 3 patient was a pedestrian struck by a moving vehicle
 4 and thrown approximately ten feet. The onset, the
 5 symptoms/episode began/occurred just prior to arrival.
 6 His injuries, the patient sustained injury to the
 7 head, abrasion, injury to the chest, specifically the
 8 right lateral posterior chest, pain with breathing,
 9 pain with movement, right bicep, right elbow and right
 10 knee abrasion. Associated signs and symptoms, loss of
 11 consciousness, the patient experienced loss of
 12 consciousness that was brief. Severity of symptoms,
 13 at their worst, the symptoms were moderate. In the ER
 14 the symptoms are unchanged. The patient has not
 15 experienced similar symptoms in the past and hasn't
 16 recently been seen by a physician.
 17 Outside of that history, do you have any
 18 independent recollection of receiving any additional
 19 history from the patient?
 20 **A Most of that was probably from the patient**
 21 **and EMS. I don't know what portions were from either.**
 22 Q Okay. And then the historical aspect, those
 23 go through allergies.
 24 What does PMHx stand for?
 25 **A Past -- PMH -- past medical history.**

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1 Q Okay. And hypertension.
 2 And then PSHx, what's that?
 3 **A Past surgical history.**
 4 Q Oh, past surgical. Okay.
 5 And are you acquiring that information? Are
 6 you specifically asking that, or is that something the
 7 nurse asks?
 8 **A Usually the nurse will ask. I sometimes**
 9 **confirm it.**
 10 Q Okay. And do you have any recollection one
 11 way or the other in this case if you asked?
 12 **A No. But I usually do.**
 13 Q All right. And then the next notation is
 14 written at 21:18.
 15 ROS, is that review of symptoms?
 16 **A Review of systems.**
 17 Q Systems? Okay.
 18 And so constitutional, negative for body
 19 aches, chills, fatigue, and fever.
 20 Eyes, negative for any visual disturbances,
 21 although it -- it talks about the right contact lens
 22 was lost; is that correct?
 23 **A Yes.**
 24 Q ENT, negative for drainage. Neck, negative
 25 for stiffness. Cardiovascular, positive for chest

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1 pain of the right lateral posterior chest. Negative
 2 for palpitations.
 3 Is that correct?
 4 **A Yes.**
 5 Q Okay. And the respiratory, negative for
 6 hemo- -- what's that word?
 7 **A Hemoptysis. Spitting up blood.**
 8 Q Okay. And shortness of breath.
 9 Does that mean that he was negative for
 10 shortness of breath at that point?
 11 **A Yes.**
 12 Q Okay. Abdomen, negative for nausea and
 13 vomiting.
 14 Now, is it -- is it true that Mr. Schwartz
 15 was given Zofran in transport to --
 16 **A Yes.**
 17 Q -- the hospital?
 18 **A Yes.**
 19 Q Okay. And at that time that he got to the
 20 hospital, he wasn't experiencing -- at this time, at
 21 21:18, it says he wasn't experiencing nausea; correct?
 22 **A This is the initial assessment, yes.**
 23 **Correct.**
 24 Q Okay. And back, positive for pain at rest
 25 of the left scapular area and left scapular -- well,

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1 it says the same thing, I guess. Oh, subscapular
 2 area. Positive for abrasions on the extremities.
 3 Neuro, negative. Skin, negative for pallor and --
 4 what -- how do you say that? Di- --
 5 **A Diaphoresis.**
 6 **Q Yeah.**
 7 Neuro, negative for dizziness, gait
 8 disturbance, or headache. And negative for anxiety
 9 and depression for psychiatry or psychological.
 10 Is that consistent with your recollection of
 11 Mr. Schwartz when he presented?
 12 **A Review of systems are usually things that**
 13 **are happening prior to the incident.**
 14 **Q Okay.**
 15 **A This is like past history kind of stuff.**
 16 **But also it's computer generated, so the scribe**
 17 **doesn't put a lot of this in with her own words. So a**
 18 **lot of it is computer generated, so...**
 19 **Q Okay.** So this is information that upon
 20 presentation, that you're getting from -- is it from
 21 an evaluation that you're doing as well?
 22 **A Yes.**
 23 **Q Okay.**
 24 **A I asked most of those questions, if not all**
 25 **of those questions.**

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1 **Q Okay.** And then it says "Exam." So that's
 2 ROS and then "Exam." And I don't want to have to go
 3 through each line again, but we can go through --
 4 that's at 21:20. So that's only a couple minutes
 5 later.
 6 And if you go to page 4 --
 7 **A Those times are when it was put in the**
 8 **computer, not the times that it was done.**
 9 MR. WEAVER: Let her ask you the question.
 10 THE WITNESS: Okay.
 11 **Q (BY MS. MORALES) Okay.** So this is -- this
 12 21:20 was the time that it was entered?
 13 **A Yes.**
 14 **Q Okay.** How do we know the exact time that
 15 the -- like the examination, for instance, took place
 16 of Mr. Schwartz?
 17 **A You have to peruse the rest of the record.**
 18 **But the initial evaluation occurred on his arrival of**
 19 **just after 20:51. I think I was there at the time,**
 20 **and that's when all that initially occurred.**
 21 **Q Okay.** So at the beginning of your
 22 deposition when I asked you if there were any changes
 23 or any inaccuracies in the records, you had indicated
 24 the timing on some of these.
 25 **A Oh, that's -- that --**

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1 **Q Is that what you're talking about?**
 2 **A Those are some of the things I'm talking**
 3 **about. The times were the times they were inputted in**
 4 **the computer, not the times they were done.**
 5 **Q Okay.** So to the best of your recollection,
 6 you would believe that the exam would have been done
 7 at or around 20:51?
 8 **A It was done at or about 20:51.**
 9 **Q Okay.** When you go into the computer
 10 system -- you said you have a scribe.
 11 So does the scribe actually enter it for
 12 you? Like, you write it on -- on something, and then
 13 it's entered by someone else?
 14 **A No. The scribe watches the interaction,**
 15 **listens to the answers to the questions, and -- or**
 16 **puts down what I tell them I found on the exam.**
 17 **Q Okay.** So they're actually sitting with you.
 18 **A They are there the whole time.**
 19 **Q So at -- at least what's documented as**
 20 21:20, the respiratory -- well, it says cardiovascular
 21 rate normal, rhythm regular. Respiratory, the patient
 22 does not display signs of respiratory distress.
 23 Respirations are normal. Breathing sounds are normal
 24 and clear throughout.
 25 **Is that correct?**

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1 **A Yes.**
 2 **Q The abdomen, your examination of the abdomen**
 3 **also resulted in normal findings; is that correct?**
 4 **A Yes.**
 5 **Q At this time?**
 6 **A Yes.**
 7 **Q And then neuro assessment was normal as**
 8 **well; is that correct?**
 9 **A Except for loss of recent memory.**
 10 **Q When you say "recent memory," what does that**
 11 **mean? Because here it says, "Immediate memory is**
 12 **intact. Remote memory is intact."**
 13 So what's the difference between recent and
 14 immediate?
 15 **A Recent being within the last hour or so. He**
 16 **didn't remember the accident.**
 17 **Q Okay.** But that would mean after the actual
 18 incident itself, that he was able to recall; correct?
 19 **A Yes.**
 20 **Q And he was conscious and, actually, it says**
 21 **pleasant and cooperative.**
 22 **A Yes.**
 23 **Q Did you know Mr. Schwartz prior to --**
 24 **A No, I did not.**
 25 **Q -- treating him? Okay.**

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1 So after your evaluation of Mr. Schwartz,
 2 what -- what was it within your differential
 3 diagnosis?
 4 **A Multiple trauma. Multiple systems involved.**
 5 **Serious situation based on the mechanism of injury.**
 6 **And -- I'll probably leave it at that.**
 7 Q And when you say "multiple systems
 8 involved," your exam didn't show that there were any
 9 urgent concerns; is that correct?
 10 **A No, not necessarily. It -- multiple systems**
 11 **involved, he had a head injury. He had chest trauma**
 12 **with a lot of pain in the right chest. And, again,**
 13 **the mechanism of injury is a Level II trauma with a**
 14 **pedestrian versus motor vehicle at supposedly like**
 15 **30 miles an hour. Anything over five miles an hour is**
 16 **a major trauma.**
 17 Q But you would agree that he was stable at
 18 the time that you first evaluated him; correct?
 19 **A He was stable at the time we first -- first**
 20 **evaluated him.**
 21 Q Okay. And so based on your evaluation and
 22 your differential diagnoses, what tests did you want
 23 Mr. --
 24 **A Pretty much --**
 25 Q -- Schwartz to undergo?

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1 **A Pretty much a full trauma workup based on**
 2 **the seriousness of his -- the potential injuries. He**
 3 **had CTs of almost his entire body.**
 4 Q Okay. Did you get any details besides -- I
 5 think it talked about the rate of speed pertaining to
 6 Mr. Schwartz's accident?
 7 **A I just remember the paramedics saying that**
 8 **he was -- he went over the car and landed on the**
 9 **pavement, and it was about ten feet from the actual**
 10 **place where the accident occurred.**
 11 Q Okay. So at the time -- after this initial
 12 evaluation, had you made a determination at that point
 13 whether or not you were going to transfer Mr. Schwartz
 14 to another facility?
 15 **A No, not at that time.**
 16 Q Okay. And so you just indicated that you
 17 pretty much ordered every CT available; correct?
 18 **A Pretty much.**
 19 Q And any other tests that you ordered?
 20 **A Lab. Routine trauma lab tests. Blood tests**
 21 **and urine.**
 22 Q Let me ask you this. At the time that
 23 Mr. Schwartz presented to the emergency room, was he
 24 already on oxygen?
 25 **A Yes.**

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1 Q And the EMTs, the -- the paramedics had
 2 indicated that was for precautionary measure; correct?
 3 MR. WEAVER: Object as to form.
 4 THE WITNESS: No. I don't remember them
 5 indicating anything precautionary. They typically
 6 would put -- put a patient on oxygen en route,
 7 especially with chest trauma.
 8 Q (BY MS. MORALES) And so at the time that he
 9 presented to the hospital, he still had on a nasal
 10 cannula; is that correct?
 11 **A He still had the nasal cannula from EMS,**
 12 **yes.**
 13 Q Do you recall at what point you met
 14 Ms. Schwartz? Was it upon the -- before or after your
 15 initial evaluation of Mr. Schwartz?
 16 **A It was probably -- again, it was -- she**
 17 **probably was not there when he first arrived. That**
 18 **was EMS, and we usually let family come in after the**
 19 **initial assessment. So it was probably after the**
 20 **initial assessment.**
 21 Q Okay. And do you have an independent
 22 recollection of Ms. Schwartz?
 23 **A Yes. I mean not specifics, but yes.**
 24 Q Had you ever met her prior to that day?
 25 **A No.**

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1 Q Okay. Okay. So besides -- so we don't have
 2 to go through every single record.
 3 Besides ordering all of the CT scans or
 4 several CT scans, lab work for trauma, what else, if
 5 anything, did you order or provide to Mr. Schwartz?
 6 MR. WEAVER: Just let me object as to the term
 7 "provide."
 8 THE WITNESS: Well, we -- since it was a major
 9 trauma, we started a second IV as we typically do
 10 with -- with significant trauma.
 11 We probably typed and crossed for blood just
 12 to have that on hold in case there was any internal
 13 bleeding found that required blood and put him on
 14 the -- the -- the typical monitors and switched him
 15 over to our own oxygen source.
 16 Q (BY MS. MORALES) And when you say switched
 17 him over to your own oxygen source, is it -- was it
 18 the same type of oxygen source, that cannula?
 19 **A We -- yeah. Usually we'll probably keep --**
 20 **keep whatever he's maintained on. Usually we do a**
 21 **quick assessment on what his room air oxygen**
 22 **saturations would be during the transition. So taking**
 23 **him off of the EMS's and then putting him on ours, we**
 24 **usually will have a number in between that shows**
 25 **that -- what he would have saturated on if he was not**

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1 **on oxygen.**
 2 Q And what amount of oxygen did you put him
 3 on? Do you remember?
 4 A **I think it was documented. Four liters**
 5 **again.**
 6 Q And is that what he was on at the time that
 7 he presented to the hospital?
 8 A **He was on four liters. We took him off of**
 9 **the EMS four liters and put him on our four liters,**
 10 **yes.**
 11 Q And you're pointing at something.
 12 What page are you pointing to?
 13 A **Page 4. It shows oxygen levels.**
 14 Q Now, did you have any discussion with
 15 Ms. Schwartz or any of the friends or family that were
 16 in the room prior to Mr. Schwartz going in for the CT
 17 tests?
 18 A **Probably. Because Ms. Schwartz probably**
 19 **came before we sent him to the CT scanner, yes.**
 20 Q And do you have an independent recollection
 21 of any of those discussions that you had with her?
 22 A **No, not really.**
 23 Q Now, Mr. Schwartz was given Zofran en route.
 24 What's the -- what's the life of the Zofran
 25 when you give it? How long does it last?

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1 A **It usually lasts two to four hours.**
 2 Q And Mr. Schwartz was also given Dilaudid
 3 en route; is that correct?
 4 A **I think Fentanyl. Maybe Dilaudid, but I**
 5 **thought it was Fentanyl. I'd have to look at the EMS**
 6 **record.**
 7 **I thought the record said Fentanyl and**
 8 **Zofran, but maybe it was Dilaudid and Zofran. They're**
 9 **fairly equivalent.**
 10 Q So do you have any independent recollections
 11 of your initial discussions with Ms. Schwartz?
 12 A **Initial discussions, no.**
 13 Q Okay. So -- and I kind of want to break it
 14 into time frames to make it a little easier.
 15 So before Mr. Schwartz went in for the
 16 radiology testing, do you remember any specific
 17 discussions that you had with Ms. Schwartz during that
 18 period of time?
 19 A **Before he went in, no.**
 20 Q Okay. Do you have any independent
 21 recollection of there being other friends in the room
 22 with Mr. Schwartz prior to him going in for CT scan?
 23 A **Prior to him going in to CT scan, I --**
 24 **prior. So that was about a half hour worth of time.**
 25 **I don't -- I don't recall who all was in the room**

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1 **prior to him going. There was probably about a half**
 2 **hour there, and I -- I'm not sure who was there before**
 3 **he left for the CT scanner.**
 4 Q Okay. So he goes for the CT, for the
 5 radiology studies.
 6 Had you -- before he went for that testing,
 7 had -- had you made any determinations of whether or
 8 not he was going to get transferred?
 9 A **No. I already said no.**
 10 Q Okay. So after Mr. Schwartz gets back from
 11 the radiology testing, did you already have the lab
 12 work done back by then?
 13 A **Yes.**
 14 Q Okay. And what were the results of the lab
 15 work?
 16 A **Most of the labs were pretty normal, except**
 17 **there was some blood in his urine, which could**
 18 **indicate a kidney injury. But most of his hemoglobin**
 19 **and everything, other -- other things that we'd look**
 20 **at were pretty normal. I don't know what page that's**
 21 **on.**
 22 Q Page 13 I think.
 23 A **Where's the pages?**
 24 MR. WEAVER: Right there.
 25 MS. MORALES: Thirteen and 14.

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1 THE WITNESS: There on the bottom. I got it.
 2 MR. WEAVER: It's confusing.
 3 I'm sorry, Jenn, what was the question?
 4 MS. MORALES: Oh, so I was letting him look at
 5 it.
 6 Q So everything was pretty normal?
 7 A **Pretty normal. We looked at mainly the**
 8 **hemoglobin, the hematocrit. We looked at amylase to**
 9 **make sure there's no pancreatic injuries, and then**
 10 **usually the urine. But he did have blood in his**
 11 **urine. He's got three plus hemoglobin and 20 to**
 12 **30 microscopic hematuria in the blood.**
 13 Q All right. And you said that could be
 14 indication of a kidney --
 15 A **Kidney or bladder injury, yes.**
 16 Q Is it consistent with anything else besides
 17 those two things? What's in your differential
 18 diagnosis when you see that?
 19 A **Well, unless he has some kind of kidney**
 20 **condition, which he's not supposed to have with his**
 21 **past medical history, it would probably more than**
 22 **likely be a result of the trauma. So probably a**
 23 **kidney contusion would be the most likely since most**
 24 **of his injury was the right flank.**
 25 Q Okay. So besides that, besides the

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1 kidney -- potential kidney or bladder issue, there was
 2 nothing else --
 3 **A Nothing else remarkable, no.**
 4 Q So after you got the lab work back, did you
 5 make any additional orders?
 6 **A Probably not, no.**
 7 Q Okay. And after you saw the lab work, did
 8 you make a determination whether or not you were going
 9 to transfer the patient --
 10 **A No.**
 11 Q -- to --
 12 MR. WEAVER: Wait till she's finished the
 13 question before you answer.
 14 Q (BY MS. MORALES) -- if you're going to
 15 transfer the patient out?
 16 **A No, I did not.**
 17 Q Okay. The radiology studies, in between
 18 getting the lab work and the radiology studies, did
 19 Mr. Schwartz physically remain stable for evaluation?
 20 Did you check on him in between that period of time?
 21 **A Between what time?**
 22 Q The time you got the lab results back and
 23 the time before you got the radiology results.
 24 **A Yes. Usually there's communication between**
 25 **the lab -- the radiology tech, the nurse, and myself.**

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1 **And oftentimes if it's taking a while, I'll go down to**
 2 **radiology and check things out myself. I can't recall**
 3 **if I did or not, but I usually do.**
 4 Q Okay. So -- and I was going to get there,
 5 but -- so how does the process work? It's -- it's now
 6 probably 10:00 or so at night, right, when the
 7 radiology studies are done?
 8 **A Yes.**
 9 Q Is there a radiologist on site --
 10 **A No.**
 11 Q -- at night?
 12 **A No.**
 13 Q Okay. So do they have a system in place
 14 like where there's wet reads? Like, they do the --
 15 the films and then someone reads them and then someone
 16 reviews them later?
 17 **A The radiologist at -- at Northeastern Nevada**
 18 **will usually review all of the radiology -- any**
 19 **radiology done while they're not physically present**
 20 **that -- that are read by what we call Night Hawk, and**
 21 **they will read them in the morning and either agree or**
 22 **disagree with them. If they see something different,**
 23 **they will let the emergency physician know.**
 24 Q And so Night Hawk is actually a technician,
 25 it's not a radiologist?

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1 **A It's a radiologist.**
 2 Q Oh, it is a radiologist. Okay.
 3 **A It's a service provided.**
 4 Q So they're not on site. They're sending the
 5 films out to be read.
 6 **A Sending them out electronically to be read.**
 7 **They're usually done in bulk after they're all done.**
 8 Q And when you have a -- a trauma patient, is
 9 that something that comes back on a more expedited
 10 basis?
 11 **A We try to get everything back, especially**
 12 **for trauma, STAT, at which --**
 13 Q Is that how these were ordered, STAT?
 14 **A Always, yes.**
 15 Q And do you have an independent recollection
 16 if you had to go down to the radiology department or
 17 if the technician from Night Hawk called you?
 18 **A Oh, the technician from Night Hawk called**
 19 **me. But I also viewed the -- the -- the -- I -- I**
 20 **look at all the radiographs myself.**
 21 Q Okay. And do you look at them while you're
 22 talking to the radiologist, or do you get the
 23 radiologist's opinion and then look at them? What's
 24 your custom and practice?
 25 **A I will usually look at them immediately**

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1 **after they are done and then make my opinion. If I**
 2 **see something that I can interpret, sometimes I will**
 3 **make a decision based on that. Otherwise, I will**
 4 **usually wait for the official radiology report to**
 5 **decide how I'm going to proceed.**
 6 Q Okay. And in this specific case, did you
 7 review all the films?
 8 **A Yes. I always review all the films.**
 9 Q And did you have any specific concerns with
 10 the films that you reviewed?
 11 MR. WEAVER: Just let me object as to the phrase
 12 "specific concerns."
 13 But go ahead.
 14 You mean the quality or what's on them?
 15 Q (BY MS. MORALES) Yeah, what you -- the
 16 findings.
 17 **A The main thing that I did see when I**
 18 **reviewed the films was a pneumothorax and injury to**
 19 **the right lung. And at that point in time, just based**
 20 **on that finding, I knew the patient was going to need**
 21 **transfer.**
 22 Q So was that -- the pneumothorax after you
 23 reviewed the film, did you discuss that in any more
 24 detail with the radiologist to determine the size of
 25 the pneumothorax?

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1 **A No. The radiologist after -- when they read**
 2 **it would have called me and told me their opinion on**
 3 **any -- any of the readings of the film.**
 4 **When I looked at it, I can determine the**
 5 **size. And -- and being a traumatic pneumothorax,**
 6 **that's -- that's significant, and I know -- knew the**
 7 **patient was going to be needing to be transferred to a**
 8 **trauma center.**
 9 Q Okay. And can you explain for the jury what
 10 a pneumothorax is.
 11 **A A collapsed lung.**
 12 Q And it means when there's -- does it mean
 13 when there's like a pocket of air around the lung?
 14 **A A traumatic pneumothorax usually means that**
 15 **something penetrated the lung and caused it to**
 16 **collapse.**
 17 Q And is there a difference as far as the
 18 sizes -- the size of the pneumothorax as -- as far as
 19 urgency is concerned?
 20 **A Not necessarily.**
 21 Q Can a pneumothorax of ten percent or less
 22 resolve on its own?
 23 **A Usually not a traumatic pneumothorax. A**
 24 **spontaneous, yes, but not a traumatic. Almost always**
 25 **requires a chest tube.**

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1 Q Is there -- when you say "almost always
 2 requires a chest tube," is there any other form of
 3 treatment for pneumothoraxes that are less than
 4 ten percent? Ten percent or less?
 5 **A Significantly less than ten percent. If --**
 6 **if you have an occult pneumothorax that's shown up on**
 7 **CT scan, sometimes you can sit on them even if it's in**
 8 **the setting of trauma. But -- but once they get more**
 9 **than just a little sliver of an occult pneumothorax, I**
 10 **can't think of any cases in 35 years that the patient**
 11 **did not require a chest tube.**
 12 Q Okay. And is chest tube something that you
 13 commonly are familiar with doing in the emergency
 14 room?
 15 **A Yes.**
 16 Q And is there a way to determine -- besides
 17 just saying that a pneumothorax is ten percent or
 18 less, to determine if it's five percent, six percent?
 19 Is there such a rating or is it just that's how it's
 20 categorized?
 21 **A It's a guess -- guesstimate.**
 22 Q And did you agree with the radiologist that
 23 it was ten percent or less?
 24 **A I didn't pay too much attention to the size,**
 25 **but yes, I saw it was around ten percent. They might**

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1 **be able to determine it with the computer-generated**
 2 **images that they get. They might be able to be closer**
 3 **than my guesstimate, but that's probably about right.**
 4 Q So if I understand you correctly, the fact
 5 that he had a traumatically-induced pneumothorax,
 6 regardless if it was five, six, seven, even
 7 15 percent, you would have transferred him to a
 8 different facility?
 9 **A Yes.**
 10 Q And is that for observation purposes?
 11 **A No. It would be for continued treatment.**
 12 **He's going to have a chest tube in, and it will**
 13 **probably be three to five days before he gets that**
 14 **pulled out. So he will be under the care of a trauma**
 15 **surgeon and the trauma team until that -- if that is**
 16 **his only injury.**
 17 Q And are there any trauma surgeons available
 18 at -- in Elko, at the Elko hospital?
 19 **A No, there are not.**
 20 Q Can a regular -- like a pulmonologist or a
 21 regular general surgeon take care of pneumothoraxes?
 22 **A They can take care of pneumothoraxes --**
 23 Q Pneumothoraxes. Sorry.
 24 **A Pneumothoraxes. But I would not give them**
 25 **traumatic pneumothoraxes to take care of. That's why**

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1 **we have trauma centers.**
 2 Q And do you have general surgeons and
 3 pulmonologists that contract out of Elko hospital?
 4 **A We have no pulmonologists, and we don't have**
 5 **any trauma surgeons that contract out of Elko.**
 6 Q In reviewing the film, I assume that you
 7 were looking at the CT of the chest; is that correct?
 8 **A Yes.**
 9 Q What other findings did you see on the CT of
 10 the chest?
 11 **A I'm not sure if I saw the rib fractures or**
 12 **not, but I think I sort of -- once I saw the**
 13 **pneumothorax, I started arranging for transfer.**
 14 MR. WEAVER: It's page 57.
 15 Q (BY MS. MORALES) Okay. So as you sit here
 16 today, you don't recall whether or not you
 17 specifically were able to see the same fractures as
 18 identified by the radiologist?
 19 **A I don't remember whether I did or not.**
 20 Q And whether or not you saw the fractures
 21 yourself or read this report, did you have any
 22 concerns regarding the rib fractures?
 23 **A I'm -- I'm not quite sure of what your**
 24 **question is.**
 25 Q Did you have any additional concerns with

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1 the fractures of the ribs?
 2 **A After the radiologist told me about the**
 3 **fractures?**
 4 Q Yes.
 5 **A Yes. He went -- the patient went from**
 6 **serious to critical once I got the radiology report.**
 7 Q And why did he go from serious to critical?
 8 **A Because a flail chest is an immediate life**
 9 **threat. One of the deadly dozen.**
 10 Q And can you explain for the jury what a
 11 flail chest is.
 12 **A Multiple rib fractures, adjacent ribs**
 13 **fractured in multiple places. So you've got a segment**
 14 **that is independent of the rest of the chest.**
 15 Q And is it two ribs that are broken in two
 16 places or is it three ribs? How many ribs have to be
 17 broken to --
 18 **A Two or more.**
 19 MR. WEAVER: Just let her get her whole question
 20 out before you answer.
 21 Q (BY MS. MORALES) So is it -- is it two ribs
 22 broken in the same area?
 23 **A Two or more ribs broken -- broke -- two or**
 24 **more adjacent ribs broken in multiple places, yes.**
 25 Q And what are the symptoms that are

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1 associated with flail chest?
 2 **A Well, the main problem with the failed -- a**
 3 **flail chest usually is the underlying pulmonary**
 4 **contusion where the lung itself is bruised and filling**
 5 **with blood.**
 6 **But you also have an area of the chest that**
 7 **when the patient breathes, there's paradoxical**
 8 **movements. So when you do an inspiration, the rest of**
 9 **the chest goes out and the flail segment goes in, so**
 10 **ventilation isn't adequate.**
 11 Q And was Mr. Schwartz -- did Mr. Schwartz
 12 have any of those symptoms?
 13 **A Yes, he did.**
 14 Q And did you document that somewhere?
 15 **A It's documented in the -- the reports,**
 16 **especially the radiology findings. His oxygen**
 17 **saturations are documented, and they started**
 18 **diminishing. He required to be placed on a Venti mask**
 19 **as opposed to a four-liter nasal cannula.**
 20 Q And when you're talking about the -- the
 21 breathing pattern, did you document that anywhere in
 22 the medical record?
 23 **A No. Well, it's not obvious.**
 24 Q And when you -- you mentioned or made
 25 reference to pulmonary contusion.

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1 When you reviewed the radiology film, did
 2 you actually see a pulmonary contusion?
 3 **A I saw injury to the right lung. I didn't**
 4 **necessarily know what it was. You usually do not see**
 5 **pulmonary contusions immediately after the injury.**
 6 **When you do, it pretty much means that the injury was**
 7 **pretty significant.**
 8 Q Okay. And it's fair to say that the
 9 radiologist didn't definitively identify or diagnose a
 10 pulmonary contusion; correct?
 11 **A Correct. However, the injury on the**
 12 **radiograph was in the same spot as the area of the**
 13 **questionable contusion versus aspiration. And either**
 14 **one of them would have been significant, whether the**
 15 **patient had already aspirated or has a lung filling**
 16 **with fluid. Neither one are trivial.**
 17 Q And I just want to make sure we're clear.
 18 But when you looked at the film, you weren't
 19 able to distinguish one way or the other what the
 20 injury was to the lung; correct?
 21 **A No.**
 22 Q Now, after -- well, let's go through it.
 23 The other CT scans that you reviewed, was
 24 there anything else that -- that was concerning to
 25 you?

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1 **A No. Most of the other findings were subtle,**
 2 **and I did not get -- I mean, I was not alarmed until I**
 3 **got the CT report back.**
 4 Q And just to be clear, there were several CT
 5 reports, so CT of the chest.
 6 **A Several. CT of the chest.**
 7 MR. WEAVER: She's -- she's asking about the
 8 other films as well, whether there was anything
 9 concerning on the other CTs of the spine and --
 10 THE WITNESS: Yes.
 11 MR. WEAVER: -- head.
 12 Would that -- that was your question?
 13 MS. MORALES: Uh-huh.
 14 THE WITNESS: Yeah. There -- there were findings
 15 concerning on every one of the CTs that were
 16 performed.
 17 Q (BY MS. MORALES) Okay. Anything that made
 18 it emergent?
 19 **A Yes. All of them.**
 20 Q Okay. All of them on every finding made it
 21 emergent.
 22 **A Every CT scan that was done had an emergent**
 23 **finding that the patient would have been transferred**
 24 **to a trauma center.**
 25 Q Okay. And so let's go over what those

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1 emergent findings are.
 2 **A All right.**
 3 Q So CT of the C-spine, that --
 4 **A Except the C-spine.**
 5 Q Okay. So the C --
 6 **A Okay.**
 7 Q The CT of the C -- the C-spine, nothing on
 8 that; right?
 9 **A Nothing major on that. It was pretty**
 10 **unremarkable. But that is only -- that doesn't**
 11 **necessarily mean that there's no spinal injury. There**
 12 **could be a ligamentous injury. So we still keep the**
 13 **patient in -- in a collar even though that the CT was**
 14 **negative.**
 15 Q Okay. So Mr. Schwartz was in a -- had a
 16 C collar on at the time?
 17 **A Yes. The entire time.**
 18 Q Okay. The CT of the head without contrast,
 19 that's on NEN 62.
 20 Anything emergent on that?
 21 **A Yes. He had what clinically -- 62? I'll**
 22 **get there.**
 23 **Clinically it would be a possibility of a**
 24 **small subdural hematoma.**
 25 Q And did you look at that film yourself? Do

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1 you recall?
 2 **A I looked at it after the reading. I could**
 3 **see what the radiologist was looking at. And based on**
 4 **the clinical situation with the head trauma and the**
 5 **amnesia and possible loss of consciousness, I made the**
 6 **determination that the subdural was much more likely**
 7 **than patient being dehydrated because clinically he**
 8 **was not dehydrated.**
 9 Q Okay. And the radiologist came up with the
 10 opposite impression; correct?
 11 **A Yes. But he wasn't in the room and didn't**
 12 **know the entire story of the patient.**
 13 Q The thoracic spine, was there something
 14 emergent on that?
 15 **A Yes. Two pedicle fractures.**
 16 Q And on what levels?
 17 **A It was 10 and 11 or 11 and 12.**
 18 **Let me see. What page are we on?**
 19 **MR. WEAVER: 66.**
 20 **THE WITNESS: Ten and 11.**
 21 Q (BY MS. MORALES) 66 and 67. Sorry.
 22 **A Uh-huh.**
 23 Q So fractures to those areas?
 24 **A That's what I have to take from that CT**
 25 **scan. Correlate for tenderness to palpation at this**

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1 **level, that's exactly where he was struck by the car.**
 2 **The pedicles are what surround the spinal cord, so**
 3 **that to me is a significant injury.**
 4 Q Okay. Anything in the -- oh, that was the
 5 thoracic. Sorry. We talked about the chest.
 6 **A The abdomen.**
 7 Q Okay. Anything in the abdomen or pelvis?
 8 **A Yes. He had blood behind the liver and then**
 9 **abdominal gutters.**
 10 Q And what is that? What's in your
 11 differential diagnoses when you see that?
 12 **A Well, he could have been bleeding from**
 13 **anything inside the abdomen. He could have**
 14 **diaphragmatic rupture. I didn't see a liver**
 15 **laceration, but he still could have. It could be**
 16 **coming from any kind of visceral injury in the**
 17 **abdomen. But it's coming from something, so he does**
 18 **have bleeding in his abdomen which needs to be**
 19 **evaluated further.**
 20 Q And did you -- did you see that on the film
 21 yourself, or were you relying on the radiologist?
 22 **A I did not see that on the film.**
 23 Q Okay. Pelvis?
 24 **A That's all one film.**
 25 Q Oh.

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1 **A Abdomen and pelvis all done together.**
 2 Q And we talked about the chest.
 3 Okay. So were -- after reviewing those
 4 films and talking with the radiologist, did -- was
 5 there any other treatment that you had to provide or
 6 that you ordered after reviewing the films?
 7 **A I knew the patient needed to be transferred.**
 8 **He came back from CT scan after -- and I looked at the**
 9 **original scan, and I knew he had to be transferred**
 10 **with me looking at the chest film. And I called -- I**
 11 **asked for an air ambulance. I probably talked to the**
 12 **wife. I think she said that she had contracts or**
 13 **insurance through REACH. So I don't know if I or the**
 14 **nurse or the clerk asked REACH to be called. And I**
 15 **told them to call. We haven't arranged transfer yet,**
 16 **but I wanted them to come early to assist if -- if**
 17 **they were able to get there.**
 18 **Usually we wait until we have an accepting**
 19 **physician, but I asked them not to wait, to go ahead**
 20 **and respond.**
 21 Q So if I understand this correctly, when
 22 Mr. Schwartz had got back from the CT, you at that
 23 point had called REACH or did you --
 24 **A At that point -- at that point I called**
 25 **REACH when he returned from CT and I looked at the CT**

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1 **film. Sometimes it takes a few minutes for the films**
 2 **to be processed enough that I can look at them. But I**
 3 **looked at them probably shortly after he arrived back**
 4 **to the emergency department.**
 5 Q Now, is there a note that you wrote within
 6 your medical records that would identify your review
 7 and diagnoses after you reviewed the films?
 8 A **I don't think there's a note. The only**
 9 **thing is that at that point in time, between the time**
 10 **that the patient returned from CT scan and the time**
 11 **the radiologist called the report, I called REACH. So**
 12 **I knew that the -- I knew that the patient needed to**
 13 **be transferred.**
 14 MR. WEAVER: The question was, was there a note.
 15 THE WITNESS: No. I said no. Not that I
 16 recollect.
 17 Q (BY MS. MORALES) Okay. And so what I'm
 18 showing is that, from the REACH Air documentation,
 19 they were contacted at 11:36 p.m.
 20 A **The patient returned from the CT scan --**
 21 MR. WEAVER: Dr. Garvey, let her ask you a
 22 question, and then answer the question she asks you.
 23 THE WITNESS: All right.
 24 Q (BY MS. MORALES) And -- and so that, you're
 25 saying, would have been at or around the time that

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1 these films -- that you had reviewed the films, talked
 2 to the radiologist.
 3 A **No.**
 4 Q Correct?
 5 A **No.**
 6 Q Or right after.
 7 A **No.**
 8 Q Okay. Go ahead.
 9 A **No.**
 10 Q When -- when was it?
 11 A **REACH was called after I reviewed the films**
 12 **personally --**
 13 Q Okay.
 14 A **-- and saw the pneumothorax.**
 15 **At that time I knew the patient needed to be**
 16 **transferred. He was still in serious condition. He**
 17 **was not critical at that point in time.**
 18 Q And do you recall what you told the -- did
 19 you personally call REACH Air?
 20 A **No.**
 21 Q Okay.
 22 A **No.**
 23 Q Who do you have -- what's the custom and
 24 practice? Who do you have call REACH Air?
 25 A **Usually the clerk, if there was a clerk**

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1 **working. Otherwise a nurse would do it.**
 2 Q And do you tell the nurse or the clerk what
 3 to convey to REACH Air?
 4 A **In this case, probably told them to have --**
 5 **"We don't have accepting yet, but Dr. Garvey wants you**
 6 **to come up to the emergency department."**
 7 Q So from the time that you reviewed the
 8 films, you had someone reach out to REACH Air, did you
 9 administer any additional treatment before -- before
 10 you get -- before trying -- attempting to intubate or
 11 put the chest tube in? Was there any --
 12 A **Well, the only treatment that we -- I**
 13 **remember coming back, we had to put the Venti mask on**
 14 **him because his oxygen saturation had gotten close to**
 15 **90 percent -- 90, 91 percent while he was in CT scan.**
 16 **And he returned back from CT scan still very**
 17 **nauseous, so I had to give him another dose of Zofran.**
 18 **So his airway was potentially unstable. So we -- you**
 19 **know, he's on a backboard and a collar and complaining**
 20 **of nausea, so he could have vomited at any time.**
 21 Q And so did you order more Zofran?
 22 A **Yes.**
 23 Q And do you know what dose you ordered?
 24 A **Usually four milligrams.**
 25 Q And did you have an understanding that

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1 Mr. Schwartz had a full meal just prior to getting hit
 2 by the car?
 3 A **Yes, I knew that.**
 4 Q And when you say he could have vomited at
 5 any time, what -- what was your fear with that?
 6 A **We would lose his airway. He would vomit**
 7 **and aspirate. He's on a backboard and a C collar.**
 8 Q And at what point did you call the
 9 University of Utah?
 10 A **Right after I got the CT readings.**
 11 Q And did you personally call?
 12 A **I didn't. The clerk usually calls. And as**
 13 **soon as they get on the line, the transfer center, I**
 14 **speak to whatever the accept -- whoever the receiving**
 15 **is. It's usually an emergency room physician.**
 16 Q And how did you make the determination to
 17 send him to the University of Utah as opposed to
 18 somewhere else?
 19 A **Probably his wife or -- he or his wife chose**
 20 **the University of Utah versus Renown or Saint Mary's.**
 21 **Those are the three typical trauma centers that we**
 22 **will transfer to.**
 23 MR. WEAVER: Can we take a break whenever you get
 24 through whatever line of questions?
 25 MS. MORALES: Yeah. That's fine.

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1 Was there a question pending?
 2 MR. WEAVER: No.
 3 MS. MORALES: We can take a break.
 4 THE VIDEOGRAPHER: We are off the record,
 5 3:01 p.m.
 6 (Recess taken.)
 7 THE VIDEOGRAPHER: We are back on the record,
 8 3:12 p.m.
 9 Q (BY MS. MORALES) Okay. Doctor, you
 10 understand you're still under oath; correct?
 11 A Yes, I do.
 12 Q Okay. So you contact -- you contacted the
 13 receiving facility sometime after you reviewed the --
 14 the CT films; correct?
 15 A After I spoke with the radiologist, yes.
 16 Q And that would have been -- and you can look
 17 at your record, but that would have been sometime
 18 around 11:40 to the time -- 11:40 to midnight; is that
 19 fair?
 20 A Yeah. 11:45 to midnight. Somewhere in
 21 between there.
 22 Q Okay. And at the time that you contacted
 23 the receiving doctor or the receiving facility, had
 24 Mr. Schwartz already -- had -- had his oxygenation
 25 started to get worse at that point?

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1 A The -- at -- when he returned back from CT
 2 scan, his oxygenation was worse.
 3 Q And are you able to pinpoint a time of when
 4 that occurred?
 5 A He came back from CT around 11 -- let's see.
 6 Well, when he was put on the Venti mask. Just one
 7 second.
 8 Q So I have NEN 4. I don't know if that helps
 9 you.
 10 A What -- what page?
 11 Q Four and 5. Number 4 and 5. Or -- 4 and 5.
 12 A I think he was put -- he came back 23:27.
 13 Yeah, some -- somewhere around 11:30 he came back, was
 14 put on the Venti mask.
 15 MR. WEAVER: What -- what's the question, Jenn?
 16 I'm sorry.
 17 Q (BY MS. MORALES) Yeah, When his oxygenation
 18 decreased. So you're --
 19 A Oh, maybe -- maybe 11:15.
 20 Q And where are you looking to get that
 21 information?
 22 A When the 91 percent started.
 23 Q And where does it say he's on a Venti mask
 24 at that point?
 25 A It doesn't. It probably does in some of the

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1 other records because I pinpointed at every --
 2 everything when I went through the records.
 3 MR. WEAVER: You're thinking out loud. Just
 4 wait --
 5 THE WITNESS: Okay.
 6 MR. WEAVER: -- until you find the answer and
 7 then give it to her.
 8 THE WITNESS: Okay. Yeah, he -- it -- it was
 9 probably closer -- between 11 o'clock and
 10 11:20 because that's when the Zofran was also given.
 11 So the Venti mask and the Zofran were about the same
 12 time as soon as he got back from the CT scanner.
 13 Q (BY MS. MORALES) Okay. And you see on
 14 page 4 where it says four liters, and it starts at
 15 20:53, and up until 6/23 at 12:10 in the morning, it
 16 doesn't show that there was a change in the type of
 17 oxygenation that was used; correct?
 18 A It's somewhere in the record it says he was
 19 started on a Venti mask. I -- I mean, it's in here
 20 somewhere, the timing of the Venti mask.
 21 Q Okay.
 22 A And it was immediately after he returned
 23 from CT scan his oxygen saturations were 91 percent.
 24 Q Okay. So when you talked to the receiving
 25 facility, do you recall who you talked to?

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1 A Dr. Ray, an emergency physician.
 2 Q And have you worked with Dr. Ray before?
 3 A No, I have not.
 4 Q Okay. And so you never transferred a
 5 patient that you can recall to this specific
 6 physician?
 7 A Not that I can recall. I possibly have.
 8 Q And what information did you convey to him
 9 when you talked to him?
 10 A I pretty much listed all the injuries that
 11 we know -- knew of at the time. Pneumothorax, flail
 12 chest, pulmonary contusion, hemoperitoneum.
 13 Q So just so we're clear, you told him the
 14 flail chest, the --
 15 A Pulmonary contusion.
 16 Q -- pulmonary contusion, although you didn't
 17 know whether or not there actually was a contusion;
 18 correct?
 19 A Clinically there was and radiographically
 20 concurred, so yes.
 21 Q Okay. What else did you tell him?
 22 A Hemoperitoneum. Blood in the belly.
 23 Q Okay.
 24 A That's probably -- I mean, I may have listed
 25 everything else, but those are indicators of major

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1 **trauma, so he needed to go to a trauma center.**
 2 Q And what information did Dr. Ray convey back
 3 to you?
 4 A **If I recall in my notes, he recommended a**
 5 **chest tube and possible intubation. But that was**
 6 **already planned. That's why I asked REACH to come**
 7 **early.**
 8 Q Okay. So he said chest tube, possible
 9 intubation.
 10 A **Yes.**
 11 Q He didn't tell you to conclusively intubate
 12 the patient.
 13 A **No.**
 14 Q He left that up to you; correct?
 15 A **That's my decision. I'm the transferring**
 16 **physician.**
 17 Q Prior to talking to the receiving facility,
 18 do you send over any paperwork or do you call first?
 19 A **We -- after acceptance, we send the**
 20 **paperwork. So once he accepted the transfer, we**
 21 **will -- we would forward all our paperwork over to**
 22 **them. Whatever is complete at the time.**
 23 Q Okay. Did -- did that receiving doctor
 24 request that -- that you do any additional
 25 interventions before you send them over?

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1 MR. WEAVER: Other than what they talked about?
 2 Q (BY MS. MORALES) Other than the chest tube.
 3 A **No.**
 4 Q Is there a -- a categorization for patients
 5 that you send by flight transfer? Like, for example,
 6 emergent? Immediate? I mean, are there -- is there a
 7 category -- strike that.
 8 You're -- you're also a medical director of
 9 REACH Air, so is there a category that shows the
 10 urgency of the transfer?
 11 A **Almost all our transfers are emergent. I**
 12 **mean, we're transferring to a higher level of care, a**
 13 **tertiary care center. In this case, a trauma center.**
 14 Q And that's not categorized in any way by you
 15 as a ER doctor or by the flight team that's
 16 transferring.
 17 A **I'm not sure how to answer that. At this --**
 18 **at this point in time, he's a Level I trauma. He has**
 19 **multiple life-threatening injuries, so you can't get**
 20 **much more urgent than that unless you're in full**
 21 **arrest.**
 22 Q And do you recall -- well, strike that.
 23 Tell me what you recall after you talked to
 24 the receiving doctor at the University of Utah.
 25 Did you instruct someone to send over

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1 records for Mr. Schwartz to the receiving hospital?
 2 A **That's automatically done. I don't have to**
 3 **request it.**
 4 Q Okay. After you called the hospital -- you
 5 had already contacted REACH -- what's the next thing
 6 that you did as it pertains to Mr. Schwartz?
 7 A **All this was occurring pretty much after**
 8 **the -- speaking with the radiologist, so I probably**
 9 **got Mrs. Schwartz and Mr. Schwartz together to discuss**
 10 **what the next steps were going to be and what had to**
 11 **be done after finding out what the -- what all**
 12 **Mr. Schwartz's injuries were.**
 13 Q Okay. And you said you probably did that.
 14 Do you have any specific recollection of --
 15 or independent recollection of sitting down with
 16 Mr. Schwartz -- Mr. and Mrs. Schwartz?
 17 A **There was no sitting down, but we were at**
 18 **the bedside. Yes, I do recollect that -- tried to**
 19 **explain the injuries without seriously alarming**
 20 **Mrs. Schwartz, but to make sure that they understood**
 21 **the seriousness of the injuries and what we needed to**
 22 **do before we were able to transfer him to the**
 23 **University of Utah. Up to that point, there was**
 24 **really no talk about transferring.**
 25 Q And were the family friends in the room at

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1 the time that you had this discussion?
 2 A **I don't think they were, but I don't**
 3 **recollect.**
 4 Q Were there nurses in the room?
 5 A **Oh, yes.**
 6 Q I'm sorry?
 7 A **Yes. Uh-huh. This was in the patient's**
 8 **room.**
 9 Q Was this before the REACH team arrived?
 10 A **This was -- I probably -- I may have**
 11 **discussed the need for transfer with Mrs. Schwartz**
 12 **prior to the REACH team getting there but probably did**
 13 **not go through the details until after the radiology**
 14 **report came back.**
 15 **Once I knew that there was a pneumothorax**
 16 **and called REACH, I may have indicated to them that we**
 17 **were going to have to transfer him. But we probably**
 18 **did not -- I probably did not go into detail until it**
 19 **was closer to the time that we had to act, and that**
 20 **was after we got the radiology report.**
 21 Q Okay. You agree that prior to performing an
 22 intubation on a patient in the emergency room who is
 23 conscious, you must obtain informed consent; correct?
 24 MR. WEAVER: Object as to form.
 25 THE WITNESS: Not necessarily.

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1 Q (BY MS. MORALES) Okay. And why not?
 2 A **Because this is an emergency situation, and**
 3 **there really are no options. I need to explain the**
 4 **procedure to the patient, which I did, and tell him**
 5 **the indications and why it was being done, and I did**
 6 **all that.**
 7 Q Okay. So you don't believe that you're
 8 required to do anything other than just explain the
 9 procedure that is going to take place; is that
 10 correct? To Mr. Schwartz.
 11 A **Not necessarily with those words. I need to**
 12 **make sure that the patient -- Mr. Schwartz and**
 13 **Mrs. Schwartz clearly understood the severity of the**
 14 **injuries and the necessity for doing the procedures**
 15 **that I was going to do, and they were both quite --**
 16 **they -- they understood quite clearly exactly what I**
 17 **was going to do and why I was going to do it. And**
 18 **they had no -- they -- no indication that they**
 19 **disagreed with my decisions.**
 20 Q Okay. So do you -- do you have a
 21 recollection of exactly what you told Mr. Schwartz and
 22 Mrs. Schwartz?
 23 A **I told them exactly what I would tell any**
 24 **other patient. I explained the injuries to them, the**
 25 **collapsed lung, the need for the chest tube, the risks**

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1 **of transporting a patient without being intubated,**
 2 **with -- risk of the -- the necessity during**
 3 **intubation, understanding the -- explaining the**
 4 **changes in the physiology with altitude and the --**
 5 **what would -- what could occur to the collapsed lung**
 6 **in the -- in air medical transport and what could --**
 7 **could happen to his oxygenation levels in transport**
 8 **and why. And also receiving pain medications for his**
 9 **chest tube and broken ribs in flight also impairing**
 10 **his ability to oxygenate. So all that -- all those**
 11 **reasons were clearly explained to them.**
 12 Q Okay. And I'll represent to you
 13 Ms. Schwartz has testified that you said that you
 14 might intubate him and there was nothing further
 15 discussed.
 16 And so that's contrary to what you're
 17 testifying today; correct?
 18 MR. BURTON: I'm just going to object it
 19 mischaracterizes the record.
 20 Go ahead.
 21 MR. WEAVER: Join.
 22 THE WITNESS: Yeah, I -- I would not be surprised
 23 that she did not hear or understand everything that I
 24 said, but I know for a fact that I -- I do it for
 25 every patient. I know for a fact that I explained the

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1 entire situation. I don't just do a procedure without
 2 telling all those involved about the indications, the
 3 risks, and the benefits of the procedure.
 4 Q (BY MS. MORALES) Okay. So what risks did
 5 you explain to Mr. and Mrs. Schwartz that could occur
 6 by intubating him for the flight?
 7 A **Probably not much. We all -- we always**
 8 **assume that the patient has a full stomach, and**
 9 **there's also always the risk of aspiration with an**
 10 **intubation. But the main thing that was -- that was**
 11 **explained to them were the risks of not intubating,**
 12 **and the risks of not intubating were much higher than**
 13 **the risks of intubating.**
 14 Q Okay. So I just want to be clear.
 15 You did not explain the risks of intubating
 16 the patient; correct?
 17 A **No. I probably --**
 18 MR. BURTON: I'm going to object to the extent it
 19 mischaracterizes the testimony and it's argumentative.
 20 MR. WEAVER: Join.
 21 THE WITNESS: I mainly explained the risks of not
 22 intubating, which are higher than the risks of
 23 intubating.
 24 Q (BY MS. MORALES) Okay. So you explained
 25 the risks of not intubating, but you did not explain

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1 that by intubating Mr. Schwartz, he could aspirate.
 2 MR. WEAVER: Object as to form.
 3 Q (BY MS. MORALES) Correct?
 4 MR. BURTON: And join. Also, mischaracterizes
 5 the testimony.
 6 THE WITNESS: Yes. There's always a risk of
 7 aspiration, but that risk is low. There's a much
 8 greater risk of aspiration if he remained on a
 9 backboard in an airplane trying to transport him for
 10 two hours to the trauma center.
 11 Q (BY MS. MORALES) Okay. But I just -- I --
 12 I want to make sure that our question and answer is
 13 clear.
 14 You did not explain any risks or alternative
 15 treatments to Mr. or Mrs. Schwartz regarding
 16 intubation; correct?
 17 MR. WEAVER: Object as to form.
 18 MR. BURTON: And objection. Asked and answered
 19 as well and join the objection.
 20 THE WITNESS: There were no alternative
 21 treatments. The patient required intubation before he
 22 was transferred. I mean, I'm -- I'm -- I was the one
 23 responsible for the transfer, and I had to -- I had
 24 made that determination that he had to be transferred.
 25 There's no way to get him to Salt Lake City without

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1 intubating him before he went on the air medical
 2 transport.
 3 Q (BY MS. MORALES) Okay. And I appreciate
 4 your answer, but I want to make sure it's clear.
 5 You did not explain the risks or alternative
 6 treatments to Mr. and Mrs. Schwartz besides intubating
 7 for transfer; correct?
 8 MR. WEAVER: Object -- sorry. Object as to form.
 9 It's been asked and answered.
 10 MS. MORALES: No, he didn't --
 11 MR. BURTON: Several times.
 12 MS. MORALES: -- directly answer.
 13 MR. BURTON: Several times. And I join the
 14 objection.
 15 THE WITNESS: I said that I -- there were no
 16 alternative treatments. So no, I did not explain
 17 alternative treatments because there were no
 18 alternative treatments. He had to be intubated.
 19 Q (BY MS. MORALES) Okay. Would it surprise
 20 you that there were other people, friends in the room,
 21 who also indicated that they didn't -- they never
 22 heard you explain that you were going to intubate
 23 Mr. Schwartz?
 24 MR. WEAVER: Object --
 25 MR. BURTON: Object -- sorry.

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1 MR. WEAVER: Sorry. Object as to form. Lacks
 2 foundation.
 3 MR. BURTON: And mischaracterizes the record as
 4 well.
 5 THE WITNESS: I do not think there were anybody
 6 in -- there was anybody in the room for that last ten
 7 minutes other than Mrs. Schwartz and Mr. Schwartz. So
 8 I don't think there were friends in the room during
 9 the time period where the patient went from serious to
 10 critical and the gears shifted.
 11 And there was -- there was about a
 12 ten-minute period there between the time I got off the
 13 phone with the University of Utah and the time the
 14 intubation was attempted. There's ten minutes. So I
 15 don't think there were a lot of people in the room
 16 during those ten minutes while we were setting up to
 17 do a chest tube and do the intubation.
 18 So if someone heard it, they may have been
 19 talking about the period before the time I made the
 20 decision to transfer and called REACH and the time
 21 that the report came back, but not after the report
 22 came back.
 23 Q (BY MS. MORALES) Okay. And so do you --
 24 you know Dr. Patent; correct?
 25 A Yes.

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1 Q And do you recall when he was in the room?
 2 A He was in the room. I don't recall exactly
 3 when he was in the room.
 4 Q Do you recall Dr. Patent -- well, I'll --
 5 I'll represent to you Dr. Patent indicated that he had
 6 no knowledge, along with Diane and everyone else
 7 sitting in the waiting room, that Mr. Schwartz was
 8 being intubated. Their understanding was just a chest
 9 tube was being placed.
 10 MR. WEAVER: Go ahead.
 11 Q (BY MS. MORALES) Do you recall any
 12 discussions that you had with Dr. Patent before
 13 Mr. Schwartz died?
 14 MR. WEAVER: Let me object. It misstates
 15 testimony. Lacks foundation.
 16 But you can answer the question.
 17 MR. BURTON: And join.
 18 THE WITNESS: Well, Dr. Patent would have no
 19 reason to question -- I would have no reason --
 20 MR. WEAVER: Whoa, whoa, whoa. The question is
 21 do you recall talking to Dr. Patent?
 22 THE WITNESS: I don't recall talking -- I do
 23 recall talking to Dr. Patent, but --
 24 MR. WEAVER: All right. So you've answered.
 25 Q (BY MS. MORALES) Okay. When do you recall

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1 talking to Dr. Patent?
 2 A During the care of Mr. Schwartz. Probably
 3 not after the results of the CT scans came back.
 4 Q Okay. So you don't have a specific
 5 recollection of discussing or talking with Dr. Patent
 6 after -- after you got the radiology results.
 7 A No. There was only a ten-minute period
 8 there, and I do not think I would have wasted time
 9 talking to Dr. Patent.
 10 Q Do you have a recollection of Dr. Patent
 11 after Mr. Schwartz died asking you why you intubated
 12 Mr. Schwartz?
 13 A I don't recall that, no.
 14 Q Okay. And Dr. Patent testified that your
 15 response was that the receiving facility told you to
 16 intubate Mr. Schwartz.
 17 Do you have that recollection?
 18 A It's my --
 19 MR. BURTON: Object. Lacks foundation. He's
 20 already testified he doesn't recall the conversation.
 21 Go ahead and answer the question.
 22 THE WITNESS: Yeah. No, I do not recall that.
 23 But --
 24 MR. WEAVER: You've answered. Just answer the
 25 question.

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1 Q (BY MS. MORALES) What -- what do you recall
 2 of the discussion with Dr. Patent?
 3 MR. BURTON: Objection. Lacks foundation.
 4 Which conversation are you talking about?
 5 MS. MORALES: After Mr. Schwartz died.
 6 MR. BURTON: So objection. Lacks foundation.
 7 THE WITNESS: I don't recall him asking me about
 8 the intubation at all. And I told him that -- I -- I
 9 told him that we weren't able to secure an airway.
 10 That was -- that was about it. That's all -- all I
 11 remember -- recalling talking to Dr. Patent about.
 12 Q (BY MS. MORALES) Are you aware that another
 13 friend who was in the room also testified that he
 14 directly asked you why you were transferring
 15 Mr. Schwartz to Utah, and you responded, "For
 16 observation."
 17 MR. WEAVER: Lacks foundation and misstates
 18 testimony.
 19 Go ahead.
 20 MR. BURTON: Join.
 21 THE WITNESS: Again, if that occurred, then it
 22 was before the results of the CT scan where we did not
 23 know the extent of his injuries. I do not recall
 24 anybody in the room for the 10 or 15 minutes between
 25 the time we got the results back and the time we did

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1 the intubation.
 2 Q (BY MS. MORALES) And you agree that
 3 aspiration is -- is a known complication of
 4 intubation; correct?
 5 A Oh, yes.
 6 Q And it's a complication that's more
 7 prevalent to occur when a patient hasn't been MPO
 8 or -- or if they've recently eaten; correct?
 9 A Which is almost all our patients in the
 10 emergency department. Yes, correct.
 11 Q Was it an option to provide a CPAP for
 12 Mr. Schwartz during flight?
 13 A Absolutely not.
 14 Q Why not?
 15 A Because all that would do was increase the
 16 pressure in his stomach. With a full stomach, it
 17 increases risks of aspiration.
 18 Q Was it an option to attempt ground
 19 transportation to get Mr. Schwartz to the University
 20 of Utah?
 21 A Absolutely not.
 22 Q Why not?
 23 A Because it's a -- almost a three-and-a-half
 24 to four-hour transport. He's already got
 25 life-threatening injuries. We're -- at that point, as

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1 soon as we got the results, that's when the old golden
 2 hour of trauma kicked in, and we needed to get him to
 3 a trauma center as soon as possible.
 4 Q So it's fair to say that you never tried to
 5 get ground transport; correct?
 6 A I have never tried in ten years in Elko --
 7 MR. WEAVER: Dr. Garvey, just answer the question
 8 she's asking.
 9 THE WITNESS: No, I did not try to get ground
 10 transport.
 11 Q (BY MS. MORALES) Did you ever try -- well,
 12 strike that.
 13 Did you ever tell Mr. or Mrs. Schwartz that
 14 you were going to delegate the intubation to a -- an
 15 EMT?
 16 MR. BURTON: Objection. Sorry. Objection. Form
 17 and foundation.
 18 MR. WEAVER: Join.
 19 THE WITNESS: I'm not sure "delegate" is the word
 20 I would use. I called REACH up there to assist me
 21 because I knew that we had to intubate the patient,
 22 and we had to put a chest tube in the patient, and we
 23 had to do it as expeditiously as possible.
 24 Q (BY MS. MORALES) Do we know -- or do you
 25 know if Barry Bartlett is an EMT or an RN?

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1 A He's an EMT. Critical care flight -- flight
 2 paramedic.
 3 Q So when you discussed -- when you allegedly
 4 discussed the intubation with Ms. -- Ms. Schwartz --
 5 Mr. and Mrs. Schwartz, you did not advise them that
 6 you would be having an EMT perform the procedure;
 7 correct?
 8 A I probably did not, no.
 9 Q Is it your custom and practice to have
 10 patients and/or their families sign written consents
 11 to undergo intubation?
 12 A I've never done that in 35 years. No, it's
 13 not my customary practice.
 14 Q And what about for a chest tube placement?
 15 A Not in an emergency situation, no.
 16 Q Did you consider this specific intubation
 17 high risk?
 18 A Oh, yes.
 19 Q And why is that?
 20 A Because we have a patient that had just
 21 finished a large meal. He was on a backboard in a
 22 C collar, and his body habitus all lend to a difficult
 23 intubation.
 24 Q And knowing that it was going to be a
 25 high-risk procedure, did you try to call in a nurse

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1 anesthetist?

2 **A No, I did not.**

3 Q Are there nurse anesthetists available at

4 Northeastern Regional?

5 **A There probably was one on call, yes.**

6 Q And you would agree that nurse anesthetists

7 are more experienced to deal with high-risk

8 intubations; correct?

9 **A Absolutely not.**

10 Q Why? Why do you say that?

11 **A I have no idea what the qualifications and**

12 **the capabilities of the nurse anesthetists are. I**

13 **know that they intubate in a controlled environment**

14 **with fasted patients, but this is a completely**

15 **different situation. This is a rapid-sequence**

16 **intubation and not an operation-room intubation.**

17 Q Would you agree that a nurse anesthetist

18 would have more experience than an EMT?

19 MR. WEAVER: Object as to form.

20 THE WITNESS: No, I do not. I --

21 Q (BY MS. MORALES) And why is that?

22 **A I know that -- I know that all of the REACH**

23 **flight -- flight crew were very competent and**

24 **qualified in airway management. That's the primary**

25 **focus of their training. I do not know anything of**

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1 **the competency or the qualifications of the nurse**

2 **anesthetists, and I don't know if they've ever -- a**

3 **nurse anesthetist have -- has ever done a**

4 **rapid-sequence intubation on a patient with a full**

5 **stomach. But the paramedic does it quite frequently.**

6 Q Was it an option to attempt to transfer

7 Mr. Schwartz without intubation?

8 **A No, it wasn't an option.**

9 Q Why not?

10 MR. BURTON: I'm just going to object. It's been

11 asked and answered several times.

12 MR. WEAVER: Join.

13 THE WITNESS: Because of the risk of aspiration

14 en route, I would never be able to defend a bad

15 outcome in a patient requiring intubation inflight or

16 aspirating inflight and me having not intubated him.

17 I can defend attempting to intubate, but I cannot

18 defend not intubating.

19 Q (BY MS. MORALES) And it's the same risk

20 that he had with trying to intubate on a full stomach

21 at the hospital; correct?

22 **A No. Completely different situation. You're**

23 **in a cramped aircraft without the resources of the**

24 **hospital. We had three suction units going, we had**

25 **multiple hands involved, and we had plenty of room.**

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1 **And that -- that would have been disastrous for the**

2 **patient and the crew if that happened inflight to --**

3 **to Salt Lake City.**

4 Q Can you tell me where in the medical records

5 it identifies that his oxygenation started to drop

6 that identified -- or that necessitated the -- the

7 mask.

8 **A Like I said, he got back from CT scan around**

9 **11:15, somewhere around that. And that's when his**

10 **oxygen saturations started hitting around 91 percent**

11 **on the four-liter nasal cannula.**

12 Q Right. And on page 4, it shows a nasal

13 cannula all the way up until 23 -- well, actually

14 until ten minutes after midnight --

15 **A That's not --**

16 Q -- on the 23rd --

17 **A That's not true. There -- there's notes,**

18 **there's documentation in the record when the Venti**

19 **mask was started. I don't -- I -- I'd have to go**

20 **through each of the pages of the record. But the**

21 **Venti mask was started as soon as he got back from**

22 **CT scan. Forty percent Venti mask.**

23 **I -- I don't know the time, but I know it's**

24 **somewhere in the record. I saw it yesterday.**

25 MR. WEAVER: It's on page 10.

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1 MS. MONTET: Page 10.

2 Q (BY MS. MORALES) Okay. Is the Venti mask

3 different than the non-breather (sic) mask?

4 **A Yes.**

5 Q Okay. And what was the non-breather mask

6 used for?

7 **A That was to preoxygenate the patient prior**

8 **to intubation. We not only put a non-rebreather mask**

9 **on, we put a nasal cannula at 15 liters on, and we**

10 **assist the patient in respirations until we can get**

11 **the oxygen saturation up as high as we can before we**

12 **intubate.**

13 Q Okay. And that -- his oxygen dropped right

14 after he was being moved back to the emergency room;

15 correct?

16 **A No. They actually dropped in the**

17 **CT scanner.**

18 Q I'm sorry?

19 **A They dropped while he was in the CT scanner.**

20 Q Where -- where are you seeing that?

21 **A Just on the times. The 91 percent began**

22 **before he got back.**

23 **They were 94 percent initially. That first**

24 **gas, the 83 percent, is a room air gas. That's when**

25 **the transition was made from four-liter nasal cannula**

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1 **from the EMS to ours. So that would be his baseline,**
 2 **which is pretty darn low.**
 3 Q And at 23:51, you take the Venti mask off,
 4 and you're preoxygenating for the intubation?
 5 **A I've changed pages, but yeah, that's about**
 6 **right.**
 7 MR. WEAVER: Ten.
 8 THE WITNESS: I was looking at that.
 9 I don't know if this is right or this is
 10 right.
 11 Q (BY MS. MORALES) Have you ever called in an
 12 anesthesiologist, the anesthesiologist or a nurse
 13 anesthetist to perform a high-risk intubation in the
 14 ER?
 15 **A Never.**
 16 Q But it's your understanding that they're
 17 available if you need them; correct?
 18 MR. WEAVER: Well, who? Who's available?
 19 Q (BY MS. MORALES) The nurse there on call.
 20 MR. WEAVER: Who?
 21 Q (BY MS. MORALES) The nurse anesthetist
 22 and/or anesthesiologist.
 23 **A There are no anesthesiologists in Elko,**
 24 **Nevada.**
 25 Q Okay. So there's nurse anesthetists that

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1 were named by Greg Michael, and Jim Cooper; is that
 2 correct?
 3 **A I -- I believe there are. I don't associate**
 4 **with them very often.**
 5 Q How many intubations have you performed?
 6 **A Oh, I don't know. Hundreds.**
 7 Q And are you -- so at the point that -- the
 8 page that we were just on when the oxygen mask was
 9 placed, is that when you're indicating it became
 10 emergent for Mr. Schwartz to have -- to be intubated?
 11 MR. BURTON: Objection. Vague and ambiguous.
 12 MR. WEAVER: Join.
 13 THE WITNESS: No. The decision to intubate was
 14 made once I knew the extent of his injuries and we
 15 knew he had to be transferred. I would not have
 16 transferred him without intubating him.
 17 Saturations were 91 percent on the -- on the
 18 Venti mask, and the -- at altitude of 10- to
 19 20,000 feet would drop another 20 to 30 percent, and
 20 he would be below the risk level.
 21 Q (BY MS. MORALES) Was it an option to keep
 22 him for observation at Elko until -- until his food
 23 digested from eating?
 24 **A Absolutely not.**
 25 Q Why not?

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1 **A He's a high-risk critical trauma patient.**
 2 **He needed to be at a trauma center.**
 3 Q Do you recall -- do you recall having any
 4 discussions with a -- any of the nurses after
 5 Mr. Schwartz passed away?
 6 **A Yes. I recall a mini stress debriefing**
 7 **after the incident.**
 8 Q And who -- do you recall who was involved in
 9 the debriefing?
 10 **A Probably the nurses involved. Donna, Sue.**
 11 **I think the respiratory tech. I don't know if any of**
 12 **the paramedics or the flight crew were still there,**
 13 **but definitely the nursing staff.**
 14 Q And was it that same night that you had the
 15 debriefing?
 16 **A Yes.**
 17 Q And when you do a debriefing, what is it --
 18 what's included in that?
 19 **A After any -- any critical case, codes or**
 20 **whatever, I usually get the nursing crew and the --**
 21 **and the staff together to discuss their feelings,**
 22 **options. It's common for people to think that they**
 23 **could have done something different to -- for a -- for**
 24 **a different outcome, and I make sure that they**
 25 **understand that we've done everything we could and --**

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1 **and it's -- you know, it wasn't anybody in**
 2 **particular's fault.**
 3 Q Any other meetings besides that one?
 4 **A No. I haven't talked to any of them since**
 5 **then.**
 6 Q Do you recall any of the nurses
 7 communicating any concerns about how any of the
 8 medical treatment was provided on that day?
 9 **A No. I never heard any of that.**
 10 Q Looking at page 4, can you tell -- can you
 11 tell the jury what rapid-sequence induction is.
 12 **A Well, we call it rapid-sequence intubation.**
 13 **Induction is an anesthesia term.**
 14 Q Okay.
 15 **A But it's a technique -- because our patients**
 16 **usually have a full stomach and are not fasting, so we**
 17 **quickly sedate them and paralyze them and try to**
 18 **quickly do the intubation as rapidly as possible.**
 19 Q So is the main objective to intubate as
 20 quickly as possible?
 21 **A Knowing that the patient is probably not**
 22 **going to be fasted, yes.**
 23 Q And pulmonary aspiration is -- is the most
 24 common risk of that procedure; correct?
 25 MR. WEAVER: Object as to form.

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1 MR. BURTON: Join.
 2 THE WITNESS: I don't know if it's the most
 3 common risk, but it is -- it is always a risk, yes.
 4 Q (BY MS. MORALES) And that's more likely to
 5 occur between the loss of consciousness and the
 6 inflation of the cup; is that correct? The
 7 endotracheal tube?
 8 A Yes.
 9 Q Why in this case did you delegate or order
 10 that Mr. Bartlett perform the intubation?
 11 A Because what my -- the plan was to --
 12 instead of -- to do both the chest tube and the
 13 intubation during one administration of the
 14 medications, the sedative and the paralytic, so that
 15 the patient did not have to receive multiple doses
 16 of -- of either.
 17 And I'm -- I'm credentialed to do the chest
 18 tube, and Mr. Bartlett is certified, competent to do
 19 the intubation. And they -- and so I figured the --
 20 the -- I made the decision that the best way forward
 21 is to have them both done at the same time. While I
 22 put the chest tube in, he could do the intubation, and
 23 we could get the patient on the plane a little quicker
 24 than to try to do the procedures simultaneous -- or
 25 sequentially.

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1 Q Okay. Did you -- did you have any
 2 discussions with Mr. Bartlett prior to performing the
 3 procedures?
 4 A Discussions like what? They had just
 5 arrived. Probably outlined the injuries to him and
 6 pretty much said what -- you know, what -- and they --
 7 they're aware. They -- they transport trauma patients
 8 all the time. I'm sure that they -- almost all the
 9 flight crews would have agreed that the patient needed
 10 a chest tube and needed to be intubated before they
 11 were put on the airplane.
 12 Q Okay. Did you advise Mr. Bartlett that
 13 Mr. Schwartz had a full meal prior to getting hit by a
 14 vehicle?
 15 A I think he knew the history, that he just
 16 came out of a restaurant. And, again, our assumption
 17 is always the patient has a full stomach, so that's
 18 nothing new.
 19 Q Well, here you didn't make that assumption.
 20 You actually had that information; correct?
 21 A That's right.
 22 Q Are -- is there equipment that you need to
 23 have ready in preparation for high risks -- high-risk
 24 intubations?
 25 A Yes.

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1 Q Okay. And what equipment is that?
 2 A Suction for one thing. Rescue airways.
 3 Some of the ones would not be quite -- would not be
 4 feasible in Mr. Schwartz's case, like an LMA airway.
 5 Ability or accessibility to do -- something to do a
 6 cricothyrotomy if that proved necessary.
 7 Q And do you believe all that equipment was
 8 available in the emergency room?
 9 A Yes.
 10 Q Were you able to watch as Mr. Bartlett was
 11 performing the intubation, or were you doing your own
 12 thing as far as inserting the chest tube?
 13 A I was on the right side of the patient
 14 preparing to insert the tube while he was at the head
 15 of the bed preparing to intubate -- intubate the
 16 patient.
 17 Q So you had a good view of everything going
 18 on at the time?
 19 A Yes. Plus they -- they have equipment
 20 that's fiberoptic, video that -- which was more --
 21 especially in the case of Mr. Schwartz, there's
 22 assessments that we do for the intubation, and we
 23 pretty much knew he was going to be a difficult airway
 24 with a short -- his short neck and his -- his body
 25 habitus, that they have what's called a C-MAC that has

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1 a -- more of a curved blade that is much more able to
 2 get to an anterior larynx than my more straight,
 3 direct laryngoscope blade.
 4 Q And do you recall the actual steps that were
 5 taken by Mr. Bartlett as he performed the intubation?
 6 A Yes. They have a routine that they always
 7 go through. They -- before any procedure, they sort
 8 of do a timeout and make sure everybody was aware of
 9 what was going to be happening.
 10 Then he -- they administered the
 11 medications, which in this case were Rocuronium and
 12 Ketamine, and waited about a minute, and then
 13 attempted the first pass at the intubation. And at
 14 the time, I was preparing the right chest for the
 15 chest tube insertion.
 16 Q So when is the first time that you realized
 17 that there were problems?
 18 MR. WEAVER: Object as to form.
 19 Go ahead.
 20 Q (BY MS. MORALES) With the intubation.
 21 A When the intubation was -- attempt was
 22 initiated, it was taking a while for him to visualize
 23 the cords. And in the process of him visualizing the
 24 cords, the oxygen saturations started to drop. And
 25 usually we have a cutoff point of 90, 92 percent. If

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1 it gets to that level, we abort the attempt and then
 2 try to reoxygenate the patient back up to a higher
 3 oxygen level before we do a second attempt.
 4 And so I asked him -- he says he can't
 5 visualize. And I said, "The oxygen saturations are
 6 dropping. Why don't you go ahead and pull out. Let's
 7 get him oxygenated back up and then go ahead and
 8 reattempt."
 9 And so when he inserted the blade for the
 10 second attempt, that's when the reflux and
 11 regurgitation started.
 12 Q Okay. And if you can look at -- let's see.
 13 If you're able to tell on page 4, let me know, but I
 14 know there's handwritten notes I have to find as far
 15 as when after the first attempt and you had to pull
 16 out and reoxygenate, where that happened in the
 17 timeline there.
 18 Here it is.
 19 Okay. So going to page -- sorry, I asked
 20 you a question, to see if you can find it.
 21 And you might -- I -- I don't know if it
 22 will help any more, but there is additional
 23 documentation on page 42 of intubation.
 24 A **Forty-two.**
 25 MR. WEAVER: What -- what was the question?

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1 MS. MORALES: Yeah, so --
 2 MR. WEAVER: -- or were you just getting him --
 3 Q (BY MS. MORALES) So at -- at what point --
 4 you just mentioned that after the first, like, failed
 5 attempt, he pulled out and you told him to
 6 reoxygenate.
 7 Can you show me where that occurred.
 8 A **Well, I don't --**
 9 MR. WEAVER: Just -- just let me object. I -- I
 10 don't think -- I think it misstates his testimony. I
 11 don't think he said it was a failed attempt.
 12 But go ahead.
 13 MR. BURTON: Join.
 14 Q (BY MS. MORALES) Was it a failed attempt?
 15 A **There was no failure -- I mean, there was no**
 16 **tube that passed or anything. It was trying to**
 17 **visualize the cords. So at the first attempt to**
 18 **visualize the cords, that was unsuccessful, so we**
 19 **pulled out and tried to reoxygenate.**
 20 **And let's see in my notes somewhere...**
 21 MR. WEAVER: Jenn, tell me the question one more
 22 time. I'm not saying you didn't say it. I just -- I
 23 just forgot what the question is.
 24 MS. MORALES: So at the point that he pulled out
 25 to try again, he said he reoxygenated.

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1 MR. WEAVER: Oh.
 2 MS. MORALES: So we're trying to find out where
 3 he reoxygenated --
 4 MR. WEAVER: Right.
 5 MS. MORALES: -- after pulling out.
 6 THE WITNESS: Yeah, I'm not sure where -- you can
 7 read my -- my -- these are all, like I say,
 8 retrospective.
 9 MR. WEAVER: The question is can you tell what
 10 time the reoxygenation occurred?
 11 THE WITNESS: Right after he pulled out. I mean,
 12 that's what was -- he was told to pull out and
 13 reoxygenate.
 14 Q (BY MS. MORALES) Okay. So if you look at
 15 page 4, it shows -- you would agree that it shows
 16 oxygenation level, correct, at different intervals of
 17 time?
 18 A **Yes.**
 19 Q And so just so we're clear -- and I only
 20 have a few minutes I was warned -- at ten minutes
 21 after on June 23, it shows 97 percent on 15 percent
 22 nonbreather mask.
 23 Would -- that was preoxygenating the patient
 24 for the procedure to begin with; correct?
 25 A **Let's see. When was the first attempt at --**

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1 **Ketamine. Eighteen, 20. Okay. 20. Right there.**
 2 **That may be the number that the patient**
 3 **dropped to before the patient was reoxygenated, yes.**
 4 Q Okay. But the procedure didn't start
 5 until -- it looks like at the beginning of this it has
 6 0018. So this oxygenation was actually before the
 7 procedure started.
 8 A **No. No.**
 9 Q Okay.
 10 A **The procedure before the -- 99 percent on**
 11 **15-liter mask. That would probably be the -- the**
 12 **oxygen level when the procedure was started, the**
 13 **99 percent.**
 14 Q That wasn't preoxygenating the patient
 15 for --
 16 A **That --**
 17 Q -- the procedure?
 18 A **That was preoxygenating the patient for the**
 19 **procedure.**
 20 Q Okay. So that's why -- I just want you to
 21 follow along and make sure I'm right.
 22 So that's preoxygenating the patient at
 23 10 minutes after and 15 minutes; is that correct?
 24 During that period of time.
 25 MR. WEAVER: I think where the confusion is, is

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1 it's the way that you sound, it makes it sound like
 2 the start of the procedure, but you mean 10 or
 3 15 minutes after midnight; right?
 4 MS. MORALES: Yeah.
 5 THE WITNESS: Okay. Yeah. And that's when the
 6 procedure started. That is -- and that level would be
 7 maintained for several minutes after the medications
 8 were given.
 9 Q (BY MS. MORALES) Okay. So -- and -- and
 10 that's why I just wanted to kind of start from the
 11 beginning and follow along.
 12 You just testified that Bartlett had tried
 13 to visualize the tubes, couldn't visualize, pulled
 14 out. You told him to oxygenate again. And that's
 15 where I'm trying to see where he oxygenated.
 16 A Okay. I don't know if -- if or where
 17 it's -- it's recorded that he oxygenated, but that's
 18 what we typically do to try to bag the patient back
 19 up.
 20 Now, I don't specifically remember if we
 21 were successful in getting the patient reoxygenated,
 22 but whether or not we were successful, we had -- we
 23 had to get the patient intubated. So he may have
 24 attempted somewhere in between that 15 and the 20, and
 25 I don't -- I mean, there's -- there's five minutes of

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1 no oxygen levels recorded, so I don't know what the
 2 oxygen levels were between --
 3 Q So as you're sitting here today, do you know
 4 definitively if he tried to oxygenate again after
 5 pulling out -- after not being able to visualize on
 6 point?
 7 A Yes. We always try. I don't know if
 8 there's respiratory tech notes, but the respiratory
 9 tech was a very competent tech, and -- and he would
 10 have been right there with the bag and -- and
 11 100 percent oxygen, trying to get the patient's oxygen
 12 levels back up.
 13 Q And you would agree, though, that it
 14 doesn't -- besides this preoxygenation, it doesn't
 15 show that the patient on this -- on page 4, it doesn't
 16 show that the patient was oxygenated again; correct?
 17 A No. But you have a ten-minute gap between
 18 numbers, and it just doesn't say what -- there was a
 19 lot of things going on for those ten minutes.
 20 Q Okay. And on page 42, do you see any
 21 notation on that page that indicates that there was
 22 any type of, for lack of a better word, reoxygenation?
 23 A No. I don't even know whose notes these
 24 are, so...
 25 Q Okay. But you don't see that that was done

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1 on this page either; right?
 2 A No. I -- again, I -- I have no idea who
 3 wrote those notes, but my --
 4 MR. WEAVER: The question is do you see it on
 5 there?
 6 THE WITNESS: No, I don't see anything. But I
 7 don't know what I'm looking at.
 8 MS. MORALES: Okay. I think we have to take a
 9 break because I just got the two-minute mark.
 10 THE VIDEOGRAPHER: We are off the record,
 11 4:12 p.m.
 12 (Recess taken.)
 13 THE VIDEOGRAPHER: We are back on the record,
 14 4:22 p.m.
 15 Q (BY MS. MORALES) Okay. You understand
 16 you're still under oath.
 17 A Yes, I do.
 18 Q Okay. So before we took a quick break, we
 19 were discussing the part where Barry Bartlett had
 20 pulled out because he couldn't visualize --
 21 A Visualize the cords.
 22 Q He couldn't visualize the cord.
 23 And then we were talking about the
 24 oxygenation; correct?
 25 A Yes.

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1 Q At this point, why didn't you take over the
 2 intubation?
 3 A Because there was no reason. He just wasn't
 4 able to visualize the cords, which happens sometimes.
 5 Q Okay. And not being able to visualize the
 6 cords and knowing that Mr. Schwartz had a full stomach
 7 and had been nauseous during his time in the ER, you
 8 didn't feel that the more experience that you would
 9 have would be necessary to resume the intubation or
 10 take over the intubation?
 11 A I'm not sure how you quantify more
 12 experience. But he was competent. I'm competent.
 13 And someone competent needed to do the intubation, and
 14 I felt he was competent to do the intubation. So no,
 15 I did not see a need to intervene at that time.
 16 Q Okay. But you definitely could have;
 17 correct?
 18 A I could have.
 19 Q What happened -- what happened next?
 20 A Okay. If I'm -- reading from the record,
 21 my -- my didactic description, we bagged the patient.
 22 He tried a second attempt. And during that second
 23 attempt, the patient began to regurgitate.
 24 At that point, I aborted putting the chest
 25 tube in and went to the head of the bed. We tried to

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1 suction as best we could with the suction we had
 2 available, but none of it was working very well. We
 3 suctioned it out as well as we could for my attempt at
 4 the intubation with the direct laryngoscope blade.
 5 And I thought I saw the tips of the cords. I thought
 6 I saw the tube pass.
 7 I put the tube in. We inflated the balloon,
 8 and the tube filled with emesis.
 9 We tried to clear it. We couldn't clear it
 10 adequately. We couldn't get a CO2 reading on it.
 11 Wasn't sure what the placement was. We kept that in
 12 for several minutes because I was almost positive that
 13 I had it in the proper position.
 14 And eventually, since it was still filling
 15 with emesis, I said, "We got to pull it, and we got to
 16 try again." Pulled that, and we were never really
 17 able to clear the airway well enough to be able to
 18 ventilate the patient.
 19 Q And are there any other options when that
 20 occurs as far as a patient then begins to regurgitate
 21 or aspirate? Is there -- are there any options to try
 22 to wake the patient?
 23 A No. The -- the Rocuronium is going to last
 24 at least 10 to 20 minutes. That's the paralytic. And
 25 the Ketamine is going to last 10, 15 minutes at least.

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1 So no, there's no attempt -- no way that we're going
 2 to be able to wake the patient.
 3 At that point in time, I decided that I was
 4 going to probably do the cricothyrotomy.
 5 Q And that's when you --
 6 A Yes.
 7 MR. WEAVER: Wait.
 8 Q (BY MS. MORALES) -- open up near the trach
 9 area?
 10 A Yes.
 11 Q And on this timeline, when did you decide
 12 to -- to do that?
 13 A When I decided to do that was probably -- it
 14 was after those few intubations, right when the
 15 patient pretty much arrested. He went into cardiac
 16 arrest probably because of the low oxygen levels.
 17 So I was going over to do the
 18 cricothyrotomy, and the -- one of the EMTs said, "I
 19 have a King airway. Do you want -- do you want us to
 20 insert that?"
 21 Q Okay. And can you explain what a King
 22 airway is?
 23 A A King airway is a rescue airway that has
 24 two balloons. One -- it's inserted into the
 25 esophagus. You blow up that esophageal balloon. At

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1 the same time you blow up a oral balloon, and then
 2 there's a opening right at the glottis that you can
 3 ventilate the patient with a bag. And some -- some
 4 EMS units use that as their primary rescue airway as
 5 opposed to doing intubations.
 6 Q Okay. And was that -- do you use that on
 7 higher risk procedures if you know that the patient
 8 has a full stomach?
 9 A No. We wouldn't -- you use that as an
 10 alternative to intubations, maybe for difficult
 11 intubation. It is considered a rescue airway. We
 12 don't have one in the emergency department. It just
 13 so happened that the EMS crew was there, and we used
 14 their King airway.
 15 On my way over to the side of the bed to do
 16 the cricothyrotomy, he mentioned the King airway, and
 17 I said, you know, that's probably an excellent choice.
 18 We might be able to occlude the esophagus enough to
 19 get the oral airway suctioned.
 20 Q And that was before you attempted to do the
 21 cricothyrotomy?
 22 A That was before. Yes, that was right when
 23 the patient required CPR. We had CPR in progress
 24 during the placement of the King airway.
 25 Q And how many suction machines did you have

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1 going?
 2 A We had both of our wall suction machines and
 3 we had one of EMS's portable suction machines all
 4 going. Just with our suction machine, we got over a
 5 liter of emesis, and not telling how much the other
 6 ones got.
 7 Q And so there were three people suctioning?
 8 A Possibly three people. We had three suction
 9 units. I don't know if one had two in their hands or
 10 whatever, but we had three units going at once.
 11 Q And did the King airway help?
 12 A Yes, it did. I was pretty amazed. CPR was
 13 started. I think we gave a milligram of epinephrine.
 14 We were doing chest compressions. They placed the
 15 King airway, started bagging with the King airway.
 16 The oxygen saturations improved, and the patient
 17 regained a pulse.
 18 Q And can you look at this timeline on page 4
 19 and tell me when the King airway -- are you able to
 20 tell on here?
 21 A Not on page 4. Page 4 is just sort of a
 22 computer-generated timeline, so I don't know what I'm
 23 looking at there.
 24 But I would say the King airway was placed
 25 around 0335 -- 0035. That's when the patient

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1 arrested. King airway was placed, the oxygen
 2 saturations started improving with the King airway,
 3 and the pulse came back.
 4 Q And then what happened?
 5 A Then the patient started sort of
 6 deteriorating again. His pulse -- his oxygen
 7 saturation started dropping. And -- let's see. 035,
 8 King.
 9 What I did -- since they started dropping, I
 10 thought maybe we could leave the King airway in place
 11 and deflate the balloons, suction the oral cavity, and
 12 see if I could pass the bougie into the cords while we
 13 still had the King airway in place occluding the
 14 esophagus.
 15 I had digitally placed the bougie. I
 16 thought I felt the cords. I felt the bougie -- felt
 17 the bougie go through the cords. I put an ET tube in,
 18 blew up the balloon, pulled the King airway, and the
 19 ET tube filled up with emesis again.
 20 Again, I, you know, in retrospect, feel that
 21 the tube -- both those tubes that I placed were in the
 22 proper positions, but the patient with his initial
 23 aspiration filled his trachea and had a massive
 24 aspiration from the -- from the initial attempts.
 25 Q So he would have been -- strike that.

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1 So at what point -- I'm looking at 42.
 2 So when you did -- did you actually wind up
 3 doing the cric procedure?
 4 A Yes. We did the cric procedure after I
 5 pulled the King, after we pulled the tube that I
 6 thought I had in. I don't know if -- I can't remember
 7 if he arrested right prior to the cric procedure, but
 8 right around that time he went into arrest again. Did
 9 the cric. Put the cric tube in, and the cric tube
 10 filled with emesis.
 11 Q Was Barry Bartlett still helping with this
 12 intubation after his initial failed attempts?
 13 A It depends on what we were doing at the
 14 time. There -- both of us were -- after people
 15 thought they -- they suctioned enough, both of us
 16 attempted to visualize the cord and attempted
 17 intubations. But none were -- well, again, some were
 18 probably successful, but none were -- none secured the
 19 airway. Everything filled with -- with emesis.
 20 Q And was a code called in this case?
 21 A After the cric tube was switched out to
 22 another tube that was a little longer that I could
 23 float down an ET tube further down into the trachea,
 24 it also plugged up and -- which confirmed that it was
 25 a pretty massive aspiration. We pulled that tube.

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1 The patient stayed arrested, and a code was called.
 2 Q So there was -- if I understand correctly,
 3 there was only the one time that he regained a pulse
 4 before he started crashing again?
 5 A He went into the first arrest, King airway
 6 was placed, he regained vital signs, then went into a
 7 second arrest, and never regained it the second time.
 8 Q So did you actually get the chest tube
 9 placed before this occurred?
 10 A No.
 11 Q How far along did you get in that process?
 12 A All I did was prep the skin. Put the drapes
 13 on. I ended up putting needles in both chests just in
 14 case there was a tension pneumothorax that formed,
 15 but...
 16 Q Since you're also medical director of REACH
 17 Air, did you ever have any ongoing or any
 18 communications with Mr. Bartlett after this incident
 19 occurred?
 20 A No, I did not.
 21 Q Did you work with him after this incident?
 22 A I can't recall if I did or not. Again, I'm
 23 only there once a month, and it depends which crew is
 24 on. And I can't recall working with him since the --
 25 after that incident. I have no recollection.

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1 Q Do you recall any of your discussions that
 2 you had with Diane Schwartz?
 3 A When? After we --
 4 Q After this occurred.
 5 A Not -- I don't remember specifically. I
 6 just know it was very difficult to go and tell her
 7 that her husband passed away.
 8 Q Okay. Do you have any recollection of
 9 explaining the intubation procedure or the need to
 10 intubate with Ms. Schwartz after he passed?
 11 A No. I probably would not have gotten into
 12 that at all. Not the time.
 13 Q And besides what we've talked about already
 14 with Dr. Patent, do you recall any other discussions
 15 with him or anyone else at the hospital?
 16 A The only one I remember talking to was
 17 Dr. Patent. He's a podiatrist and a close friend.
 18 And -- and I may have even mentioned that he passed,
 19 that Mr. Schwartz passed before I spoke with
 20 Mrs. Schwartz, but I don't remember the specifics of
 21 the conversation.
 22 Q Besides that day, the actual day that
 23 Mr. Schwartz passed, did you have any additional
 24 conversations with Dr. Patent regarding this case?
 25 A I don't think I spoke to Dr. Patent at all

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1 **since the case.**
 2 Q There's been testimony that one of the
 3 employees at the hospital was yelling out that
 4 Ms. Schwartz should sue the hospital.
 5 Do you recall hearing that?
 6 **A No, I do not.**
 7 Q Were you called in for -- or requested to
 8 provide any statements in your recredentialing with
 9 the hospital regarding this case?
 10 **A Yes. I --**
 11 **MS. RIES-BUNTAIN: Objection. Yeah, sorry. I**
 12 **have an objection. You're essentially requesting**
 13 **privileged material.**
 14 MR. WEAVER: So just let me get the foundation.
 15 Are you just asking whether on
 16 recredentialing he needed to put the -- this lawsuit
 17 happened?
 18 MS. MORALES: I'm asking if he made any
 19 statements or -- regarding this lawsuit at the time
 20 that he recredentialed with the hospital.
 21 MR. WEAVER: Okay. So you can answer that
 22 specific question, but don't get into any details.
 23 THE WITNESS: Only that the case was filed.
 24 Q (BY MS. MORALES) Okay. And the hospital
 25 never called you in for any kind of peer-review

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1 meeting to explain what happened in this case?
 2 **A No.**
 3 **MS. RIES-BUNTAIN: Same objection.**
 4 Q (BY MS. MORALES) Do you know as you sit
 5 here today whether or not the hospital has any
 6 protocols pertaining to or critical pathways
 7 pertaining to high-risk intubations?
 8 **A I don't -- I'm not aware of any.**
 9 Q Okay. Or intubations generally?
 10 **A Except for just basic credentialing, no.**
 11 **And training required.**
 12 Q Do you recall telling anyone from REACH Air
 13 that the receiving doctor told you to intubate the
 14 patient?
 15 MR. WEAVER: I'm sorry. Could you -- I think it
 16 was okay.
 17 Could you just reread that, please.
 18 (Question read.)
 19 THE WITNESS: No. Intubation was my decision.
 20 Q (BY MS. MORALES) And did you write any
 21 orders or notations in the file pertaining to
 22 intubating the patient? Your plans to intubate the
 23 patient.
 24 **A I don't recall any. Everything was**
 25 **happening pretty quickly. That was all within a**

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1 **ten-minute period. I don't think I went to the**
 2 **computer to document anything at that time.**
 3 Q When you talked to Ms. Schwartz and Doug
 4 Schwartz, did Doug already have a mask on at that
 5 point?
 6 **A He had a Venti mask on, yes.**
 7 Q Would it surprise you if the friends and the
 8 wife in the room don't recall him having a mask on?
 9 **A It wouldn't surprise me. There was a lot**
 10 **going on, so I'm not sure what they remember or**
 11 **whatever, but he had a mask on.**
 12 Q On a scale of one to ten, how important is
 13 patient safety to you?
 14 MR. WEAVER: Object as to form.
 15 Go ahead.
 16 THE WITNESS: It's very important.
 17 Q (BY MS. MORALES) Okay. On a scale of one
 18 to ten, one being the least and ten being the most,
 19 how important is patient safety to you?
 20 MR. WEAVER: Well, you -- you don't have to give
 21 a number.
 22 I mean, he's not required to give a numeric
 23 number. He's already said it's important.
 24 Q (BY MS. MORALES) Can -- can you answer that
 25 question? Are you able to categorize it?

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1 **A It depends -- you've got to weigh the risks**
 2 **and benefits. I -- patient safety is very important.**
 3 **But it depends on the situation and -- and, you know,**
 4 **in the context of what we're talking about, you**
 5 **know --**
 6 MR. WEAVER: If you can't give her a number, just
 7 tell her you can't give her a number.
 8 THE WITNESS: I guess I can't give you a number.
 9 Q (BY MS. MORALES) Okay. You agree that --
 10 you agree that there are limitations on the way
 11 doctors practice medicine?
 12 MR. WEAVER: Object as to form.
 13 THE WITNESS: I don't understand the question.
 14 Q (BY MS. MORALES) You've heard the term
 15 "clinical judgment"; correct?
 16 **A Oh, yes.**
 17 Q You've heard the word -- the term "best
 18 judgment."
 19 **A Yes.**
 20 Q Does that mean the same thing to you?
 21 **A It should.**
 22 Q And you understand that in using clinical
 23 judgment, that clinical judgment must be within the
 24 standard of care; true?
 25 MR. WEAVER: Object as to form.

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1 MR. BURTON: Join.
 2 THE WITNESS: Again, it should.
 3 Q (BY MS. MORALES) You would agree that
 4 doctors using clinical judgment, it doesn't give them
 5 free rein to go outside the standard of care; correct?
 6 MR. WEAVER: Object as to form.
 7 MR. BURTON: Join.
 8 THE WITNESS: I -- I -- I guess I should answer
 9 that no, it does not give them free rein to go outside
 10 the standard of care.
 11 Q (BY MS. MORALES) Tell me three things that
 12 you've learned from this experience.
 13 MR. WEAVER: Well, I'm going to instruct you not
 14 to answer that. Anything that --
 15 MS. MORALES: Based on what?
 16 MR. WEAVER: Anything that he would offer now by
 17 definition is going to include attorney-client
 18 privilege, so I'm instructing him not to answer.
 19 Q (BY MS. MORALES) Anything you've learned
 20 outside of -- outside of speaking with your attorney?
 21 MR. WEAVER: Well, I'm still instructing him not
 22 to answer. You -- you can ask him what he thought at
 23 the time, but I'm not going to let him answer
 24 questions about currently anything having to do with
 25 the case.

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1 MS. MORALES: Okay. I'm going to reserve my
 2 right on that.
 3 MR. WEAVER: Fair enough.
 4 MS. MORALES: I think it's fair he answer
 5 anything outside of anything you've told him.
 6 MR. WEAVER: You might be right, but I don't
 7 think so.
 8 MS. MORALES: I think I am.
 9 MR. WEAVER: You may be. I'm wrong a lot, but I
 10 don't think I am on this one.
 11 Q (BY MS. MORALES) Tell me three things you
 12 could have done differently.
 13 MR. WEAVER: Same objection. Same instruction.
 14 Q (BY MS. MORALES) Outside of your attorney,
 15 have you considered anything, without talking with
 16 him -- because there was a period of time before you
 17 even hired an attorney that this incident occurred;
 18 correct?
 19 A Correct.
 20 Q Okay. And during that period of time --
 21 obviously you knew this man died; correct?
 22 A Correct.
 23 Q So did you think about this case and this
 24 incident before a case was actually filed?
 25 A Oh, many times.

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1 Q Okay. And when you thought about the case,
 2 was there anything that you were thinking that you
 3 should have done differently before the case was
 4 filed?
 5 MR. WEAVER: So I just got the hand, which was
 6 okay, because I -- I could have jumped in before you
 7 were finished.
 8 So you can answer that question if -- if it
 9 was before I was involved in the case. If it has --
 10 if you had an opinion of what you could have done
 11 differently at the time before I was involved, you can
 12 give the answer. Once I'm involved, then I'm
 13 instructing you not to answer.
 14 MR. BURTON: And we're going to assert the same
 15 objection with respect to any discussions you may have
 16 had with counsel, in-house counsel for REACH.
 17 So if you -- so just to make sure the
 18 record's clear, if opinions were formed after
 19 discussions with anybody -- any attorney for REACH,
 20 we'll instruct you not to answer.
 21 THE WITNESS: Okay. I'll try to answer, I guess.
 22 I think the decisions that I made at the
 23 time were the correct decisions, and no, I would not
 24 change any of those decisions.
 25 Q (BY MS. MORALES) Okay. And when you say

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1 that you thought about it several times, what -- what
 2 would you think of regarding this case?
 3 A How catastrophic the -- the case was to
 4 everybody involved, the nurses, the EMS people, the
 5 family, the friends of the -- of Mr. Schwartz. You
 6 know, he's a good man, and it was a terrible, terrible
 7 situation, what happened to him.
 8 Q Is this the first patient that you lost in
 9 the emergency room?
 10 A Not -- under these circumstances, yes. But
 11 not my -- not the first person that's died in my care.
 12 I was medical director of a Level I trauma center, so
 13 I saw a lot of people die. But this one was just a
 14 bad situation for everyone involved.
 15 MS. MORALES: I'll pass the witness.
 16 MR. WEAVER: Jenn, do you have any questions?
 17 MS. RIES-BUNTAIN: No questions.
 18 MS. MONTET: No questions.
 19 MR. BURTON: Can we take a five-minute break --
 20 MR. WEAVER: Sure.
 21 MR. BURTON: -- for me to can talk to my client?
 22 We're going --
 23 MR. WEAVER: Sure.
 24 MR. BURTON: We're going to have just a few
 25 questions.

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1 THE VIDEOGRAPHER: We are off the record at
 2 4:48 p.m.
 3 (Recess taken.)
 4 THE VIDEOGRAPHER: We are back on the record,
 5 4:55 p.m.
 6 MR. BURTON: I don't have any questions.
 7 MR. WEAVER: We'll read and sign. Thank you.
 8 Good-bye.
 9 THE VIDEOGRAPHER: We are off the record,
 10 4:55 p.m.
 11 (The deposition was concluded at
 12 4:55 p.m.)
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1 REPORTER'S CERTIFICATE
 2 STATE OF NEVADA)
) ss:
 3 COUNTY OF CLARK)
 4 I, Vicki Turner, a certified court reporter in
 5 Clark County, State of Nevada, do hereby certify:
 6 That I reported the taking of the deposition of the
 7 witness, DAVID JAMES GARVEY, M.D., commencing on
 8 June 25, 2019, at 10:17 a.m.
 9 That prior to being examined, the witness was by me
 10 first duly sworn to testify to the truth, the whole
 11 truth, and nothing but the truth.
 12 That I thereafter transcribed my said shorthand
 13 notes into typewriting and that the typewritten
 14 transcript of said deposition is a complete, true, and
 15 accurate transcription of shorthand notes taken down
 16 at said time.
 17 I further certify that I am not a relative or
 18 employee of an attorney or counsel of any of the
 19 parties, nor a relative or employee of any attorney or
 20 counsel involved in said action, nor a person
 21 financially interested in the action.
 22 IN WITNESS WHEREOF, I have hereunto set my hand in
 23 my office in the County of Clark, State of Nevada,
 24 this 16th day of July 2019.
 25 Vicki Turner



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1 CERTIFICATE OF DEPONENT
 2 PAGE LINE CHANGE
 3
 4 _____
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 8 _____
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 11 _____
 12 _____
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 15
 16
 17 I, DAVID JAMES GARVEY, M.D., deponent
 18 herein, do hereby certify and declare under penalty of
 19 perjury the within and foregoing transcription to be
 20 my testimony in said action, that I have read,
 21 corrected, and do hereby affix my signature to said
 22 transcript
 23 this _____ day of _____, 2019.
 24
 25 _____
 DAVID JAMES GARVEY, M.D.
 Deponent

Blank page for deponent signature and additional notes.

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156:13	164:23 165:7	120:6,20 121:15	workup 82:1	<hr/> Z <hr/>
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weather 52:25	59:2,4,12,14 61:6	124:22 125:7,21	worst 74:13	Zofran 76:15 85:23
Weaver 2:5 4:23	61:8,10,11 64:8	127:9,19 129:20	worth 86:24	85:24 86:8,8
5:1,1 9:2,4 10:16	71:25	130:13 133:8	wouldn't 68:1	107:17,21 111:10
11:9 13:1,21	weeks 11:18,19	134:13 137:2	151:9 159:9	111:11
14:14 16:1,3 19:1	59:2,3	143:6,11 145:5	Wright 8:13	<hr/> 0 <hr/>
20:22 22:20,24	weigh 160:1	147:6 157:23	write 79:12 158:20	0018 144:6
32:3 33:21 34:17	went 5:21 9:23 16:5	158:19 159:16	writing 73:16	0035 152:25
34:20,22,24 35:3	19:6 82:8 86:15	160:8,13 161:2,8	written 62:25 75:14	0335 152:25
35:8,12,15,17,23	86:19 87:6 97:5,5	163:21 164:15	128:10	035 153:7
35:25 36:3,6,14	111:2 121:1 122:9	167:7,9,22	wrong 162:9	
36:17,21 37:2	148:25 150:15	word 55:5 76:6	wrote 105:5 147:3	<hr/> 1 <hr/>
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45:1,5 48:13 49:8	159:1	160:17	<hr/> X <hr/>	1:00 27:4,4

10 102:17 125:24 131:25 132:1 144:23 145:2 149:24,25 10- 134:18 10:00 90:6 10:17 1:21 4:3 167:8 100 2:3 146:11 11 102:17,17,20 110:5 111:9 11:15 110:19 131:9 11:19 40:18 11:20 111:10 11:30 110:13 11:36 105:19 11:40 40:21 109:18 109:18 11:45 109:20 12 9:22 102:17 12:10 111:15 12:36 69:12,13 13 87:22 14 87:25 15 30:11 95:7 125:24 132:9 143:21 144:23 145:3,24 149:25 15-liter 144:11 16th 167:24 1900 2:17 1984 8:16	2016 16:13,16,22 17:22 21:4,12,16 21:23 30:1,24 37:19 46:23 49:2 50:19 51:1 54:6 54:16 64:2 66:10 70:10,22 2019 1:20 4:3 166:20 167:8,24 21:15 73:11 21:18 75:14 76:21 21:20 78:4,12 79:20 22 70:22 23 131:13 143:21 23:27 110:12 23:51 133:3 23rd 131:16 24 59:9 25 1:20 4:3 167:8 26 29:25 260 2:14	154:1		
<hr/> 2 <hr/> 2:00 69:15 20 12:3 39:13 47:15 58:5 60:1 88:11 134:19 144:1,1 145:24 149:24 20,000 134:19 20:51 71:14 72:2 78:19 79:7,8 20:53 111:15 200 2:10 2012 33:4 37:14,20 37:21,22 2014 37:21,22 38:1	<hr/> 3 <hr/> 3 71:10,10 73:10 3:01 109:5 3:12 109:8 30 8:18 47:15 58:6 60:2 81:15 88:12 134:19 3300 2:10 35 94:10 128:12 36 2:16 375 1:24	<hr/> 5 <hr/> 5 3:3 110:11,11,11 57 96:14		
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NORTHEASTERN NEVADA REGIONAL HOSPITAL

MEDICAL RECORD NUMBER	MRSA	Facesheet				VRE	PATIENT ACCOUNT NUMBER
000330967							6139781
PATIENT (Name, Address, Phone)		BIRTH DATE	AGE	BIRTH PLACE		SOCIAL SECURITY NUMBER	
SCHWARTZ DOUGLAS R 736 WESTCOTT DR		06/02/1958	58				
SPRING CREEK NV 89815		SEX	RACE	M/S	ED CD	PREV ADM	REL
COUNTY: ELKO PHONE: (702)373-2436		M	W	M		07/22/14	R
		ADMIT DATE & TIME	DISCHARGE DATE & TIME		SERVICE	ROOM / BED NO.	
		06/22/16 21:10	06/23/16 06:05		ED	/	
PATIENT EMPLOYER (Name, Address, Phone, Occ.)		EMERGENCY CONTACT (Name, Address, Phone, Rel.)			REFERRAL SOURCE / AGENCY / TEAM MEMBER		
ELKO FEDERAL CREDIT MOUNTAIN CITY HWY ELKO NV 898010000 PHONE: (775)738-4083 OCC: EXEC VICE PRES		SCHWARTZ DIANE 736 WESTCOTT DR SPRING CREEK NV 89815 PHONE: (702)277-6455 REL: Spouse			PHONE: CONTACT NAME:		
GUARANTOR (Name, Address, Phone)		GUARANTOR EMPLOYER (Name, Address, Phone)			FINANCIAL CLASS		
SCHWARTZ DOUGLAS R 736 WESTCOTT DR SPRING CREEK NV 89815 PHONE: (702)373-2436 REL: Patient is insured		ELKO FEDERAL CREDIT MOUNTAIN CITY HWY ELKO NV 898010000 PHONE: (775)738-4083			94 LIABILITY (TPL)		
					ATTENDING PHYSICIAN		
					GARVEY DAVID J MD 2818		
					ADMISSION STATUS	DISCHARGE STATUS	
						20	
PRIMARY INSURANCE		SECONDARY INSURANCE			TERTIARY INSURANCE		
MRA AUTO LIABILITY 6840 CAROTHERS PKWY STE 1 FRANKLIN TN 37067 PHONE: (877)324-2722 POLICY# 518864393 GROUP #: GRP NAME: AUTH#: NR/ER SCHWARTZ DOUGLAS R DOB: 06/02/1958 SEX: M REL: Patient is insured		BCBS PREFIX YF PO BOX 5747 DENVER CO 802175747 PHONE: (877)833-5742 POLICY# YF0841M50938 GROUP #: A46847 GRP NAME: AUTH#: NR/ER SCHWARTZ DOUGLAS R DOB: 06/02/1958 SEX: M REL: Patient is insured			PHONE: POLICY# GROUP #: GRP NAME: AUTH#: DOB: REL:		
CHIEF COMPLAINT		ENCOUNTER FOR EXAM AND OBS FOLLOWING TRANSPORT ACC					Z041
COMMENTS:							
2242 ALL PAPERWORK SIGNED COPY OF INS CARD AND ID CONSENTS SCANNED PT WAS HIT BY A CAR HIT AND RUN GAVE PT MRA PACKET NO PAYMENT OR DISCOUNT OFFERED							

06/24/16

12:12

NN1000/033011



**Physician
Documentation**

Northeastern Nevada Regional Hospital

Name: Douglas Schwartz

Age: 58 yrs Sex: Male DOB: 06/02/1958

Arrival Date: 06/22/2016 Time: 20:51

Bed 16

ED Physician Garvey, David

HPI:

06/22
21:15 This 58 yrs old White Male presents to ED via EMS with complaints of **pedestrian versus auto.**

djg/jkp

21:15 The patient was a pedestrian struck by a moving vehicle, and thrown approximately 10 feet. Onset: The symptoms/episode began/occurred just prior to arrival. Associated injuries: The patient sustained injury to the head, abrasion, injury to the chest, specifically the right lateral posterior chest, pain with breathing, pain with movement, right bicep, right elbow and right knee, abrasion. Associated signs and symptoms: Loss of consciousness: the patient experienced loss of consciousness, that was brief. Severity of symptoms: At their worst the symptoms were moderate, in the emergency department the symptoms are unchanged. The patient has not experienced similar symptoms in the past. The patient has not recently seen a physician.

djg/jkp

Historical:

- **Allergies:** Lortab;
- **PMHx:** Hypertension
- **PSHx:** None

- **Exposure Risk/Travel Screening::** Patient has not been out of the country in last 30 days. Have you been in contact with anyone who is ill that has traveled outside of the country in the last 30 days? No.
- **Social history::** Tobacco Status: The patient states he/she has never used tobacco. The patient/guardian denies using alcohol, street drugs, IV drugs, The patient lives with family, The patient's primary language is English. The patient's preferred language is English..
- **Tuberculosis screening::** No symptoms or risk factors identified..
- **Family history::** Not pertinent..
- **The history from nurses notes was reviewed:** and I agree with what is documented up to this point..

ROS:

21:18

Constitutional: Negative for body aches, chills, fatigue, fever.
Eyes: Negative for blurry vision, visual disturbance, the patient's right contact lens was lost during the accident.
ENT: Negative for drainage from ear(s), nasal discharge.
Neck: Negative for stiffness, swelling.
Cardiovascular: Positive for chest pain, of the right lateral posterior chest, Negative for palpitations.
Respiratory: Negative for hemoptysis, shortness of breath.
Abdomen/GI: Negative for nausea, vomiting.
Back: Positive for pain at rest, of the left scapular area and left subscapular area.
MS/extremity: Positive for abrasion.
Skin: Negative for diaphoresis, pallor.
Neuro: Negative for dizziness, gait disturbance, headache.
Psych: Negative for anxiety, depression.

djg/jkp

Exam:

21:20

Constitutional: The patient appears awake, in obvious pain, uncomfortable.
Head/face: Noted is abrasion(s), that are mild, of the forehead.
Eyes: Pupils: equal, round, and reactive to light and accommodation.
ENT: TM's: are normal, no hemotympanum, Nose: is normal, no bleeding, no clotted blood, no drainage.
Neck: External neck: is normal, C-spine: Nexus Criteria: Nexus criteria: no cervical midline tenderness, patient is not intoxicated, mental status is normal, no focal/neurologic deficits, and no painful distracting injuries are present.

djg/jkp

Physician Documentation Con't.

Chest/axilla: Inspection: normal, Palpation: tenderness, that is moderate, of the right lateral posterior chest.

Cardiovascular: Rate: normal, Rhythm: regular.

Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, Breath sounds: are normal, clear throughout.

Abdomen/GI: Inspection: abdomen appears normal, Bowel sounds: normal, active, all quadrants, Palpation: abdomen is soft and non-tender, in all quadrants.

Back: pain, that is moderate, of the left scapular area and left subscapular area.

Musculoskeletal/extremity: Extremities: grossly normal except: noted in the right knee and right elbow and right bicep: abrasion, ROM: intact in all extremities, Circulation is intact in all extremities. Sensation intact.

Skin: Appearance: normal except for affected area.

Neuro: Orientation: is normal, to person, place & time. Memory: immediate memory is intact, remote memory is intact. recent memory is impaired.

Psych: Behavior/mood is pleasant, cooperative.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
20:53	162 / 96	69	20	98.4(T)	94% on 4 lpm NC	92.99 kg	5 ft. 10 in. (177.80 cm)	5/10	dk
20:53	162 / 96 (auto/)	71 MON			83%				dk
20:55		69 MON	18		94%				dk
23:17	116 / 75 (auto/)								dk
23:17		67 MON	16		91%				dk
23:27	115 / 74 (auto/)								dk
23:27		67 MON	17		91%				dk
23:30	120 / 78 (auto/)								dk
23:30		67 MON	18		92%				dk
23:45	114 / 73 (auto/)								dk
23:45		68 MON	18		91%				dk
06/23 00:10		66	17		97% on 15% Non- rebreather mask				dk
00:15		73	19		99% on 15% Non- rebreather mask				dk
00:20		97	22		83%				dk
00:25		108			76%				dk
00:30	225 / 136	127			76%				dk
00:35		36			37%				dk
00:40		111			77%				dk
00:41	249 / 140	125			81%				dk
00:45	221 / 148	119			75%				dk
00:50		126			62%				dk
00:55		128			43%				dk
01:00	207 / 143	124			69%				dk
01:05		120			71%				dk
01:10		126			52%				dk
01:14	202 / 125	124			60%				dk

Name: Douglas Schwartz

MRN: 330967

Account#: 6139781

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Physician Documentation Con't.

01:15	126 / 95	119		46%			dk
01:20		36		39%			dk
01:25				64%			dk
01:30				60%			dk
01:32	149 / 55	134		49%			dk

06/22 Body Mass Index 29.41 (92.99 kg, 177.80 cm)
20:53

dk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
06/23 02:29	spontaneous(4)	oriented(5)	obeys commands(6)		15	djg

Procedures:

05:04 Performed Cricothyrotomy performed due to inability to orally intubate patient. Initially the small trach tube that came with kit was placed - it quickly became occluded with gastric contents. The tube became dislodged while attempting to clear the obstruction, and after repositioning it, development of SQ air in the neck was noticed. The trach tube was removed and replaced with a 5-0 ET tube. The pt was very difficult to ventilate thru the crich tube with most of the bagged air expelled from the mouth, but there was chest rise and equal air movement with bagging thru the cric and occluding the mouth and nose. O2 sats however did not improve and the patient went into full cardiac arrest and CPR was restarted. .

djg

MDM:

06/22 MSE Initiated by Provider.
20:52

djg

06/23

djg

02:05 **ED course:** Discussed with Dr Ray at U of U who excepted pt in transfer. He requested that a chest tube be placed and possibly intubation prior to air medical transport due to flail segment, pulmonary contusions, low O2 sats and a traumatic R pneumothorax. Plan was discussed with pt and his wife. Reach critical care transport team arrived just after the discussion with patient and family. Plan was to sedate the patient with Ketamine. I would place the CT while the Reach crew performed the intubation. The pt was give Rocuronium and Ketamine with appropriate sedation and paralysis. The initial attempt at intubation was unsuccessful. The pt was bagged for a few mins and a 2nd attempt was made. During the 2nd attempt the pt vomited and aspirated a large amount of gastric contents. Suctioning was difficult due to large food particles occluding the suction. I attempted the 3rd attempt at intubation w/o success - mainly due to a very anterior larynx and vomitus in the airway that couldn't be completely cleared. The pt bradied down due to low O2 sats and CPR was begun while the pt was bagged. The O2 sats improved and the pt regained a strong pulse. Several more attempts at intubation were made by myself and the Reach team, and although each time it was felt that the ET tube was properly placed, large amts of gastric contents continued to fill the ET tube and each time the tube was pulled and the patient bagged. At the point when bagging did not achieve adequate oxygenation, a cricothyrotomy was performed. Again there was a significant amt of vomitus plugging the small ET tube used for the cric. Bilateral needle thoracostomies were also done. The patient could not be adequately ventilated, even through the cric tube and again bradyed down to full arrest and CPR was restarted. The patient did not respond to CPR efforts and the code was called and the pt pronounced at 0133. I informed the pt's wife and friends of the occurrences in the ED..

Data reviewed: vital signs, nurses notes, EMS record, lab test result(s), radiologic studies, CT scan.

04:20 I have reviewed and agree with the scribe's documentation on my behalf.

djg

05:21

djg

ED course: Note: after the pt's initial regurgitation and aspiration, a patent airway was never secured - multiple oral ET attempts with direct and video fiberoptic laryngoscopes, bougie and King airway. Some of the initial ETT placements may have been in the trachea, but because of the large amt of gastric contents filling the tube with each placement and poor ET CO2 readings, all placed tubes were pulled, and the pt was bagged via BVM until the cric was placed. But, even with the cric the pt could not be adequately ventilated or oxygenated. .

21:55 I have reviewed and agree with the scribe's documentation on my behalf.

djg

Name: Douglas Schwartz

MRN: 330967
Account#: 6139781
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Print Time: 6/24/2016 12:08:23

Physician Documentation Con't.

Time	Order name	Complete Time	Staff
06/22 21:02	Cbc W/ Auto Diff	23:42	djg
06/22 21:02	CMP	23:42	djg
06/22 21:02	Amylase	23:42	djg
06/22 21:02	Lipase	23:42	djg
06/22 21:02	Urinalysis	23:42	djg
06/22 21:02	Urine, Obtain	23:19	djg
06/22 21:02	NS saline lock	21:33	djg
06/22 21:02	Ct Brain Head Wo	03:18	djg
06/22 21:02	CT C Spine Wo	23:42	djg
06/22 21:02	CT T Spine W/O	03:18	djg
06/22 21:02	Ct Chest W	03:18	djg
06/22 21:02	CT Abd/Pelvis IV Only	23:42	djg
06/22 21:02	Dilaudid 1 mg IVP once	22:33	djg
06/22 21:02	Zofran - Ondansetron 4 mg IVP once; over 2 minutes	22:33	djg
06/22 23:18	Zofran - Ondansetron 4 mg IVP once; over 2 minutes	23:19	dk
06/23 04:29	Ativan 2 mg PO once; 2 mg Ativan given to wife at 0225h	02:25	djg

Dispensed Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
06/22 22:33	Dilaudid 1 mg		IVP			left hand		dk
23:17	Follow up: Response: No adverse reaction; Pain is decreased							dk
22:33	Zofran - Ondansetron 4 mg		IVP			left hand		dk
23:18	Follow up: Response: No adverse reaction; Nausea is decreased							dk
23:19	Zofran - Ondansetron 4 mg		IVP			left hand		dk
23:53	Follow up: Response: No adverse reaction; Nausea is decreased							dk
06/23 02:25	Ativan 2 mg		PO					dk
03:20	Follow up: Response: No adverse reaction							dk

Disposition:

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Physician Documentation Con't.

02:29 Electronically signed by Garvey, David, MD at 02:29 on 06/23/2016.

djg

Disposition:

Patient pronounced on 06/23/16 01:33 by Garvey, David. Impression: Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum, Cardiac arrest - Due to Asphyxiation .

Critical care time excluding procedures:

02:29 Critical care time: Bedside Care excluding time for separate services.: 2.5 minutes. Total time: 2 minutes djg

02:29 Critical care time: Consultation: 10 minutes, Family Intervention: 15 minutes. Total time: 25 minutes djg

Signatures:

MedHost	EDMS	Garvey, David, MD	MD	djg
Kevitt, Donna	dk	Price, Julia		jkg

Nurse's Notes

Northeastern Nevada Regional Hospital

Name: Douglas Schwartz

Age: 58 yrs **Sex:** Male **DOB:** 06/02/1958

Arrival Date: 06/22/2016 **Time:** 20:51

Bed 16

MRN: 330967

Account#: 6139781

Private MD:

Diagnosis: Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum; Cardiac arrest - Due to Asphyxiation

Presentation:

06/22 Presenting complaint: EMS states: right sided rib pain, right knee pain, right shoulder. Hit by car going 20:53 approx 35-40 mph. Possible loss of consciousness. Alert/oriented at time EMS arrive. VSS during transfer. A/O at this time. EMS administered 100 mcg Fentanyl and 4 mg Zofran in the field. Airway is patent with good air movement. The patient is breathing without difficulty. The patient is pink, warm and dry. Heart rate is within normal limits. Pain: Complains of pain in right supraclavicular area, diaphragm and right breast. Influenza risk: Fever: The patient has no complaints of fever. Suicide Screening: Have you recently had thoughts about hurting yourself or others? No. dk

20:53 Acuity: Emergent (2). dk

20:53 Care prior to arrival: Medication(s) given: See presentation complaint for treatment and medications given prior to arrival. dk

20:53 Compressions began at 00:35. dk

Historical:

- **Allergies:** Lortab;
- **PMHx:** Hypertension
- **PSHx:** None

- **Exposure Risk/Travel Screening::** Patient has not been out of the country in last 30 days. Have you been in contact with anyone who is ill that has traveled outside of the country in the last 30 days? No.
- **Social history::** Tobacco Status: The patient states he/she has never used tobacco. The patient/guardian denies using alcohol, street drugs, IV drugs, The patient lives with family, The patient's primary language is English. The patient's preferred language is English..
- **Tuberculosis screening::** No symptoms or risk factors identified..
- **Family history::** Not pertinent..

Screening:

21:05 **Fall Risk:** dk
History of Falls: No (0 points): The patient does not have a history of falls. Secondary Diagnosis: No (0 points): The patient has no chronic conditions. Ambulatory Aids: None (0 Points): The patient uses no ambulatory aids. IV or IV Access: Yes (20 points): The patient has IV access or infusion therapy. Gait: Impaired (20 points): The patient has difficulty rising from a chair, head is down, or watches the ground, grabs walking aids or others for support, or cannot walk without assistance. Mental Status: Oriented (0 pts): The patient can recall their ability to ambulate and acknowledges limitations per medical order. Sedated or Mind altering medications: No Total Points: Med. Risk (25-44); Implement universal fall prevention interventions.

Abuse Screen:
Patient verbally denies physical, verbal and emotional abuse/neglect.

Cultural/Spirit Needs:
There are no cultural/spiritual considerations for care needed for this patient.

21:05 **Nutritional Screening:** dk
No deficits noted.

Assessment:

20:52 visited this patient and evaluated for pain, information needs and comfort. djg

21:02 dk
Mechanism of Injury: Auto vs Ped Vehicle was traveling approximately 35 mph. hit approx 35-40 mph. Thrown up and over vehicle. The level of pain that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, uncomfortable, Behavior is appropriate for age, cooperative, pleasant. **Neuro:** No deficits noted. **EENT:** No deficits noted. **Cardiovascular:** No deficits noted. Heart tones present. **Respiratory:** Breath sounds are diminished in right posterior middle lobe and

Nurse's Notes Con't

right posterior lower lobe. **GI:** No deficits noted. Bowel sounds present X 4 quads. **GU:** No deficits noted.
Sepsis Screening: Sepsis screening negative at this time.

- 21:02 Method Of Arrival: EMS: Elko EMS. dk
- 21:13 **Neuro:** Level of Consciousness is awake, alert, unknown LOC at time of injury. A/O at this time. . Oriented to person, place, time, Grips are equal bilaterally Moves all extremities. Speech is normal, Facial symmetry appears normal. dk
- 21:21 **Derm:** Abrasions noted to Right scalp area, outer right arm, right elbow and right knee. **Injury Description:** dk
 Abrasion Auto vs. Ped. Vehicle traveling approx 35-40 on impact. Pt hit right drivers door and was thrown up over vehicle. Unknown LOC at scene. EMS reported pt A/O on their arrival. Pt is alert and oriented at time of arrival to NNRH.
- 21:31 visited this patient and evaluated for pain, information needs and comfort. dk
- 23:17 visited this patient and evaluated for pain, information needs and comfort. dk
- 23:27 visited this patient and evaluated for pain, information needs and comfort. dk
- 23:31 visited this patient and evaluated for pain, information needs and comfort. dk
- 23:36 **Injury Description:** dk
- 06/23 **CPR assessment:** unresponsive, no respiratory effort, mechanical ventilation, Ambu ventilation, cyanotic, dk
 00:35 pulses absent w/ compressions.
- 00:35 Cardiac rhythm is asystole. dk
- 06/24 visited this patient and evaluated for pain, information needs and comfort. kp
 00:37

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
06/22	162 / 96	69	20	98.4(T)	94% on 4 lpm NC	92.99 kg	5 ft. 10 in. (177.80 cm)	5/10	dk
20:53	162 / 96 (auto/)	71 MON			83%				dk
20:55		69 MON	18		94%				dk
23:17	116 / 75 (auto/)								dk
23:17		67 MON	16		91%				dk
23:27	115 / 74 (auto/)								dk
23:27		67 MON	17		91%				dk
23:30	120 / 78 (auto/)								dk
23:30		67 MON	18		92%				dk
23:45	114 / 73 (auto/)								dk
23:45		68 MON	18		91%				dk
06/23		66	17		97% on 15% Non-rebreather mask				dk
00:10									
00:15		73	19		99% on 15% Non-rebreather mask				dk
00:20		97	22		83%				dk
00:25		108			76%				dk
00:30	225 / 136	127			76%				dk
00:35		36			37%				dk
00:40		111			77%				dk
00:41	249 / 140	125			81%				dk

Name: Douglas Schwartz

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Nurse's Notes Con't

00:45	221 / 148	119		75%		dk
00:50		126		62%		dk
00:55		128		43%		dk
01:00	207 / 143	124		69%		dk
01:05		120		71%		dk
01:10		126		52%		dk
01:14	202 / 125	124		60%		dk
01:15	126 / 95	119		46%		dk
01:20		36		39%		dk
01:25				64%		dk
01:30				60%		dk
01:32	149 / 55	134		49%		dk

06/22 Body Mass Index 29.41 (92.99 kg, 177.80 cm)
20:53

dk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
06/23 02:29	spontaneous(4)	oriented(5)	obeys commands(6)		15	djg

ED Course:

06/22 Patient arrived in ED. dk
20:51
20:51 Patient moved to Waiting. dk
20:51 Patient moved to 12. dk
20:52 Garvey, David, MD is Attending Physician. djg
20:58 Triage completed. dk
21:08 Kevitt, Donna is Primary Nurse. dk
21:20 Maintain field IV. Dressing intact. Good blood return noted. Site clean & dry. Gauge & site: 20g left wrist. dk
Oxygen administration via nasal cannula @ 4L/min.
21:20 Cardiac monitor on. Pulse ox on. NIBP on. Warm blanket given. dk
21:25 Patient has correct armband on for positive identification. Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Adult w/ patient. dk
21:29 Awaiting Per MD- hold medication administration at this time due to meds given by EMS. OK to wait on urine at this time until after CT completed. dk
21:32 Inserted peripheral IV: 20 gauge left hand blood drawn and sent to lab per order. dk
21:33 Patient moved to CT. hr
21:33 Patient moved to CT Scan. hr
21:33 Lipase Sent. dk
21:33 Amylase Sent. dk
21:33 CMP Sent. dk
21:33 Cbc W/ Auto Diff Sent. dk
21:40 Patient moved to CT. dk
23:00 Patient moved back from CT. hr
23:00 Patient moved to 12. hr
23:37 Pt placed on 40% Venti mask per respiratory. Pt sats: 92-93%. dk
23:51 Oxygen administration via non-rebreather mask @ 15L/min. dk
06/23
01:45 Wife notified of patient's death by Dr. Garvey. Dr. John Patton, friend of family at wife's side. Wife moved to Triage room. Assisted Dr. Patton in calling family members. Sons DJ, Taylor, and Mitchell notified. Called dk

Name: Douglas Schwartz

MRN: 330967

Account#: 6139781

Print Time: 6/24/2016 12:09:05

Page 3 of 5

Nurse's Notes Con't

family friend Todd Robinson @ 0220. Continuing to comfort wife. 0225am 2 mg po Ativan given to wife per MD order.

02:14 Patient moved to 16.	so
02:30 Garvey, David, MD is Pronouncing Provider.	djg
02:40 Wife escorted to room 16 via wheelchair. Friend John Patton at side.	dk
03:06 Patient moved to D1.	na
03:06 Patient moved to 16.	na
04:10 Awaiting Call to donor line. Case #: 10402647.	dk
04:13 Awaiting Elizabeth Gill with Donor line called. Release to coroner.	dk
04:25 Gastric tube NGT removed.	dk
05:46 Custody of body released to Elko Co. Sheriff Officer Coroner. Transported by Burn's Funeral home.	dk
05:50 Assist provider with intubation Unsuccessful attempts. See Code sheet.	dk

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
06/22 22:33	Dilaudid 1 mg		IVP			left hand		dk
23:17	Follow up: Response: No adverse reaction; Pain is decreased							dk
22:33	Zofran - Ondansetron 4 mg		IVP			left hand		dk
23:18	Follow up: Response: No adverse reaction; Nausea is decreased							dk
23:19	Zofran - Ondansetron 4 mg		IVP			left hand		dk
23:53	Follow up: Response: No adverse reaction; Nausea is decreased							dk
06/23 02:25	Ativan 2 mg		PO					dk
03:20	Follow up: Response: No adverse reaction							dk

Intake:

01:33 1000 plus ml from suctioning during event. Copious amounts of vomitus from posterier pharynx using 2 suction simultaneously. dk

Output:

Time	Urine	Gastric	Stool	EBL	Drainage	Other	Total	Staff
01:33		1000 ml (NGT)					1000ml	dk

01:33 1000 plus ml from suctioning during event. Copious amounts of vomitus from posterier pharynx using 2 suction simultaneously. dk

Outcome:

05:00 Outcome Patient expired. dk
Patient expired: Time of death 01:33 Pronounced by David Garvey MD Body released to ME Organ Donation no.
 05:00 dk
Condition: expired
 05:00 dk
Discharge Assessment: Patient Pt expired @ 0133.
 06:05 Patient left the ED. dk

Signatures:

Name: Douglas Schwartz

Print Time: 6/24/2016 12:09:05

MRN: 330967
 Account#: 6139781
 Page 4 of 5

Nurse's Notes Con't

Garvey, David, MD
Abrams, Nancy, PCA
Kevitt, Donna
Payne, Kimber

MD djg
PCA na
dk
kp

Rangel, Hannah
Olson, Sue
Price, Julia

hr
so
jkg

Lab Results Summary

Name: Douglas Schwartz
 58 yrs / White / Male
 Chief Complaint: Auto vs Pedestrian

MRN: 330967
 Arrival: 06/22/2016 20:51
 Departure Date 06/23/2016
 Departure Time 06:05

Order name	Last Status	Reason	Time	By	For	
Cbc W/ Auto Diff	Reviewed		06/22/16 21:02	djg	djg	
Order Method: Electronic						
Details:						
Notes:						
Interpretation:						
Test	Value	Range	Abnormal	Units	Status	Updated
WBC	13.0	4.8-10.8	Above high normal	X 10(3)	F	06/22 21:42
NEUTS	64.3	41.7-82.3		%	F	06/22 21:42
LYMPHS	27.2	15.0-51.1		%	F	06/22 21:42
MONOS	6.0	0.0-11.7		%	F	06/22 21:42
EOSINS	1.7	0.0-5.5		%	F	06/22 21:42
BASOS	0.2	0.0-3.0		%	F	06/22 21:42
NE#	8.4	2.5-9.0		X 10(3)	F	06/22 21:42
LY#	3.5	0.9-4.8		X 10(3)	F	06/22 21:42
MO#	0.8	0.1-0.9		X 10(3)	F	06/22 21:42
EO#	0.2	0.0-0.7		X 10(3)	F	06/22 21:42
BA#	0.0	0.0-0.2		X 10(3)	F	06/22 21:42
RBC	4.89	4.7-6.1		X 10(6)	F	06/22 21:42
HEMOGLOBIN	15.5	14.0-18.0		GM/DL	F	06/22 21:42
HEMATOCRIT	42.8	42.0-54.0		%	F	06/22 21:42
MCV	87.5	80.0-99.0		FL	F	06/22 21:42
MCH	31.7	27.0-34.0		PG	F	06/22 21:42
MCHC	36.2	31.0-36.0	Above high normal	G/%	F	06/22 21:42
RDW	12.1	11.5-15.2		%	F	06/22 21:42
PLATELET	234	140-440		X 10(3)	F	06/22 21:42
MPV	10.1	6.5-12.0		FL	F	06/22 21:42
CMP	Reviewed		06/22/16 21:02	djg	djg	
Order Method: Electronic						
Details:						
Notes:						
Interpretation:						
Test	Value	Range	Abnormal	Units	Status	Updated
SODIUM	134	136-148	Below low normal	mmol/L	F	06/22 21:56
K	3.4	3.5-5.2	Below low normal	mmol/L	F	06/22 21:56
CHLORIDE	100	98-108		mmol/L	F	06/22 21:56
BICARB	25.1	21-32		mmol/L	F	06/22 21:56
ANIONGAP	8.9	6-18			F	06/22 21:56
GLUCOSE	127	70-100	Above high normal	mg/dl	F	06/22 21:56
BUN	15	7-24		mg/dl	F	06/22 21:56
CREAT	1.3	0.6-1.3		mg/dl	F	06/22 21:56
BUN/CREATININE RATIO	11.5	12.0-20.0	Below low normal	ratio	F	06/22 21:56
EGFR	60	70-	Below low normal	mL/min/1.73m	F	06/22 21:56
CA	8.3	8.8-10.5	Below low normal	mg/dl	F	06/22 21:56
SGOT-AST	301	9-35	Above high normal	U/L	F	06/22 21:56
ALBUMIN	4.1	3.4-5.0		g/dl	F	06/22 21:56
PROTEIN	7.4	6.4-8.2		g/dl	F	06/22 21:56
GLOBULIN	3.3	2.3-3.5			F	06/22 21:56
A/GRATIO	1.2	1.1-1.9			F	06/22 21:56
T BIL A	0.4	0.0-1.0		mg/dl	F	06/22 21:56
ALK PHOS	55	46-116		U/L	F	06/22 21:56

Lab Results Summary

SGPT-ALT	226	23-65	Above high normal	U/L	F	06/22 21:56
Amylase		Reviewed		06/22/16 21:02	djg	djg
Order Method: Electronic						
Details:						
Notes:						
Interpretation:						
Test	Value	Range	Abnormal	Units	Status	Updated
AMYLASE	87	25-115		U/L	F	06/22 21:56
Lipase		Reviewed		06/22/16 21:02	djg	djg
Order Method: Electronic						
Details:						
Notes:						
Interpretation:						
Test	Value	Range	Abnormal	Units	Status	Updated
LIPASE	397	73-393	Above high normal	U/L	F	06/22 21:57
Urinalysis		Reviewed		06/22/16 21:02	djg	djg
Order Method: Electronic						
Details:						
Notes:						
Interpretation:						
Test	Value	Range	Abnormal	Units	Status	Updated
COLOR	YELLOW				F	06/22 23:30
CLARITY	CLEAR				F	06/22 23:30
URINE SG	1.010	1.005-1.030			F	06/22 23:30
UR GLUC	NEGATIVE	-NEG			F	06/22 23:30
UR BILI	NEGATIVE	-NEG			F	06/22 23:30
UR KETON	NEGATIVE	-NEG			F	06/22 23:30
UR PH	5.5	5.0-8.0			F	06/22 23:30
UR PROT	TRACE	-NEG			F	06/22 23:30
UROBILIN	0.2	NORM			F	06/22 23:30
NITRITE	NEGATIVE	-NEG			F	06/22 23:30
BLOODHGB	3+	NEG			F	06/22 23:30
LEUK EST	NEGATIVE	-NEG			F	06/22 23:30
URINE DIP ONLY	NO	-----			F	06/22 23:30
UR WBC	0-2			PER HPF	F	06/22 23:30
UR RBC	20-30			PER HPF	F	06/22 23:30
MUCUS	TRACE			PER HPF	F	06/22 23:30

Medication Orders Summary

Name: Douglas Schwartz
 58 yrs / White / Male
Chief Complaint: Auto vs Pedestrian

MRN: 330967
Arrival: 06/22/2016 20:51
Departure Date: 06/23/2016
Departure Time: 06:05

Order name	Last Status	Reason	Time	By	For
Dilaudid 1 mg IVP once	Administered		06/22/16 21:02	djg	djg
Order Method: Electronic					
Details:					
Notes:					
Zofran - Ondansetron 4 mg IVP once; over 2 minutes	Administered		06/22/16 21:02	djg	djg
Order Method: Electronic					
Details:					
Notes:					
Zofran - Ondansetron 4 mg IVP once; over 2 minutes	Administered		06/22/16 23:18	dk	djg
Order Method: Verbal - Read back		Sign Off: Garvey, David - 06/23 02:33			
Details:					
Notes:					
Ativan 2 mg PO once; 2 mg Ativan given to wife at 0225h	Administered		06/23/16 04:29	djg	djg
Order Method: Electronic					
Details:					
Notes:					

Douglas Schwartz
MRN: 330967
ACCT: 6139781

Northeastern Nevada Regional Hospital

2001 Errecart Blvd
Elko, Nevada 89801
775-738-5151

06/23/2016 02:33

Discharge Instructions for: **Schwartz, Douglas R**
Arrival Date: **Wednesday, June 22, 2016**

Thank you for choosing **Northeastern Nevada Regional Hospital** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Garvey, David, MD

Diagnosis: Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum; Cardiac arrest - Due to Asphyxiation

DISCHARGE INSTRUCTIONS	FORMS
None	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
None	None
SPECIAL NOTES	
None	

Suicide National Hotline: 1-800-273-8255 (800-273-TALK)

If you received a narcotic or sedative medication during your Emergency Department stay you should not drive, drink alcohol or operate heavy machinery for the next 8 hours as this medication can cause drowsiness, dizziness, and decrease your response time to events.

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

TESTS AND PROCEDURES

Labs

Cbc W/ Auto Diff, CMP, Amylase, Lipase, Urinalysis

Douglas Schwartz
MRN: 330967
ACCT: 6139781

Rad

Ct Brain Head Wo, CT C Spine Wo, CT T Spine W/O, Ct Chest W, CT Abd/Pelvis IV Only

Procedures

Labs drawn, Intubation, CPR, CPR

Other

Urine, Obtain, NS saline lock

Patient Copy

Encounter Summary

Name: Douglas Schwartz
Age: 58 yrs **DOB:** 06/02/1958
Sex: Male
Race: White
Martial Status: Married

SSN: 518-86-4393
MRN: 330967
Account#: 6139781
Home phone: (702)373-2436
Work phone:

Chief Complaint: Auto vs Pedestrian
MOA: EMS
Acuity: Emergent (2)

Arrival: 06/22/2016 20:51

Responsible Dept: Trauma

Care Complete Date 06/23/2016
Care Complete Time 02:33
Departure Date 06/23/2016
Departure Time 06:05

Special Handling:
Family Waiting: No
Bed 16

Assigned staff & roles

Name	Role	Specialty
Garvey, David	Attending Physician	Emergency Medicine
Kevitt, Donna	Primary Nurse	
Garvey, David	Pronouncing Provider	Emergency Medicine

Outcome: Expired
Time of death: 06/23/16 01:33

Location:

Condition:

Chief Complaint: Auto vs Pedestrian

Diagnosis: - Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum, Cardiac arrest - Due to Asphyxiation

Prescriptions:

Follow up:

Special Notes:

Attending Physician: Garvey

Mid Level Provider:

Orders: Cbc W/ Auto Diff, CMP, Amylase, Lipase, Urinalysis, Urine, Obtain, NS saline lock, NS saline lock, Ct Brain Head Wo, CT C Spine Wo, CT T Spine W/O, Ct Chest W, CT Abd/Pelvis IV Only, Dilaudid, Ondansetron, Ondansetron, Ativan

Discharge Instruction:

Event Log

Name: Douglas Schwartz
 58 yrs / White / Male
Chief Complaint: Auto vs Pedestrian

MRN: 330967
Arrival: 06/22/2016 20:51
Departure Date 06/23/2016
Departure Time 06:05

Encounter Events

Date/Time	Event	Event Info	Logged by
06/22/16 20:51	Encounter Creation		Kevitt, Donna
06/22/16 20:51	Responsible Dept Assignment	Automatic : Unassigned	Kevitt, Donna
06/22/16 20:51	Patient Arrival		Kevitt, Donna
06/22/16 20:51	Patient Move	Waiting	Kevitt, Donna
06/22/16 20:51	Bed Assignment	12	Kevitt, Donna
06/22/16 20:51	Patient Move	12	Kevitt, Donna
06/22/16 20:51	Responsible Dept Assignment	Automatic : Unassigned	Kevitt, Donna
06/22/16 20:52	Medical Exam		Garvey, David, MD
06/22/16 20:52	Patient Visited	12	Garvey, David, MD
06/22/16 20:58	Triage Complete		Kevitt, Donna
06/22/16 20:58	Acuity Assignment	Emergent (2)	Kevitt, Donna
06/22/16 20:58	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 21:00	Allergies Modified		Kevitt, Donna
06/22/16 21:00	Past Medical History Modified		Kevitt, Donna
06/22/16 21:00	Past Surgical History Modified		Kevitt, Donna
06/22/16 21:02	Drug Alert Override	(Ordered) Dilaudid 1 mg IVP once / MD discretion	Garvey, David, MD
06/22/16 21:05	Method of Arrival Changed	EMS:Elko EMS	Kevitt, Donna
06/22/16 21:11	HIS Merge Complete		MedHost
06/22/16 21:11	Marital Status Modified	Single	MedHost
06/22/16 21:11	Home Phone Modified	(702)435-3600	MedHost
06/22/16 21:11	Address Modified	Suite 101^3213 W. Charleston Blvd	MedHost
06/22/16 21:11	City/State/Zip Modified	Las Vegas^NV^89102	MedHost
06/22/16 21:13	Scribing For Provider	Garvey, David, MD	Price, Julia for Garvey, David, MD
06/22/16 21:31	Patient Visited	12	Kevitt, Donna
06/22/16 21:33	Patient Move	CT Scan	Rangel, Hannah
06/22/16 21:48	Chief Complaint Modified	Auto vs Pedestrian	Gonzales, Carmen, Reg
06/22/16 23:00	Bed Assignment	12	Rangel, Hannah
06/22/16 23:00	Patient Move	12	Rangel, Hannah
06/22/16 23:00	Responsible Dept Assignment	Automatic : Unassigned	Rangel, Hannah
06/22/16 23:13	Financial Reg Completed		Gonzales, Carmen, Reg
06/22/16 23:17	Patient Visited	12	Kevitt, Donna
06/22/16 23:27	Results Viewed	Cbc W/ Auto Diff	Abrams, Nancy, PCA
06/22/16 23:27	Results Viewed	CMP	Abrams, Nancy, PCA
06/22/16 23:27	Results Viewed	Lipase	Abrams, Nancy, PCA
06/22/16 23:27	Results Viewed	Amylase	Abrams, Nancy, PCA
06/22/16 23:27	Results Viewed	CT T Spine W/O	Abrams, Nancy, PCA
06/22/16 23:27	Results Viewed	Ct Chest W	Abrams, Nancy, PCA
06/22/16 23:27	Results Viewed	CT Abd/Pelvis IV Only	Abrams, Nancy, PCA

Event Log

06/22/16 23:27	Patient Visited	12	Kevitt, Donna
06/22/16 23:31	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:31	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:31	Vital Signs Modified	Very Abnormal Values present	Kevitt, Donna
06/22/16 23:31	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:31	Patient Visited	12	Kevitt, Donna
06/22/16 23:39	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:39	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:42	Results Viewed	Cbc W/ Auto Diff	Garvey, David, MD
06/22/16 23:42	Results Viewed	CMP	Garvey, David, MD
06/22/16 23:42	Results Viewed	Lipase	Garvey, David, MD
06/22/16 23:42	Results Viewed	Amylase	Garvey, David, MD
06/22/16 23:42	Results Viewed	Urinalysis	Garvey, David, MD
06/22/16 23:42	Results Viewed	Ct Brain Head Wo	Garvey, David, MD
06/22/16 23:42	Results Viewed	CT C Spine Wo	Garvey, David, MD
06/22/16 23:42	Results Viewed	CT T Spine W/O	Garvey, David, MD
06/22/16 23:42	Results Viewed	Ct Chest W	Garvey, David, MD
06/22/16 23:42	Results Viewed	CT Abd/Pelvis IV Only	Garvey, David, MD
06/22/16 23:52	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:52	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:52	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/22/16 23:52	Vital Signs Modified	Abnormal Values present	Kevitt, Donna
06/23/16 02:14	Bed Assignment	16	Olson, Sue
06/23/16 02:14	Patient Move	16	Olson, Sue
06/23/16 02:14	Responsible Dept Assignment	Automatic : Unassigned	Olson, Sue
06/23/16 02:33	Expired		Garvey, David, MD
06/23/16 02:33	ER Care Complete		Garvey, David, MD
06/23/16 02:33	Pronouncing Provider Entered	Garvey, David	Garvey, David, MD
06/23/16 02:33	Diagnosis Modified	Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum; Cardiac arrest	Garvey, David, MD
06/23/16 02:34	Outbound Msg Sent	ER Care Complete: DDI Outbound ADT	MedHost
06/23/16 03:01	Diagnosis Modified	Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum; Cardiac	Garvey, David, MD

Event Log

		present	
06/23/16 04:07	Vital Signs Modified	Very Abnormal Values present	Kevitt, Donna
06/23/16 04:07	Vital Signs Modified	Very Abnormal Values present	Kevitt, Donna
06/23/16 04:07	Vital Signs Modified	Very Abnormal Values present	Kevitt, Donna
06/23/16 04:07	Vital Signs Modified	Very Abnormal Values present	Kevitt, Donna
06/23/16 04:20	Scribe Signoff Completed		Garvey, David, MD
06/23/16 06:05	Responsible Dept Assignment	Manual : Trauma	Kevitt, Donna
06/23/16 06:05	Departure		Kevitt, Donna
06/23/16 06:06	Outbound Msg Sent	Departure: DDI Outbound ADT	MedHost
06/23/16 06:06	Outbound Msg Sent	Departure: DDI Multi Vital Signs	MedHost
06/23/16 06:06	Outbound Msg Sent	Departure: DDI Charting Choices	MedHost
06/23/16 06:06	Outbound Msg Sent	Departure: DDI Intake and Output	MedHost
06/23/16 09:24	Results Viewed	Cbc W/ Auto Diff	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	CMP	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	Lipase	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	Amylase	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	Urinalysis	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	Ct Brain Head Wo	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	CT C Spine Wo	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	CT T Spine W/O	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	Ct Chest W	Stefanko, Robert, MD
06/23/16 09:24	Results Viewed	CT Abd/Pelvis IV Only	Stefanko, Robert, MD
06/23/16 09:53	Results Viewed	Cbc W/ Auto Diff	Filippini, Mary
06/23/16 09:53	Results Viewed	CMP	Filippini, Mary
06/23/16 09:53	Results Viewed	Lipase	Filippini, Mary
06/23/16 09:53	Results Viewed	Amylase	Filippini, Mary
06/23/16 09:53	Results Viewed	Urinalysis	Filippini, Mary
06/23/16 09:53	Results Viewed	Ct Brain Head Wo	Filippini, Mary
06/23/16 09:53	Results Viewed	CT C Spine Wo	Filippini, Mary
06/23/16 09:53	Results Viewed	CT T Spine W/O	Filippini, Mary
06/23/16 09:53	Results Viewed	Ct Chest W	Filippini, Mary
06/23/16 09:53	Results Viewed	CT Abd/Pelvis IV Only	Filippini, Mary
06/23/16 10:24	Scribing For Provider	Garvey, David, MD	Price, Julia for Garvey, David, MD
06/23/16 10:35	Results Viewed	Cbc W/ Auto Diff	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	CMP	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	Lipase	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	Amylase	Dullum, Jessica, RN

Event Log

06/23/16 10:35	Results Viewed	Urinalysis	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	Ct Brain Head Wo	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	CT C Spine Wo	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	CT T Spine W/O	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	Ct Chest W	Dullum, Jessica, RN
06/23/16 10:35	Results Viewed	CT Abd/Pelvis IV Only	Dullum, Jessica, RN
06/23/16 21:55	Scribe Signoff Completed		Garvey, David, MD
06/24/16 00:37	Patient Visited	16	Payne, Kimber
06/24/16 06:05	Charges Computed	Nurse	Agent
06/24/16 06:05	Charges Computed	Physician	Agent
06/24/16 06:05	Outbound Msg Sent	Records Processed by Chart Agent: HL7 EMR Nurse Chart Initial	MedHost
06/24/16 06:05	Outbound Msg Sent	Records Processed by Chart Agent: HL7 EMR Physician Chart Initial	MedHost
06/24/16 06:05	Outbound Msg Sent	Records Processed by Chart Agent: DDI Multi Vital Signs	MedHost
06/24/16 06:05	Outbound Msg Sent	Records Processed by Chart Agent: DDI Charting Choices	MedHost
06/24/16 06:05	Outbound Msg Sent	Records Processed by Chart Agent: DDI Intake and Output	MedHost
06/24/16 07:05	Encounter Locked		Agent
06/24/16 08:06	Encounter Archived		Agent
06/24/16 08:06	Outbound Msg Sent	Encounter Archived: EMR PDF - Chart Amendment Nurse	MedHost
06/24/16 08:06	Outbound Msg Sent	Encounter Archived: EMR PDF - Chart Amendment Physician	MedHost
06/24/16 08:06	Outbound Msg Sent	Encounter Archived: EMR PDF- Disposition Cover	MedHost
06/24/16 08:06	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Followup	MedHost
06/24/16 08:07	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Form	MedHost
06/24/16 08:07	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Resources	MedHost
06/24/16 08:07	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Instructions	MedHost
06/24/16 08:07	Outbound Msg Sent	Encounter Archived: EMR PDF - ER Encounter	MedHost
06/24/16 08:07	Outbound Msg Sent	Encounter Archived: EMR PDF - Event Log	MedHost
06/24/16 08:07	Outbound Msg Sent	Encounter Archived: EMR PDF - Fax Summary	MedHost
06/24/16 08:12	Post Archive Update		MedHost
06/24/16 08:13	Encounter Locked		Agent

Event Log

06/24/16 08:13	Encounter Archived		Agent
06/24/16 08:14	Post Archive Update		MedHost
06/24/16 08:14	Encounter Locked		Agent
06/24/16 08:14	Encounter Archived		Agent
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Chart Amendment Nurse	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Chart Amendment Physician	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF- Disposition Cover	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Followup	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Form	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Resources	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Instructions	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - ER Encounter	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Event Log	MedHost
06/24/16 08:15	Outbound Msg Sent	Encounter Archived: EMR PDF - Fax Summary	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Chart Amendment Nurse	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Chart Amendment Physician	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF- Disposition Cover	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Followup	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Form	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Resources	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Disposition Instructions	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - ER Encounter	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Event Log	MedHost
06/24/16 08:16	Outbound Msg Sent	Encounter Archived: EMR PDF - Fax Summary	MedHost
06/24/16 11:16	Results Viewed	Cbc W/ Auto Diff	Jones, Daniel, DO

Event Log

06/24/16 11:16	Results Viewed	CMP	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	Lipase	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	Amylase	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	Urinalysis	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	Ct Brain Head Wo	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	CT C Spine Wo	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	CT T Spine W/O	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	Ct Chest W	Jones, Daniel, DO
06/24/16 11:16	Results Viewed	CT Abd/Pelvis IV Only	Jones, Daniel, DO

Order Events

Date/Time	Event	Event Info	Logged by
06/22/16 21:02	Order State Change	Cbc W/ Auto Diff (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	CMP (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Amylase (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Lipase (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Urinalysis (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Urine, Obtain (21:02) - Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	NS saline lock (21:02) - Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	NS saline lock (21:02) - Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Ct Brain Head Wo (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	CT C Spine Wo (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	CT T Spine W/O (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Ct Chest W (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	CT Abd/Pelvis IV Only (21:02) - Pre-Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Dilaudid (21:02) - Ordered	Garvey, David, MD
06/22/16 21:02	Order State Change	Ondansetron (21:02) - Ordered	Garvey, David, MD
06/22/16 21:11	Order State Change	Cbc W/ Auto Diff (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	CMP (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	Amylase (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	Lipase (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	Urinalysis (21:02) - Pending	MedHost

Event Log

		Ordered	
06/22/16 21:11	Order State Change	Ct Brain Head Wo (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	CT C Spine Wo (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	CT T Spine W/O (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	Ct Chest W (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	CT Abd/Pelvis IV Only (21:02) - Pending Ordered	MedHost
06/22/16 21:11	Order State Change	Ct Brain Head Wo (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	Cbc W/ Auto Diff (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	CMP (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	Amylase (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	Lipase (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	Urinalysis (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	CT C Spine Wo (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	CT T Spine W/O (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	Ct Chest W (21:02) - Ordered	MedHost
06/22/16 21:11	Order State Change	CT Abd/Pelvis IV Only (21:02) - Ordered	MedHost
06/22/16 21:13	Order State Change	Dilaudid (21:02) - Prepared	Kevitt, Donna
06/22/16 21:13	Order State Change	Ondansetron (21:02) - Prepared	Kevitt, Donna
06/22/16 21:33	Order State Change	NS saline lock (21:02) - Completed	Kevitt, Donna
06/22/16 21:33	Order State Change	Lipase (21:02) - Sent	Kevitt, Donna
06/22/16 21:33	Order State Change	Amylase (21:02) - Sent	Kevitt, Donna
06/22/16 21:33	Order State Change	CMP (21:02) - Sent	Kevitt, Donna
06/22/16 21:33	Order State Change	Cbc W/ Auto Diff (21:02) - Sent	Kevitt, Donna
06/22/16 21:36	Order State Change	CMP (21:02) - In Process Scheduled	MedHost
06/22/16 21:36	Order State Change	Amylase (21:02) - In Process Scheduled	MedHost
06/22/16 21:36	Order State Change	Lipase (21:02) - In Process Scheduled	MedHost
06/22/16 21:37	Order State Change	Cbc W/ Auto Diff (21:02) - In Process Scheduled	MedHost
06/22/16 21:42	Order State Change	Cbc W/ Auto Diff (21:02) - Returned	MedHost
06/22/16 21:52	Order State Change	CMP (21:02) - Partial Results	MedHost

Event Log

06/22/16 21:57	Order State Change	CMP (21:02) - Returned	MedHost
06/22/16 21:57	Order State Change	Amylase (21:02) - Returned	MedHost
06/22/16 21:57	Order State Change	Lipase (21:02) - Returned	MedHost
06/22/16 22:33	Order State Change	Dilaudid (21:02) - Administered	Kevitt, Donna
06/22/16 22:33	Order State Change	Ondansetron (21:02) - Administered	Kevitt, Donna
06/22/16 22:40	Order State Change	Ct Brain Head Wo (21:02) - In Process Scheduled	MedHost
06/22/16 22:40	Order State Change	CT C Spine Wo (21:02) - In Process Scheduled	MedHost
06/22/16 22:40	Order State Change	CT T Spine W/O (21:02) - In Process Scheduled	MedHost
06/22/16 22:41	Order State Change	Ct Chest W (21:02) - In Process Scheduled	MedHost
06/22/16 22:41	Order State Change	CT Abd/Pelvis IV Only (21:02) - In Process Scheduled	MedHost
06/22/16 22:55	Order State Change	CT Abd/Pelvis IV Only (21:02) - Returned	MedHost
06/22/16 23:09	Order State Change	Ct Chest W (21:02) - Returned	MedHost
06/22/16 23:17	Order State Change	Urinalysis (21:02) - In Process Scheduled	MedHost
06/22/16 23:17	Order State Change	CT T Spine W/O (21:02) - Returned	MedHost
06/22/16 23:18	Order State Change	Ondansetron (23:18) - Ordered	Kevitt, Donna
06/22/16 23:19	Order State Change	Ondansetron (23:18) - Administered	Kevitt, Donna
06/22/16 23:19	Order State Change	Urine, Obtain (21:02) - Completed	Kevitt, Donna
06/22/16 23:31	Order State Change	Urinalysis (21:02) - Returned	MedHost
06/22/16 23:32	Order State Change	Ct Brain Head Wo (21:02) - Returned	MedHost
06/22/16 23:40	Order State Change	CT C Spine Wo (21:02) - Returned	MedHost
06/22/16 23:42	Order State Change	Cbc W/ Auto Diff (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	CMP (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	Lipase (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	Amylase (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	Urinalysis (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	Ct Brain Head Wo (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	CT C Spine Wo (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	CT T Spine W/O (21:02) -	Garvey, David, MD

Event Log

		Reviewed	
06/22/16 23:42	Order State Change	Ct Chest W (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:42	Order State Change	CT Abd/Pelvis IV Only (21:02) - Reviewed	Garvey, David, MD
06/22/16 23:49	Order State Change	Ct Chest W (21:02) - Returned	MedHost
06/22/16 23:49	Order State Change	Ct Brain Head Wo (21:02) - Returned	MedHost
06/22/16 23:49	Order State Change	CT T Spine W/O (21:02) - Returned	MedHost
06/23/16 02:33	Verbal Order Signoff	Ondansetron (23:18) - ordered by dk	Garvey, David, MD
06/23/16 03:18	Order State Change	Ct Brain Head Wo (21:02) - Reviewed	Garvey, David, MD
06/23/16 03:18	Order State Change	CT T Spine W/O (21:02) - Reviewed	Garvey, David, MD
06/23/16 03:18	Order State Change	Ct Chest W (21:02) - Reviewed	Garvey, David, MD
06/23/16 04:29	Order State Change	Ativan (04:29) - Ordered	Garvey, David, MD
06/23/16 04:53	Order State Change	Ativan (04:29) - Administered	Kevitt, Donna
06/23/16 05:46	Order State Change	NS saline lock (21:02) - Canceled(Duplicate Order)	Kevitt, Donna

Chart Events

Date/Time	Event	Event Info	Logged by
06/22/16 20:58	Chart State - Active	Nurse Chart	Kevitt, Donna
06/22/16 20:58	Record State - Active	Nurse Record	Kevitt, Donna
06/22/16 21:15	Chart Template - Select Manual	MVC - Physician Chart	Price, Julia for Garvey, David, MD
06/22/16 21:17	Chart State - Active	Physician Chart	Price, Julia for Garvey, David, MD
06/22/16 21:17	Record State - Active	Physician Record	Price, Julia for Garvey, David, MD
06/22/16 21:33	Chart State - Active	Radiology Technician Chart	Rangel, Hannah
06/23/16 02:29	Chart State - Pending Complete	Physician Chart	Garvey, David, MD
06/23/16 02:29	Chart State - Complete	Physician Chart	Garvey, David, MD
06/23/16 02:29	Record State - Complete	Physician Record	Garvey, David, MD
06/23/16 05:34	Chart Template - Select Manual	CPR - Nurse Chart	Olson, Sue
06/23/16 05:45	Chart State - Pending Complete	Nurse Chart	Kevitt, Donna
06/23/16 05:45	Chart State - Complete	Nurse Chart	Kevitt, Donna
06/23/16 05:45	Record State - Complete	Nurse Record	Kevitt, Donna
06/23/16 06:05	Chart State - Pending Complete	Nurse Chart	Kevitt, Donna
06/23/16 06:59	Post Departure Record		Preece-Lednisky, Gayla, RN

Event Log

	Update		
06/24/16 06:05	Chart State - Locked	Nurse Chart	Agent
06/24/16 06:05	Chart State - Locked	Tech Chart	Agent
06/24/16 06:05	Chart State - Locked	Respiratory Therapist Chart	Agent
06/24/16 06:05	Chart State - Locked	Clerk Chart	Agent
06/24/16 06:05	Chart State - Locked	View Only Chart	Agent
06/24/16 06:05	Chart State - Locked	Radiology Technician Chart	Agent
06/24/16 06:05	Chart State - Locked	Case Manager Chart	Agent
06/24/16 06:05	Chart State - Locked	Pastoral Care Chart	Agent
06/24/16 06:05	Chart State - Locked	Nurse Extern Chart	Agent
06/24/16 06:05	Record State - Locked	Nurse	Agent
06/24/16 06:05	Chart State - Locked	Physician Chart	Agent
06/24/16 06:05	Chart State - Locked	Mid-Level Provider Chart	Agent
06/24/16 06:05	Chart State - Locked	Pharmacist Chart	Agent
06/24/16 06:05	Record State - Locked	Physician	Agent
06/24/16 06:05	Records Processed by Chart Agent		Agent

Staff Events

Date/Time	Event	Event Info	Logged by
06/22/16 20:52	Staff Role Assumption	Attending Physician: Garvey, David, MD	Garvey, David, MD
06/22/16 20:52	Staff Assignment	Attending Physician: Garvey, David, MD	Garvey, David, MD
06/22/16 21:08	Staff Role Assumption	Primary Nurse: Kevitt, Donna	Kevitt, Donna
06/22/16 21:08	Staff Assignment	Primary Nurse: Kevitt, Donna	Kevitt, Donna
06/23/16 02:30	Staff Role Assumption	Pronouncing Provider: Garvey, David, MD	Garvey, David, MD
06/23/16 02:30	Staff Assignment	Pronouncing Provider: Garvey, David, MD	Garvey, David, MD



CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

- 1. CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
- 2. MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
- 3. PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
- 4. FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.
- 5. HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer's or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
- 6. CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.
- 7. CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

Northeastern Nevada Regional Hospital
Consent for Services (English)

Page 1 of 3
NN1001A/051818

SCHWARTZ DOUGLAS R
DOB: 06/02/1958 AGE: 58 HSV: ED
ADMIT: 06/22/16 RM/BED: SEX: M
ATT: GARVEY DAVID J MD #:
MR #: 000330967 #: 2818
PT #: 6139781



16. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of your medical record.

17. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

- I have executed an Advance Directive
- I have not executed an Advance Directive
- I would like to formulate an Advance Directive and receive additional information

18. **OTHER ACKNOWLEDGEMENTS:**

- a. **Personal Valuables:** I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables and that the hospital shall not be liable for the loss of such valuables unless deposited with the hospital for safekeeping. The liability of the hospital for loss of personal property that is deposited for safekeeping is limited to \$5000 or the maximum required by law. I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices.
- b. **Smoke Free Facility Policy:** The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.
- c. **Weapons / Explosives / Drugs:** I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

19. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

20. **KENTUCKY ONLY:** In compliance with KRS 214, the undersigned has received AIDS information. Yes No

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

ESIG_DESC=Patient or Representative
Signature of Patient or Legal Representative for Health Care if Other Than Patient *Douglas Schwartz* 6/22/16
Date / Time

Relationship of Representative _____ Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

ESIG_DESC=Witness
Signature of Witness *Cg* 6/22/16
Date / Time

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781



WHITE - CHART COPY
 YELLOW - CHARGE COPY
 PINK - CO/IRM COPY

PATIENT NAME Douglas R. Schwartz

PAGE 12 OF 12

DIAGNOSIS: Cardiac Arrest
due to respiratory

BY: Dr. Sharney

LOCATION OF ARREST: ER-Red 12

FAMILY NOTIFIED TIME: 0145

TIME OF CPR INITIATED BY: 0035

ARREST: 0035

DATE: 06-23-16
 ED ARRIVAL TIME: 0033

TEAM MEMBERS (Name and Title)

- 1) David Garvey, MD
- 2) Donna Kevirt, RN
- 3) Sue Olson, RN
- 4) Cindy Finn, RN
- 5) Nancy Abraham, RN
- 6) Bonnie RN-Beach Air
- 8) Barry RU-REACH
- 9) Leon R.T. Paul EMS Board

TYPE OF ARREST (CHECK ALL APPROPRIATE)

RESPIRATORY V-FIB
 CARDIAC ASYSTOLE
 WITNESSED EMD
 UNWITNESSED OTHER
 ECG MONITORED
 VITACH.

INITIAL ASSESSMENT

RESPIRATIONS PRESENT ABSENT AGONAL
 CAROTID PULSE PRESENT ABSENT

INTUBATION

SIZE: _____
 TIME: _____
 BY WHOM: _____
 BILAT BS: PRESENT ABSENT

IV PRESENT - Site: 20g RL hand
 IV STARTED - Site: 20g RL wrist
 NEEDLE SIZE: _____
 SOLUTION: NS
 BY WHOM: EMS (1) / Paramedic (Kuntama)

TIME	RESPONSE	RHYTHM	BP	POULES	EXTERNAL PACING	SINGLE DOSES	DRIP MEDS	PH	PC ₂	ABG	COMMENTS/LAB
0038	Return 180	my EIP	Recurrence	by beach air	nume	2000	2000	2000	2000	2000	2000
0040	ET tube attempted	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	7.5 tube by Barry RN
0043	"	"	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	7.5 tube / 19 tube by Barry RN
0045	CPR in progress	HR 36	O ₂ sat 37%	while bagging	Brady	2000	2000	2000	2000	2000	King placed by Barry RN
0046	King airway placed	2000	2000	2000	2000	2000	2000	2000	2000	2000	King placed by Barry RN
0047	HR 120	O ₂ sat 82%	2000	2000	2000	2000	2000	2000	2000	2000	King placed by Barry RN
0048	ET tube attempted	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful
0050	O ₂ sat 65%	CPR continues	2000	2000	2000	2000	2000	2000	2000	2000	unsuccessful
0052	ET tube intubation attempted	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful
0053	O ₂ sat 50%	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful
0054	HR 147	42% O ₂	while bagging	2000	2000	2000	2000	2000	2000	2000	unsuccessful
0057	NPA placed	by Dr. Sharney	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful
0058	O ₂ sat 69%	2000	2000	2000	2000	2000	2000	2000	2000	2000	unsuccessful
0103	75% O ₂	O ₂ sat HR 122	2000	2000	2000	2000	2000	2000	2000	2000	unsuccessful
0104	65% O ₂	O ₂ sat 2000	2000	2000	2000	2000	2000	2000	2000	2000	unsuccessful
0108	Cub attempted	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful
0113	O ₂ sat 100%	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful	unsuccessful

OUTCOME: UNSUCCESSFUL Code Terminated At 0133 (time)

SUCCESSFUL DISPOSITION: _____

BY WHOM: MANUEL MD

SIGNATURE OF RECORDER X: Silvia Winsa EMT
 SIGNATURE OF MED NURSE X: Donna Kevirt RN
 SIGNATURE OF MD IN CHARGE X: _____

CHWARTZ DOUGLAS R
 HSAV: ED
 CB: 06/02/1958 AGE: 58 SEX: M
 RM/BED: /
 IT: GARVEY DAVID J MD
 PT #: 00030967
 #: 2818
 #: 6139781

Customer's throughout the call

SUMMARY OF CQ/IRM MONITORING AND EVALUATION

Findings: What did you see (find)? What are the statistical numbers?
Conclusions: What decisions did you make from the findings? What stories do the findings tell us?
Recommendations: What do you think needs to be done? Actions: How are you going to make improvements?
Follow-up: What did you find when reviewing this at a later date? What did you do to make sure the actions were implemented.

ASPECT OF CARE /SERVICE (INDICATOR/STUDY)	% THRESHOLD DESIRED	% THRESHOLD ATTAINED	FINDINGS-CONCLUSIONS	RECOMMENDATIONS-ACTIONS	FOLLOW-UP
CODE BLUE 1. Supplies and equipment are immediately available and operational 2. Code response immediate by at least four qualified personnel 3. ACLS protocol followed	100% 100% 100%				

CONFIDENTIAL. NOT PART OF MEDICAL RECORDS

DEPARTMENT _____

DATE _____

REVIEWER _____

WHITE - CHART COPY
 YELLOW - CHARGE COPY
 PINK - CQ/IR COPY



MR #: 00030967
 ATT: GARVEY DAVID J MD
 ADMIT: 06/22/16
 RM/BD: /
 DOB: 06/02/1958 AGE: 58
 SEX: M
 HSX: ED
 SCHWARTZ DOUGLAS R

PATIENT NAME: Douglas R. Schwartz PAGE: _____ OF _____
 DATE: 06/23/16 TIME OF ARREST: _____ CPR INITIATED BY: _____ LOCATION OF ARREST: _____ DIAGNOSIS: _____
 ED ARRIVAL TIME: _____ ATTD PHYS NOTIFIED TIME: _____ FAMILY NOTIFIED TIME: _____ BY: _____
 TEAM MEMBERS (Name and Title):
 1) _____ 2) _____ 3) _____ 4) _____
 5) _____ 6) _____ 7) _____ 8) _____

TYPE OF ARREST (CHECK ALL APPROPRIATE)
 RESPIRATORY V-FIB CARDIAC ASYSTOLE WITNESSED EMD UNWITNESSED OTHER ECG MONITORED VITACH.

INITIAL ASSESSMENT
 RESPIRATIONS PRESENT ABSENT AGONAL
 CAROTID PULSE PRESENT ABSENT

INTUBATION
 SIZE: _____ FIO₂: _____
 TIME: _____
 BY WHOM: _____
 BILAT BS: PRESENT ABSENT

IV PRESENT - Site _____
 IV STARTED - Site _____
 NEEDLE SIZE: _____
 SOLUTION: _____
 BY WHOM: _____

TIME	RESPIRATION 3-Spontaneous A-Assisted	PULSE 3-Spontaneous A-Assisted	RHYTHM	BP	Joules	EXTERNAL PACING	SINGLE DOSES			DOPAMINE (mg/min)	DRIP MEDS			ABG			COMMENTS/LAB		
							EP N or ET	ATROPINE N or ET	LIIDOCAINE		PH	pO ₂	pCO ₂						
0116																			
0117																			
0119																			
0120																			
0122																			
0124																			
0125																			
0128																			
0129																			
0131																			
0133																			

OUTCOME:
 SUCCESSFUL DISPOSITION
 UNSUCCESSFUL Code Terminated At: 0133 (time)
 SIGNATURE OF RECORDER X: [Signature]
 SIGNATURE OF MED NURSE X: [Signature]
 SIGNATURE OF MD IN CHARGE X: [Signature]

SUMMARY OF QI/RM MONITORING AND EVALUATION

Findings: What did you see (find)? What are the statistical numbers?
Conclusions: What decisions did you make from the findings? What stories do the finding tell us?
Recommendations: What do you think needs to be done? Actions: How are you going to make improvements?
Follow-up: What did you find when reviewing this at a later date? What did you do to make sure the actions were implemented.

ASPECT OF CARE /SERVICE (INDICATOR/STUDY)	% THRESHOLD DESIRED	% THRESHOLD ATTAINED	FINDINGS-CONCLUSIONS	RECOMMENDATIONS-ACTIONS	FOLLOW-UP
CODE BLUE 1. Supplies and equipment are immediately available and operational 2. Code response immediate by at least four qualified personnel 3. ACLS protocol followed	100% 100% 100%				

CONFIDENTIAL. NOT PART OF MEDICAL RECORDS

DEPARTMENT _____

DATE _____

REVIEWER _____

ID: Patient 0207
 Patient Mode: Adult
 06/23/2016 01:58:07AM
 Dept:
 Unit:
 S/N: AI11K001505
 SW Rev: 02.01.27.00

TREND SUMMARY REPORT

Name:	TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FICO2 mmHg
ID: Patient 0206	01:45	???	???	OFF	???	???	???
Patient Mode: Adult	01:40	???	???	OFF	???	???	???
Start Time:	01:35	???	???	OFF	???	???	???
06/23/2016 12:06:14AM	01:32	134	49	149/55(88)	---	0	0
Total Trend Events: 27	01:30	---	60	OFF	---	0	0
Dept:	01:25	---	64	OFF	---	0	0
Unit:	01:20	36	39	OFF	---	0	0
S/N: AI11K001505	01:15	119	46	126/95(106)	---	0	0
SW: 02.01.27.00	01:15	123	41	OFF	---	0	0

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FICO2 mmHg
01:14	124	60	202/125(150)	---	0	0
01:10	126	52	OFF	---	0	0
01:05	120	71	OFF	---	0	0
01:00	121	62	207/143(165)	---	0	0
01:00	124	69	OFF	---	0	0
00:55	128	43	OFF	46	OFF	OFF
00:50	126	62	OFF	57	OFF	OFF
00:45	118	73	221/148(173)	23	OFF	OFF
00:45	119	75	OFF	30	OFF	OFF

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M
00:41	125	81	249/140(178)	31
00:40	111	77	OFF	34
00:35	36	37	OFF	35
00:30	124	76	225/136(166)	57
00:30	127	76	OFF	57
00:25	108	92	OFF	27 ✓
00:20	97	83	OFF	22 ✓
00:15	73	99	OFF	19 ✓
00:10	66	97	OFF	17 ✓

SCHWARTZ DOUGLAS R HSV: ED
 DOB: 06/02/1958 AGE: 58 SEX: M
 ADMIT: 06/22/16 RM/BED: /
 ATT: GARVEY DAVID J MD #: 2818
 MR #: 000330967 PT #: 6139781



TREND SUMMARY REPORT

Name:
 ID: Patient 0206
 Patient Mode: Adult
 Start Time:
 06/23/2016 12:06:14AM
 Total Trend Events: 27
 Dept:
 Unit:
 S/N: A111K001505
 SW: 02.01.27.00

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:45	???	???	OFF	???	???	???
01:40	???	???	OFF	???	???	???
01:35	???	???	OFF	???	???	???
01:32	134	49	149/55(88)	---	0	0
01:30	---	60	OFF	---	0	0
01:25	---	64	OFF	---	0	0
01:20	36	39	OFF	---	0	0
01:15	119	46	126/95(106)	---	0	0
01:15	123	41	OFF	---	0	0

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:14	124	60	202/125(150)	---	0	0
01:10	126	52	OFF	---	0	0
01:05	120	71	OFF	---	0	0
01:00	121	62	207/143(165)	---	0	0
01:00	124	69	OFF	---	0	0
00:55	128	43	OFF	46	OFF	OFF
00:50	126	62	OFF	57	OFF	OFF
00:45	118	73	221/148(173)	23	OFF	OFF
00:45	119	75	OFF	30	OFF	OFF

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M
00:41	125	81	249/140(178)	31
00:40	111	77	OFF	34
00:35	36	37	OFF	35
00:30	124	76	225/136(166)	57
00:30	127	76	OFF	57
00:25	108	92	OFF	27
00:20	97	83	OFF	22
00:15	73	99	OFF	19
00:10	66	97	OFF	17

SCHWARTZ DOUGLAS R HSV: ED
 DOB: 06/02/1958 AGE: 58 SEX: M
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 ATT: GARVEY DAVID J MD #: 2818
 MR #: 000330967 PT #: 6139781



Organ and Tissue Notification:

Intermountain Organ Recovery System Must be notified of
ALL Deaths at 1-800- 83-DONOR

Spoke with : Elizabeth Mill
Time: 0304 - returned call at 0335
Date: 3-26-16

Contacted by: [Signature] (Staff Signature)

IORS rules medically eligible: YES NO

Explain: Pt. not eligible. body to
be sent for investigation

The option of Organ and Tissue Donation has been presented:

N/A Family wishes to pursue option of donation
N/A Family declines option of donation

Next of Kin signature: N/A Relationship: N/A

Completed by: [Signature] (Staff signature)

Northeastern Nevada Regional Hospital
2001 Errecart Blvd, Elko, NV 89801

SCHWARTZ DOUGLAS R	HSV: ED	
DOB: 06/02/1958	AGE: 58	SEX: M
ADMIT: 06/22/16	RM/BED: /	
ATT: GARVEY DAVID J MD	#: 2818	
MR #: 000330967	PT #: 6139781	





PATIENT TRANSFER

Name: SCHWARTZ DOUGLAS R Patient Number: 6139781
Age: 58 Date of Birth: 06/02/1958 Sex: M MR No.: 000330967
Date: 6-22-16

Section: Patient Consent (This section must be signed by the patient and / or responsible party.)

I acknowledge the patient will be transferred to: University of Utah
The risks and benefits involved in the transfer have been explained to me, as well as the risks and benefits of foregoing this transfer, and I accept full responsibility for such transfer. I acknowledge that I have received a medical screening for my condition. I give consent to this hospital to release all of my medical records and x-ray films, including information related to HIV, drug / alcohol abuse, or psychiatric treatment.

Transported Via: [] ALS [] BLS [] POV Against Medical Advice
[] Air Evacuation [] POV Reach Air

I elect to provide my own transportation and decline medical transportation for the transfer. I am aware of the risks and release the physician, this hospital, and its agents from any liability related to transportation to the receiving facility.

Signature: N/A Relationship: N/A Date: _____

Summary of Risks and Benefits:

Risk of Transfer:

- [x] Worsening of medical condition including risk to unborn/newborn in the case of pregnancy. Disease specific risks: Death
[x] Transportation Risks plane crash
[] Other: _____

Benefits of Transfer:

- [x] Immediate access to specialized practitioner / equipment / monitoring, specifically: TRAUMA
[] Bed capacity that is not currently available at this facility.
[x] Continuity of care
[] Other: _____

I release the physician, this hospital and its agents from any liability as a result of this transfer.

Signature of Responsible Party: Cleane Schwartz Relationship: Spouse Date: 6-22-16
Signature of Witness: [Signature] Relationship: Nurse Date: 6-22-16

Section II: Patient Refusal for Transfer

This risk and benefits involved in the transfer have been explained to me, as well as the risks and benefits of foregoing this transfer, and I have decided to decline the transfer. I accept full responsibility for this decision. I release the physician, this hospital, and its agents from any liability as a result of NOT being transferred.

Signature of Responsible Party: N/A Relationship: N/A Date: _____
Signature of Witness: _____ Relationship: _____ Date: _____



Ideal Bodyweight vT calc: male: $50 + 2.3$ for every inch > 60 inches. Female: $45.5 + 2.3$
T calc: 6-8ml's / kg of ideal BW, 5ml/kg for sepsis.
Vent Check: Turn on > clear alarm > Select & scroll to "Vent Check" > select.
Pressure Cntl Setup: Mode - SIMV, Breath Type - Pressure, PC = 15, PS = 10, PEEP = 5. Add the C and PEEP together and that should ~ equate to PIP. This is a safe starting point for adults and peds. Adjust fIO2 and/or PC up or down PRN to increase sPO2 or change ETCO2.
 o increase sPO2 add more PC. To manipulate ETCO2 manipulate PC.
BiPAP Setup: On > select New Pt. > select Pt. Size > select Intubate > Breath Mode = CPaP + PS
 reath Type = Pressure > Adjust PS and PEEP to desired values > select ventilate.
Alarms: Set high 10 point above PIP and low 10 points below PIP.

Epi 1mg
 Keta
 Roc

KETA ROC
 0018 0018

0102 7172
 75%
 0104 suction 6502 207/143 1217

Tube 0020 - no
 0023 unsuccessful
 0033 unsuccessful 7.5
 0033 unsuccessful 9.

0108 Crk in prog.

0035 CPR

0113 O2 60 (group)

0036 King 10657 225/136 470 797 (Pant)
 Resp O2

0040 1207 8202 Resp 25 249/140

0044 unsuccessful

0047 unsuccessful

0050 O2 65%

0052 unsuccessful 2 590 60%

0053 5000 O2 unsuccessful

0054 1272 4202 221/148

NPA 0057 (6990 0058)

SCHWARTZ DOUGLAS R HSV: ED
 DOB: 06/02/1958 AGE: 58 SEX: M
 ADMIT: 06/22/16 RM/BED: /
 ATT: GARVEY DAVID J MD #: 2818
 MR #: 000330967 PT #: 6139781



0116 3702 81% 126/95

0117 CPR started no pulse
44 O₂ 33%

0119 3602

0120 a systole - no O₂ cyanotic

0122 52 CPR still in progress

0124 6102 CPR still gastric extubation

0125 4902 CPR

0128 6402

0129 needle right no output

0131 decompression L & R ← little air

0133 stop compressions

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781



Ideal Bodyweight vT calc: male: $50 + 2.3$ for every inch > 60 inches. Female: $45.5 + 2.3$
T calc: 6-8ml's / kg of ideal BW, 5ml/kg for sepsis.
Vent Check: Turn on > clear alarm > Select & scroll to "Vent Check" > select.
Pressure Cntl Setup: Mode - SIMV, Breath Type - Pressure, PC = 15, PS = 10, PEEP = 5. Add the C and PEEP together and that should ~ equate to PIP. This is a safe starting point for adults and peds. Adjust fI_{O2} and/or PC up or down PRN to increase sPO₂ or change ETCO₂.
 To increase sPO₂ add more PC. To manipulate ETCO₂ manipulate PC.
IPAP Setup: On > select New Pt. > select Pt. Size > select Intubate > Breath Mode = CPaP + PS
 Breath Type = Pressure > Adjust PS and PEEP to desired values > select ventilate.
Alarms: Set high 10 point above PIP and low 10 points below PIP.

Epi 1mg
 Keta
 Roc

^{180mg}
 KETA ROC
 0018 0018

0102 52172
 7590

Tube 0020 - no
 0023 unsuccessful
 0033 unsuccessful 7.5
 0033 unsuccessful 9.

0104 suction 6502 207/143 1217

0108 Crick in prog.

0035 CPR

0113 O₂ 60 (gymnump)

0036 King 10657 225/136 4702 7987 (Pant)
 Resp O₂

0040 19207 8202 Resp25 249/140

0044 unsuccessful

0047 unsuccessful

0050 O₂ 65%

0052 unsuccessful ~ 5590, 6090

0053 5000 O₂ unsuccessful

0054 12752 4202 221/148

NPA 0057 (6990 0058)

SCHWARTZ DOUGLAS R HSV: ED
 DOB: 06/02/1958 AGE: 58 SEX: M
 ADMIT: 06/22/16 RM/BED: /
 ATT: GARVEY DAVID J MD #: 2818
 MR #: 000330967 PT #: 6139781



**PHYSICIAN/QUALIFIED MEDICAL PERSONNEL STATEMENT
MEDICAL NECESSITY AND REASONABLENESS FOR AIR MEDICAL TRANSPORT**

As the medical professional involved in the air ambulance transport provided by _____

(Air ambulance supplier)
Please complete this form in its entirety in order to justify why air transportation was required instead of ground transport.
(This information will be provided to third party payer)

Patient Data	Please Complete Each Section
Call # _____	Patient Name <u>SCHWARTZ DOUGLAS R</u>
Date of Service _____	Date of Birth <u>06/02/1958</u>
Diagnosis or Potential Diagnosis of Patient _____	MR # : <u>000330967</u>
	AGE: <u>58</u> SEX: <u>M</u>
	ADMIT: <u>06/22/16</u> RM/BED: <u>/</u>
	ATT: <u>GARVEY DAVID J MD</u> #: <u>2818</u>
	PT #: <u>6139781</u>

Requesting Source

Requested By (full name and title) DR David Garvey

Requesting Entity (name and contact) NNRTH

Accepting-Receiving Hospital University of Utah

Requesting Air Transport General Criteria

The Patient's condition is too critical to allow for longer transport time by ground

Patient requires higher level of care Facility on Divert

Weather / road conditions prohibit ground transport

The patient's condition is too unstable for a ground unit and requires critical care abilities of the air ambulance transport team.

Specify care:

Intubated ETCO2 Monitoring TPA Infusion EKG IABP Fetal Monitoring Neonatal Isolette Glidescope Intubation

Other _____ IV Medications, titrated drips (specify medications) _____

Mechanism of Injury

Patient requires immediate and rapid transport due to the nature and or severity of the illness / injury
(Please check the Mechanism(s) of Injury)

<input type="checkbox"/> Vehicle rollover / ejection / high speed collision	<input type="checkbox"/> Symptomatic hypotension	<input type="checkbox"/> Patient experiencing neurological impairment (CVA, Stroke, Seizures)
<input checked="" type="checkbox"/> Vehicle striking pedestrian > 10 mph	<input type="checkbox"/> High-risk obstetrical conditions	<input type="checkbox"/> Symptomatic hypertension
<input type="checkbox"/> Falls from > 15 feet	<input type="checkbox"/> Penetrating trauma	<input type="checkbox"/> Major burns of the body surface area; burns involving the face, hands, feet, perineum; burns with significant respiratory involvement; major electrical or chemical burn
<input type="checkbox"/> Motorcycle victim ejected at > 20 mph	<input type="checkbox"/> Spinal Cord / spinal column injury	<input type="checkbox"/> Same vehicle fatality
<input type="checkbox"/> Near drowning injuries	<input type="checkbox"/> Partial or total amputation	
<input type="checkbox"/> Major crush injuries	<input type="checkbox"/> 2 or more long bone fx. Pelvic fx,	
<input type="checkbox"/> AMI / Chest pain	<input type="checkbox"/> Altered level of consciousness	
<input type="checkbox"/> Other (specify) _____		

Specialty Care Required

Specialty Care likely required for this patient's immediate care. (Please check the appropriate physician consultation or skill likely required)

<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Pulmonologist	<input type="checkbox"/> ICU Not Available at referring
<input type="checkbox"/> Cardiothoracic Surgeon	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Vascular Surgeon	<input type="checkbox"/> Neonatologist	
<input type="checkbox"/> Neurologist	<input type="checkbox"/> Pediatric Intensive Care Specialist	
<input type="checkbox"/> Neurosurgeon	<input type="checkbox"/> Burn Specialist	
<input type="checkbox"/> Neuroradiologist	<input type="checkbox"/> Trauma Surgeon	

I order/certify that this patient's condition requires Air Ambulance Transportation due to the time or geographical factors. Such certification is to the best of my professional ability. By so certifying, I am NOT assuming any financial responsibility for the transportation services provided by: _____

The ambulance supplier agrees that it will bill only the patient or any applicable third party payer for any transportation cost. (Air ambulance supplier)

Signature/Date [Signature] Name (print) Donna Kerith RN

EMT Paramedic Trained First Responder Physician Physician Assistant Nurse Practitioner [Signature] per VO/TO of Dr. _____

Do you (requesting source) have a financial/employment relationship with the ambulance supplier transporting patient?
Please Indicate Yes No

Revision Date 1/1/2013

Patient Name SCHWARTZ DOUGLAS R
 DOB: 06/02/1958 AGE: 58 HSV: ED
 ADMIT: 06/22/16 RM/BED: / SEX: M
 ATT: GARVEY DAVID J MD # : 2818
 MR #: 000330967 PT #: 6139781
Privacy Practice
 a copy of its No. 
 valid as an ori

Services Signature form

Transport Date: _____ Transport #: _____

signer acknowledges that REACH Air Medical Services, LLC. (REACH) provided transport services to the patient. REACH is a party with instructions to provide the Notice to the patient. *A copy of this form is provided to the patient.

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
 NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by REACH now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by REACH, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to REACH any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to REACH. I authorize REACH to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to REACH and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by REACH, now, in the past, or in the future.

If the patient signs with an "X" or other mark, a witness should sign below

X _____ Date _____ X _____ Date _____
 Patient Signature or Mark Witness Signature

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section only if the patient is physically or mentally incapable of signing.

On the line below, explain the circumstances that make it impractical for the patient to sign:

patient unable to sign multi trauma

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by REACH now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

Authorized representatives include only the following individuals:

- Patient's legal guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the patient
- Relative or other person who arranges for the patient's treatment or exercise other responsibility for the patient's affairs
- Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services or sending facility) but furnished other care, services, or assistance to the patient

X *Deane Schwartz* 6/22/16 *Diane Schwartz*
 Representative Signature Date Printed Name

Printed Address of Representative _____

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section only if: (1) the patient was physically or mentally incapable of signing, and (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)
 My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

On the line below, explain the circumstances that make it impractical for the patient to sign:

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____
 Signature of Crewmember Title Date Printed Name of Crewmember Title of Crewmember

B. Receiving Facility Representative Signature
 The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

X _____
 Signature of Receiving Facility Representative Title Date Printed Name of Receiving Facility Representative Title

Elko County Ambulance Physician Certification for Transport

SCHWARTZ DOUGLAS R HSV: ED
 DOB: 06/02/1958 AGE: 58 SEX: M
 ADMIT: 06/22/16 RM/BED: /
 ATT: GARVEY DAVID J MD #: 2818
 MR #: 000330967 PT #: 6139781

- GENERAL INFORMATION

Patient's
 Transpo:
 Origin:



Date of Birth: _____ Medicare #: _____
 and trips on this date and for all repetitive trips in the 60-day range as noted below.)

University of Utah

Is the pt's stay covered under Medicare Part A (PPS/DRG?) YES NO
 Closest appropriate facility? YES NO If no, why is transport to more distant facility required? _____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: Multi System
 If hospice pt, is this transport related to pt's terminal illness? YES NO Describe: _____

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. The following questions must be answered by the medical professional signing below for this form to be valid:

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:
Multi System TRAUMA

2) Is this patient "bed confined" as defined below? Yes No
 To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without Assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair

- 3) In addition to completing questions 1-3 above, please check any of the following conditions that apply*:
 *Note: supporting documentation for any boxes checked must be maintained in the patient's medical records
- Contractures Non-healed fractures Patient is confused Patient is comatose Moderate/severe pain on movement
 - Danger to self/other IV meds/fluids required Patient is combative Need or possible need for restraints
 - DVT requires elevation of a lower extremity Medical attendant required Requires oxygen - unable to self administer
 - Special handling/isolation/infection control precautions required Unable to tolerate seated position for time needed to transport
 - Hemodynamic monitoring required enroute Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
 - Cardiac monitoring required enroute Morbid obesity requires additional personnel/equipment to safely handle patient
 - Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
 - Other (specify) _____

SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:

Donna Kerith RN
 Signature of Physician* or Healthcare Professional

6.22.16
 Date Signed
 (For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)
 *Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):

- Physician Assistant Clinical Nurse Specialist Registered Nurse
- Nurse Practitioner Discharge Planner

Attestation Statement – Authorized PCS Signers

Name of Patient: _____ Patient ID Number: _____

"I, _____ [print full name of the physician/practitioner that signed the PCS or other document in question], hereby attest that the document dated _____ [date of signing PCS or other document in question] accurately reflects signatures/notations that I made in my capacity as _____ [insert provider credentials, e.g., M.D., D.O., RN, etc.] when I certified that the above listed Medicare beneficiary required ambulance transport. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."


Signed

Donna Keivitt
Printed Name

10.22.14
Date



Northeastern Nevada Regional Hospital

Patient: **SCHWARTZ, DOUGLAS (Male)** DOB: 06/02/58
MR #: **330967** Status: ER
Date: 06/22/16 22:37 Slices: 0
History: Study: CT BRAIN HEAD WO Reason: Swelling with Trauma/Injury
Priors:
Tech: Exam request generated by HL7 interface
Exams: CT HEAD Without Contrast
Contrast:
Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900,
61397810001000

Final Report

EXAM: CT head without contrast.

CLINICAL INDICATION: Auto versus pedestrian with blunt force trauma to the head.

TECHNIQUE: Multiple contiguous axial images were obtained from skull base to vertex without the use of intravenous contrast.

COMPARISON: None.

FINDINGS: The ventricular system is normal in size and configuration without midline shift or ventriculomegaly. Symmetrical hyperdensity along the bilateral tentorium may represent hemoconcentration. Trace subdural blood products would be considered much less likely but not entirely excluded. There is no CT evidence of acute cortical infarction. The bilateral orbital contents are grossly unremarkable. Scattered paranasal sinus mucosal thickening is present with possible trace right maxillary sinus fluid level. Evaluation for facial fracture is limited with the provided technique. There is no significant mastoid or tympanic cavity fluid. There is no depressed calvarial fracture.

IMPRESSION:

1. Symmetrical hyperdensity along the bilateral tentorium likely reflects hemoconcentration/dehydration. Trace subdural blood products would be considered much less likely. If indicated, followup head CT could be performed to assess for stability.
2. No midline shift or depressed calvarial fracture.
3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Radiologist: Max Pollock, M.D.

Phone: 858-626-8106

Study ready at 22:40 and initial results transmitted at 23:29

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:48	Verify Receipt	Verified receipt with Dr. Garvey on 06/22 23:47 (-07:00)



Northeastern Nevada Regional Hospital

Patient:	SCHWARTZ, DOUGLAS (Male)	DOB:	06/02/58
MR #:	330967	Status:	ER
Date:	06/22/16 22:22	Slices:	0
History:	Study: CT THORACIC WO Reason: Pain with Trauma/Injury		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT T SPINE		
Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000			

Final Report

EXAM: CT thoracic spine

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the chest and back, back pain.

TECHNIQUE: Helical CT was performed through the thoracic spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS: Thoracic alignment is anatomic without spondylolisthesis and the thoracic vertebral body heights are generally well preserved with the exception of mild ventral wedging at T12. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformities. Acute nondisplaced pedicle fractures not excluded. Consider MRI for further evaluation as indicated. The thoracic facets articulate normally. Multilevel mild loss of intervertebral disc space height with small central disc protrusions are noted without significant bony spinal canal stenosis. Prominent ventral osteophytosis is present at T9/T10 on the right. Heterotopic ossification is seen within the interspinous ligament in the mid/lower thoracic spine.

Please see CT chest report for further detail regarding intrathoracic findings.

IMPRESSION:

1. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.
2. Mild thoracic spondylosis without significant spinal canal stenosis.
3. Mild ventral wedging of T12 is likely chronic/physiologic.
4. Please see CT chest report for further detail.

Radiologist: Max Pollock, M.D.

Phone: 858-626-8106

Study ready at 22:27 and initial results transmitted at 23:16

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:48	Verify Receipt	Verified receipt with Dr. Garvey on 06/22 23:47 (-07:00)

Soft tissue stranding and induration is seen overlying the left gluteal region compatible with contusion. There is no definite proximal left femoral fracture. Degenerative change in the bilateral hips is noted with marginal osteophytosis and joint space narrowing. No acute displaced pelvic fracture is clearly evident. Multilevel lumbar degenerative disc disease is present most pronounced at L2-3 and L5-S1. Lower lumbar facet arthropathy is also noted. A hypoplastic rib is present on the right at L1. Evaluation for nondisplaced transverse process fracture is limited with the provided technique. There is no clear CT evidence of acute lumbar fracture allowing for limitations of routine CT abdomen/pelvis technique.

IMPRESSION:

1. Trace hyperdense free fluid adjacent to the inferior right hepatic lobe as well as within the mid and caudal left paracolic gutter. No clear CT evidence for splenic or hepatic contusion/laceration, however, finding should be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low-grade solid organ injury is not excluded. Surgical consultation, close clinical, and as needed imaging followup recommended.
2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.
3. No free air to suggest visceral perforation.
4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture, dedicated lumbar spine CT could enter evaluate.
5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.
6. Please see CT chest report for further detail regarding intrathoracic findings.

Radiologist: Max Pollock, M.D.

Phone: 858-626-8106

Study ready at 22:24 and initial results transmitted at 22:54

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:07	Verify Receipt	Verified receipt with Cheryl in the ER for Dr. Garvey on 06/22 23:07 (-07:00)



Northeastern Nevada Regional Hospital

Patient: SCHWARTZ, DOUGLAS (Male) DOB: 06/02/58
MR #: 330967 Status: ER
Date: 06/22/16 22:20 Slices: 0
History: Study: CT CHEST W Reason: Chest Pain with Trauma/Injury
Priors:
Tech: Exam request generated by HL7 interface
Exams: CT CHEST With Contrast
Contrast:
Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900,
61397810001000

Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable.

There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup

recommended.

2. Prominent right pleural fat without definite pleural effusion.

3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.

4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.

5. Mild atherosclerosis without evidence for traumatic aortic injury.

6. Please see CT thoracic spine report for further detail.

7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Radiologist: Max Pollock, M.D.

Phone: 858-626-8106

Study ready at 22:24 and initial results transmitted at 23:08

Critical Value Communications

Clear Time	Type	Notes
	Verify Receipt	

**Northeastern Nevada Regional Hospital**

Patient: SCHWARTZ, DOUGLAS (Male) DOB: 06/02/58
MR #: 330967 Status: ER
Date: 06/22/16 22:38 Slices: 0
History: Study: CT C SPINE WITHOUT Reason: Pain with Trauma/Injury
Priors:
Tech: Exam request generated by HL7 interface
Exams: CT C SPINE
Contrast:
Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900,
61397810001000

Final Report

EXAM: CT cervical spine.

CLINICAL INDICATION: Auto versus pedestrian, trauma to the neck and cervical spine, upper back pain.

TECHNIQUE: Helical CT is performed through the cervical spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS:

Cervical alignment is anatomic without spondylolisthesis and there is preservation of the cervical lordosis. The visualized vertebral body heights are preserved without evidence for compression deformity. No acute cervical fracture is evident by CT. The atlantooccipital and atlantoaxial articulations are intact. The odontoid process is normal. The cervical facets articulate normally bilaterally without dislocation or subluxation. There is no prevertebral soft tissue thickening.

The intervertebral disc spaces are generally well preserved. Small ventral osteophytes are present at C4, C5, and C6. A partially calcified right paracentral disc protrusion is present at T1/T2. Right greater than left facet arthropathy is present most pronounced at C4-5. There is no significant bony spinal canal stenosis. Minimal foraminal stenosis is present on the left at C4-5.

Please see CT chest for further detail regarding intrathoracic findings.

IMPRESSION:

1. No CT evidence of acute cervical fracture or traumatic subluxation.
2. Very mild cervical and upper thoracic spondylosis as described above.
3. Please see CT chest report for further detail.

Radiologist: Max Pollock, M.D.

Phone: 858-626-8106

Study ready at 22:40 and initial results transmitted at 23:38

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT C SPINE WITHOUT
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT cervical spine.

CLINICAL INDICATION: Auto versus pedestrian, trauma to the neck and cervical spine, upper back pain.

TECHNIQUE: Helical CT is performed through the cervical spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS:

Cervical alignment is anatomic without spondylolisthesis and there is preservation of the cervical lordosis. The visualized vertebral body heights are preserved without evidence for compression deformity. No acute cervical fracture is evident by CT. The atlantooccipital and atlantoaxial articulations are intact. The odontoid process is normal. The cervical facets articulate normally bilaterally without dislocation or subluxation.

There is no prevertebral soft tissue thickening.

The intervertebral disc spaces are generally well preserved.

Small ventral osteophytes are present at C4, C5, and C6. A partially calcified right paracentral disc protrusion is present at T1/T2. Right greater than left facet arthropathy is present most pronounced at C4-5. There is no significant bony spinal canal stenosis. Minimal foraminal stenosis is present on the left at C4-5.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:38:13

Please see CT chest for further detail regarding intrathoracic findings.

IMPRESSION:

1. No CT evidence of acute cervical fracture or traumatic subluxation.
2. Very mild cervical and upper thoracic spondylosis as described above.
3. Please see CT chest report for further detail.

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:38
StatRad Exam Id: 2154896

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT BRAIN HEAD WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT head without contrast.

CLINICAL INDICATION: Auto versus pedestrian with blunt force trauma to the head.

TECHNIQUE: Multiple contiguous axial images were obtained from skull base to vertex without the use of intravenous contrast.

COMPARISON: None.

FINDINGS: The ventricular system is normal in size and configuration without midline shift or ventriculomegaly. Symmetrical hyperdensity along the bilateral tentorium may represent hemoconcentration. Trace subdural blood products would be considered much less likely but not entirely excluded. There is no CT evidence of acute cortical infarction. The bilateral orbital contents are grossly unremarkable. Scattered paranasal sinus mucosal thickening is present with possible trace right maxillary sinus fluid level. Evaluation for facial fracture is limited with the provided technique. There is no significant mastoid or tympanic cavity fluid. There is no depressed calvarial fracture.

IMPRESSION:

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

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:29:57

2. No midline shift or depressed calvarial fracture.
3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:29
StatRad Exam Id: 2154893

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT BRAIN HEAD WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT head without contrast.

CLINICAL INDICATION: Auto versus pedestrian with blunt force trauma to the head.

TECHNIQUE: Multiple contiguous axial images were obtained from skull base to vertex without the use of intravenous contrast.

COMPARISON: None.

FINDINGS: The ventricular system is normal in size and configuration without midline shift or ventriculomegaly. Symmetrical hyperdensity along the bilateral tentorium may represent hemoconcentration. Trace subdural blood products would be considered much less likely but not entirely excluded. There is no CT evidence of acute cortical infarction. The bilateral orbital contents are grossly unremarkable. Scattered paranasal sinus mucosal thickening is present with possible trace right maxillary sinus fluid level. Evaluation for facial fracture is limited with the provided technique. There is no significant mastoid or tympanic cavity fluid. There is no depressed calvarial fracture.

IMPRESSION:

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

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:29:57

2. No midline shift or depressed calvarial fracture.
3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Critical Value Communications

Verify Receipt

***** ADDENDUM *****

CR

Critical Value Communications

06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on

06/22 23:47 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 23:29
StatRad Exam Id: 2154893

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT THORACIC WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT thoracic spine

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the chest and back, back pain.

TECHNIQUE: Helical CT was performed through the thoracic spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS: Thoracic alignment is anatomic without spondylolisthesis and the thoracic vertebral body heights are generally well preserved with the exception of mild ventral wedging at T12.

Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformities. Acute nondisplaced pedicle fractures not excluded. Consider MRI for further evaluation as indicated. The thoracic facets articulate normally. Multilevel mild loss of intervertebral disc space height with small central disc protrusions are noted without significant bony spinal canal stenosis. Prominent ventral osteophytosis is present at T9/T10 on the right. Heterotopic ossification is seen within the interspinous ligament in the mid/lower thoracic spine. Please see CT chest report for further detail regarding intrathoracic findings.

IMPRESSION:

1. Irregularity of the right T10 and T11 pedicles may reflect

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:16:06

chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.

2. Mild thoracic spondylosis without significant spinal canal stenosis.

3. Mild ventral wedging of T12 is likely chronic/physiologic.

4. Please see CT chest report for further detail.

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.

Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:16

StatRad Exam Id: 2154865

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT THORACIC WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT thoracic spine

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the chest and back, back pain.

TECHNIQUE: Helical CT was performed through the thoracic spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS: Thoracic alignment is anatomic without spondylolisthesis and the thoracic vertebral body heights are generally well preserved with the exception of mild ventral wedging at T12.

Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformities. Acute nondisplaced pedicle fractures not excluded. Consider MRI for further evaluation as indicated. The thoracic facets articulate normally. Multilevel mild loss of intervertebral disc space height with small central disc protrusions are noted without significant bony spinal canal stenosis. Prominent ventral osteophytosis is present at T9/T10 on the right. Heterotopic ossification is seen within the interspinous ligament in the mid/lower thoracic spine.

Please see CT chest report for further detail regarding intrathoracic findings.

IMPRESSION:

1. Irregularity of the right T10 and T11 pedicles may reflect

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:16:06

chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.

2. Mild thoracic spondylosis without significant spinal canal stenosis.

3. Mild ventral wedging of T12 is likely chronic/physiologic.

4. Please see CT chest report for further detail.

Critical Value Communications

Verify Receipt

***** ADDENDUM *****

CR

Critical Value Communications

06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on

06/22 23:47 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 23:16
StatRad Exam Id: 2154865

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT CHEST W
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministrations of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable. There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup recommended.
2. Prominent right pleural fat without definite pleural effusion.
3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.
4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.
5. Mild atherosclerosis without evidence for traumatic aortic injury.
6. Please see CT thoracic spine report for further detail.
7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.

Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:08

StatRad Exam Id: 2154862

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT CHEST W
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable. There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup recommended.
2. Prominent right pleural fat without definite pleural effusion.
3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.
4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.
5. Mild atherosclerosis without evidence for traumatic aortic injury.
6. Please see CT thoracic spine report for further detail.
7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Critical Value Communications

Verify Receipt

***** ADDENDUM *****

CR

Critical Value Communications

06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on

06/22 23:47 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 23:08
StatRad Exam Id: 2154862

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT ABD PELVIS IV ONLY
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT abdomen and pelvis with contrast.

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the abdomen/pelvis, abdominal pain.

TECHNIQUE: Contrast-enhanced helical CT was performed through the abdomen and pelvis following the administration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

Please see separate CT chest report for further detail regarding intrathoracic findings.

The liver is enlarged with the right hepatic lobe measuring 19.9 cm. No hypoenhancement is present to suggest hepatic contusion or laceration. A small amount of hyperdense free fluid is seen adjacent to the inferior portion of the right hepatic lobe. The gallbladder is nondistended and the common bile duct is normal in caliber. The pancreas enhances uniformly without evidence for laceration. Small calcifications are seen within the spleen and there is no definite splenic laceration allowing for limitations of streak artifact related to arms down scanning technique. The bilateral adrenal glands are normal. The bilateral kidneys enhance uniformly without evidence for contusion or laceration and there is no hydronephrosis. The small bowel loops are

Legally authenticated by POLLOCK MAX MD 2016-06-22 22:54:44

nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes. Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right.

No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

Soft tissue stranding and induration is seen overlying the left gluteal region compatible with contusion. There is no definite proximal left femoral fracture. Degenerative change in the bilateral hips is noted with marginal osteophytosis and joint space narrowing. No acute displaced pelvic fracture is clearly evident. Multilevel lumbar degenerative disc disease is present most pronounced at L2-3 and L5-S1. Lower lumbar facet arthropathy is also noted. A hypoplastic rib is present on the right at L1.

Evaluation for nondisplaced transverse process fracture is limited with the provided technique. There is no clear CT evidence of acute lumbar fracture allowing for limitations of routine CT abdomen/pelvis technique.

IMPRESSION:

1. Trace hyperdense free fluid adjacent to the inferior right hepatic lobe as well as within the mid and caudal left paracolic gutter. No clear CT evidence for splenic or hepatic contusion/laceration, however, finding should be considered to reflect trace hemoperitoneum in the setting of significant trauma.

Low-grade solid organ injury is not excluded. Surgical consultation, close clinical, and as needed imaging followup recommended.

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.
3. No free air to suggest visceral perforation.
4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture, dedicated lumbar spine CT could enter evaluate.
5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.
6. Please see CT chest report for further detail regarding intrathoracic findings.

Critical Value Communications

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Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 22:54
StatRad Exam Id: 2154859

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT ABD PELVIS IV ONLY
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT abdomen and pelvis with contrast.

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the abdomen/pelvis, abdominal pain.

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No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

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1. Trace hyperdense free fluid adjacent to the inferior right hepatic lobe as well as within the mid and caudal left paracolic gutter. No clear CT evidence for splenic or hepatic contusion/laceration, however, finding should be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low-grade solid organ injury is not excluded. Surgical consultation, close clinical, and as needed imaging followup recommended.

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.
3. No free air to suggest visceral perforation.
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6. Please see CT chest report for further detail regarding intrathoracic findings.

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***** ADDENDUM *****

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06/22/16 23:07 Verify Receipt Verified receipt with Cheryl in the

ER for Dr. Garvey on 06/22 23:07 (-07:00)

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StatRad Exam Id: 2154859

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT CHEST W
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable. There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

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There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup recommended.
2. Prominent right pleural fat without definite pleural effusion.
3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.
4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.
5. Mild atherosclerosis without evidence for traumatic aortic injury.
6. Please see CT thoracic spine report for further detail.
7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

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Dictating Radiologist: Pollock, Max M.D.

Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:08

StatRad Exam Id: 2154862

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT CHEST W
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT chest with contrast.

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The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable. There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

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5. Mild atherosclerosis without evidence for traumatic aortic injury.
6. Please see CT thoracic spine report for further detail.
7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Critical Value Communications

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***** ADDENDUM *****

CR

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06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on

06/22 23:47 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 23:08
StatRad Exam Id: 2154862

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

DIANE SCHWARTZ

VS

DAVID GARVEY, M.D.

Case No. CV-C-17-439



JOHN EVERLOVE

February 19, 2021

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4	Shirley Blazich	4	Examination by Mr. Burton. 5
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<p style="text-align: right;">Page 6</p> <p>1 February 19, 2021 2:44 p.m. 2 PROCEEDINGS 3 JOHN EVERLOVE, 4 called as a witness herein, having been first duly 5 sworn by the Certified Court Reporter to tell the 6 truth, was examined and testified as follows: 7 EXAMINATION 8 BY MR. BURTON: 9 Q. Mr. Everlove, can you tell me when you were 10 retained in this matter? 11 A. Approximately one year ago, best of my 12 recollection. 13 Q. Do you have a date on which you were 14 retained? 15 A. Not that I recall. I recall it being 16 approximately March of last year, or at least that's 17 the first reference that I have, but I would be happy 18 to look it up for you. 19 Q. Do you recall who retained you? 20 A. Yes. Ms. Blazich. 21 Q. Do you know how she found you? 22 A. I don't recall if we had that conversation. 23 Q. Do you know if she was one of your on-line 24 advertising sites or not? 25 A. I don't recall exactly how she found me.</p>	<p style="text-align: right;">Page 8</p> <p>1 you intend to offer an opinion on if this case goes to 2 trial? 3 A. I intend to offer an opinion on the REACH 4 Air Medical Services care. I don't intend to offer an 5 opinion on the care of Dr. Garvey, which are the two 6 that I qualify as the providers of care. I know there 7 are nursing staff that were involved. I don't intend 8 to offer an opinion on the nursing staff from NNRH 9 Hospital. 10 Q. On the REACH side, you indicated that you 11 intend to offer an opinion on the REACH Air Medical 12 Services care. 13 Do you intend to offer an opinion as to the 14 care provided by both Barry Bartlett, the flight 15 paramedic, and Ronnie Lyons, the flight nurse? 16 A. Specifically related to the care, I don't 17 intend to offer an opinion related to Ronnie Lyons as a 18 nurse. However, related to issues of consent and the 19 transition or transport of care related to the 20 transport company, offering interfacility transport, my 21 opinions may apply. 22 Q. Well, today's the day for us to know if you 23 intend to offer those opinions. So do you intend to 24 offer an opinion regarding the care of Ronnie Lyons? 25 A. The care provided Mr. Schwartz by Ronnie</p>
<p style="text-align: right;">Page 7</p> <p>1 Q. You do advertise your expert services; 2 right? 3 A. Yes, I do. 4 Q. Where all do you advertise? 5 A. Seek Expert Directory, Juris Pro, and 6 experts.com, I believe are the only three I've used. 7 Q. How long have you advertised your expert 8 services? 9 A. Approximately four to five years. 10 Q. Mr. Everlove, what is your understanding of 11 your -- of the role that you've been asked to fill in 12 this case? 13 A. I was asked to review the materials related 14 to the treating of Doug Schwartz in the hospital and in 15 the care treatment and potential transportation 16 provided by REACH Air Medical Services. 17 Q. Is there some way to turn up your volume? 18 I know you're using your headset, but sometimes when 19 you turn away from your -- the mic I think is on your 20 headset. Sometimes when you turn away, it fades out. 21 A. Okay. I'll do a better job of trying to 22 project. Hopefully that will help. 23 Q. The burdens of Zoom. 24 A. Yes. 25 Q. Can you identify every provider whose care</p>	<p style="text-align: right;">Page 9</p> <p>1 Lyons, those -- any of that would have been outlined in 2 my report. I don't believe I offered a specific 3 opinion regarding care provided by Ronnie Lyons. 4 Q. And I'm not so much worried about what's in 5 your report. I want to know, do you intend to offer an 6 opinion regarding the care provided by Ronnie Lyons? 7 A. I believe I've given you my best answer. 8 And as I sit here today, under oath, my report, I 9 believe, touches on the areas that I intend to offer an 10 opinion. 11 Q. I understand that. I'm not asking you to 12 qualify it in terms of your report. What matters is 13 your testimony. Your report is not what I'm worried 14 about. 15 When we go to trial, do you intend to offer 16 testimony regarding the care provided by Ronnie Lyons? 17 Yes or no? 18 MS. BLAZICH: I'll object that it's asked 19 and answered. 20 THE WITNESS: Giving you the qualification 21 regarding care, that may touch on issues related to 22 consent that involved Ronnie Lyons. So I believe I'm 23 giving you the best answer and most truthful answer I 24 can. 25 BY MR. BURTON:</p>

<p style="text-align: right;">Page 10</p> <p>1 Q. All right. 2 Outside of the issue of consent, do you 3 intend to offer any opinion regarding the care provided 4 by Ronnie Lyons? 5 A. I would ask that care may also apply to the 6 oversight of the care provided by Barry Bartlett as a 7 field training officer or training superior, that 8 Ronnie Lyons was overseeing Barry Bartlett, that may be 9 an applicable opinion to care. 10 Q. And you keep qualifying as it "may be." 11 Today is the only shot I get to know your opinions. 12 And I'm -- I need a direct answer to this. 13 Do you intend to -- outside of the issue of 14 informed consent, do you intend to offer opinions 15 regarding the care provided by Ronnie Lyons to 16 Mr. Schwartz? 17 MS. BLAZICH: Objection. It's been asked 18 and answered. 19 MR. BURTON: It's not been answered. 20 BY MR. BURTON: 21 Q. Go ahead. 22 A. Yes, I think I would ask you, then, to 23 clarify your use of the term "care," to make sure that 24 I understand completely what you're asking. 25 Q. Well, you're the one holding yourself out</p>	<p style="text-align: right;">Page 12</p> <p>1 Q. Remind me what your answer is. I don't 2 think you actually gave one, but remind me what your 3 answer is. 4 A. My answer is that as it applies to care, 5 that would include the oversight of Barry Bartlett as a 6 trainee for the REACH Medical team, and it would also 7 apply to issues related to consent. 8 Q. You do understand Mr. Lyons is a nurse; 9 correct? 10 A. Yes, I understand that. 11 Q. And you're not a nurse? 12 A. Yes, I understand that. 13 Q. And you're not a flight nurse; correct? 14 A. Yes. That is correct. 15 Q. Do you intend to offer an opinion as to the 16 care that Ronnie Lyons, as a flight nurse, should have 17 given in his role as a supervisor to Barry Bartlett, 18 knowing that you lack the credentials to do that? 19 A. If we isolate care to the administration of 20 medications, yes, I do not intend to offer an opinion 21 related to Ronnie Lyons. 22 Q. I don't know why you would isolate it that 23 way. That's not what my question was. My question was 24 very specific. 25 Do you intend to offer an opinion as to the</p>
<p style="text-align: right;">Page 11</p> <p>1 as a medical expert; right? 2 A. Yes. 3 Q. And you don't understand the term "care," 4 in the terms of a medical malpractice case? 5 A. I understand that the term care can apply 6 to a lot of different interactions between a patient 7 and a caregiver. Hence, the reason it's the depth of 8 that understanding that I'm asking for either more 9 clarification or my original answer still applies. 10 Q. All right. 11 Based on your understanding of the term 12 medical care, do you intend to provide any criticism of 13 the medical care provided by Ronnie Lyons, outside of 14 the issue of consent, if this case goes to trial? Yes 15 or no? 16 A. I believe I've given you my best answer. 17 Q. I want you to answer the question again. 18 MS. BLAZICH: Objection. It's asked and 19 answered. 20 BY MR. BURTON: 21 Q. Go ahead. 22 A. Again, I believe I've given you my best 23 answer, understanding my interpretation of the word 24 care as it applies to all aspects of the patient 25 caregiver relationship.</p>	<p style="text-align: right;">Page 13</p> <p>1 care that Ronnie Lyons, as a flight nurse, should have 2 provided in his role of a supervisor of Barry Bartlett? 3 A. I believe I've given you my best answer. 4 Q. I want you to answer the question. Go 5 ahead and answer it. 6 MS. BLAZICH: He's answered the question. 7 MR. BURTON: No, he hasn't. 8 BY MR. BURTON: 9 Q. Go ahead. 10 MS. BLAZICH: He's answered the question. 11 He's delineated the testimony about a supervisor, that 12 he does plan to give that. 13 MR. BURTON: Shirley, that's a speaking 14 objection. Please don't do that. 15 BY MR. BURTON: 16 Q. Go ahead, Mr. Everlove, and give me your 17 answer again. 18 A. My answer is that in the context of care 19 that can apply to several different layers of patient 20 caregiver interaction, that the administration of 21 medications by Mr. Lyons would not be part of my 22 opinions, but that the care may include issues related 23 to consent and issues related to oversight by the 24 private medical transportation team of a patient like 25 Mr. Schwartz.</p>

<p style="text-align: right;">Page 14</p> <p>1 Q. Is it fair to say that your report contains 2 all of your opinions? 3 A. As I sit here today, yes. 4 Q. Do you intend to offer additional opinions 5 at trial? 6 A. I intend to review further documentation 7 subject to discovery that may either support, amend or 8 create new opinions. 9 Q. But based on the records that exist today, 10 does your report contain all of your opinions? 11 A. Yes, it does, with the caveat that there 12 was discovery I received from other experts that I have 13 not submitted a supplemental report for or been able to 14 offer opinions, such as the reports of Dr. Jobin, the 15 deposition transcript of Dr. Osborn, and the report by 16 Mr. Byrd. 17 Q. Do you -- does your report contain all the 18 factual support that underlies your opinions? 19 A. Yes, I believe it does. 20 Q. Did anybody help you review records for 21 purposes of creating your report? 22 A. No, they did not. 23 Q. Did anybody help you draft your report? 24 A. No, they did not. 25 Q. Did anybody proofread or offer revisions to</p>	<p style="text-align: right;">Page 16</p> <p>1 How many hours have you spent reviewing any 2 records in this case, whether they be medical records 3 or transcripts or policies, etcetera? 4 A. I would be able to give you an estimate of 5 how much time I spent on the case, which would include 6 a drafting of the report up to today, which would 7 estimate approximately 32 to 33 hours. 8 Q. But you can't break it down by how much 9 time you spent reviewing records? 10 A. As I sit here, I regret I don't have a 11 recollection to the details of that. 12 Q. Are all of the materials that you've 13 reviewed for purposes of forming your opinion contained 14 in the -- in your report? 15 A. Yes. At the time of the report, yes, all 16 of those documents were included. 17 Q. You didn't review any other documents -- 18 again, I'm trying to characterize at the time of your 19 report. You didn't review any other documents to come 20 up with your opinions besides what was listed? 21 A. Yes, that's correct. If I reviewed a 22 document that was relevant to my opinions, I included 23 it in the report. 24 Q. But did you only include documents you 25 thought were relevant or did you include all documents</p>
<p style="text-align: right;">Page 15</p> <p>1 your report? 2 A. Yes. I did have somebody proofread for 3 grammatical and sentence structure. Nothing of 4 content. 5 Q. Nothing of substance? 6 A. Yes, that's correct, nothing of substance. 7 Q. Are you aware of any typos in your report? 8 A. As I sit here now before you, I'm not aware 9 of them. 10 Q. What about any mistakes? Are you aware of 11 any factual mistakes in your report? 12 A. Not to the best of my knowledge. 13 Q. Aside from Ms. Blazich, have you spoken 14 with any of the other attorneys at Claggett & Sykes, if 15 you can recall? 16 A. I recall a phone conversation with another 17 representative. I don't recall her name. It would 18 have been some time ago. 19 Q. Was it a female? 20 A. Yes, it was. 21 Q. How many hours do you think you've spent 22 reviewing medical records in this case? 23 A. Isolating it just to medical record review, 24 I don't recall exactly how many hours. 25 Q. Let's make it more broad.</p>	<p style="text-align: right;">Page 17</p> <p>1 that you reviewed? 2 A. To the best of my knowledge, it was 3 documents that I reviewed that were provided to me. 4 And then others that were isolated -- I'm sorry, of 5 that list, they were specifically denoted in the 6 report. 7 Q. And it sounds like you've reviewed 8 documents since submitting your report? 9 A. Yes, I have. 10 Q. Can you identify all of those for me? For 11 purposes -- again, documents obviously that are 12 relevant to your opinions. 13 A. Yes. Thank you for clarifying. 14 The documents I've reviewed were ones 15 provided to me subject to submission. Again, I recall 16 Dr. Jobin's report, Dr. Osborn's deposition transcript, 17 Mr. Byrd's report. I also believe there was one other 18 physician report that I have to pull up if you'd like. 19 Q. If you don't recall, I don't need you to 20 pull it up. 21 Anything else you recall reviewing? 22 A. I believe there was also one other 23 procedural filing, if I recall, but I -- nothing that I 24 recall as being substantive to my opinions. 25 Q. Of the materials that you've reviewed since</p>

<p style="text-align: right;">Page 18</p> <p>1 your deposition, do any of those materials change your 2 opinions? 3 A. None of those change my initial opinions. 4 Q. When I -- I'm a lawyer so I focus on the 5 words that you use. When you say "initial opinions," 6 I'm talking about your opinions today. Because, again, 7 this is my one time to talk to you. 8 The materials that you've reviewed since 9 you issued your report on October 25th, do any of those 10 subsequently reviewed materials change your opinions? 11 A. No. 12 Q. Have you talked with any member of the 13 Schwartz family? 14 A. I have not. 15 Q. Have you communicated with any of the other 16 experts in this matter regarding this case? 17 A. I have not. 18 Q. You've previously worked on cases with 19 Dr. Womack; is that correct? 20 A. Yes, I have. 21 Q. And you and he have -- correct me if I say 22 this wrong -- referred cases back and forth to each 23 other? 24 A. Yes. My understanding of a referral is an 25 attorney phone number or email address that may look</p>	<p style="text-align: right;">Page 20</p> <p>1 It is just a printout copy of the documents 2 that are listed in my report. Currently, my -- it's 3 open to my report, for the ease of reference and to 4 expedite the process. 5 I also have with me several of the texts 6 that I used within my report regarding my opinions 7 related to the standard of care. 8 Q. Do you have any documents in front of you 9 that have not been disclosed or itemized in your 10 report? 11 A. Yes, with the clarification, those 12 documents are the ones I just described to you, which 13 would have been Mr. Byrd's report and -- I don't recall 14 whether I printed up a copy of Dr. Osborn's deposition 15 transcript. I don't think I did. Absent those 16 documents we've already discussed, there is no other 17 additional information in front of me. 18 Q. Do you have any devices in front of you 19 that would allow you to communicate? Let me clarify 20 that. I don't think that you will communicate, I'm 21 just asking if you do. 22 A. I don't have any devices in front of me 23 that I have access to communicate outside of what you 24 are doing. 25 Q. You will agree not to communicate to anyone</p>
<p style="text-align: right;">Page 19</p> <p>1 for somebody with that area of expertise. 2 Q. And you and Dr. Womack have done that with 3 each other in the past; correct? 4 A. Yes, we have. 5 Q. How many other cases have you worked on 6 with Dr. Womack? 7 A. Only one -- well, first of all, I haven't 8 worked on any cases with Dr. Womack. Dr. Womack's been 9 retained as an expert for other cases I've been 10 involved in as a retained expert. I recall only one 11 other time. 12 Q. Where you and he were retained by the same 13 party? 14 A. Yes. That's correct. 15 Q. What about the other experts in this case, 16 have you ever been on a case where another expert in 17 this case also provided an opinion? 18 A. Not to the best of my knowledge. 19 Q. What documents do you have in front of you? 20 Obviously, if we were here in person I could see what 21 you have. I assume you're at your home or your office. 22 What documents do you have in front of you? 23 A. I created a three-ring binder. I'll show 24 it to you on camera, for purposes of you being able to 25 see it.</p>	<p style="text-align: right;">Page 21</p> <p>1 when we're on the record? 2 A. Yes, I understand that. 3 Q. Again, it's not that I think that you 4 would, I just want to ask. 5 Have you ever had any action taken against 6 any of your medical or paramedic licensure? 7 A. No. 8 Q. No discipline with respect to your medical 9 licensure? 10 A. No. 11 Q. Have you ever been convicted of a crime? 12 A. No. 13 Q. Have you ever been sued for malpractice? 14 A. No. 15 Q. In your past expert experience, have you 16 ever been excluded as an expert, whether -- let me say, 17 whether partially or in full? 18 A. Not to the best of my knowledge, I've never 19 been excluded. 20 Q. And you would know; right? If you had been 21 told you can't participate at trial or can't offer an 22 opinion, you would remember that, wouldn't you? 23 A. Yes. The reason I clarify or qualify my 24 statement is I don't know what attorneys have 25 experienced that maybe I didn't know at the time.</p>

<p style="text-align: right;">Page 22</p> <p>1 However, the expectation is that if any of that took 2 place, I would be told about it and know about it. And 3 to the best of my knowledge, I've never had anything 4 excluded. 5 Q. If a lawyer never tells you that you're not 6 excluded, you better get after that lawyer. That's not 7 a good thing. 8 A. I wouldn't disagree. And it's an 9 expectation that we have communication about something 10 that important. 11 Q. Have you ever had anybody attempt to 12 exclude you as an expert, either in full or with 13 respect to any of your opinions? 14 A. Yes, I did have one case. 15 Q. What case was that? 16 A. That was a case in Montana related to the 17 services provided by a volunteer emergency medical 18 services organization. 19 Q. Do you recall approximately what year that 20 was? 21 A. It's listed on my transcript -- I'm sorry, 22 my testimony log. It was a case in Montana. I believe 23 it was approximately two or three years ago. 24 Q. So I've got your testimony log in front of 25 me, and I appreciate you providing the states. I know</p>	<p style="text-align: right;">Page 24</p> <p>1 Q. All right. 2 What percentage of your annual income is 3 tied to doing expert work in legal cases? 4 A. Approximately 20, 25 percent. 5 Q. Are you aware of other cases where you said 6 it's been as high as 40? 7 A. I don't recall saying as high as 40 for 8 expert witness work. If I said 40, it may have 9 included the education and consulting component, which 10 would have been inclusive of all of my work with the 11 claim consulting. 12 Q. And your work -- how would you say it's 13 split between -- on your testimony log, it didn't 14 identify whether you were working for the plaintiff or 15 the defendant -- well, maybe it did. 16 So I've got this in front of me. It's got 17 a P and a D. Is that the way that you allocate between 18 plaintiff and defendant? 19 A. Yes, it is. 20 Q. And I'll let you go through the numbers, 21 but what's the percentage plaintiff to defense work, if 22 you know? 23 A. I estimate 60 to 40 percent plaintiff or 24 defense. 25 Q. You've got an acting career as well I</p>
<p style="text-align: right;">Page 23</p> <p>1 that we asked for that. And I don't see, unless I'm 2 misunderstanding, that MT is the acronym for Montana, I 3 don't see Montana listed. 4 A. That was my error. I believe I listed MO, 5 which is Missouri, and that would have been an 6 oversight and I did it quickly. That's an error. That 7 would have been the Montana case and I believe it was 8 -- the name of the case was Williams versus Laurel EMS. 9 Q. Do you know if that was in Montana state 10 court or federal court? 11 A. To the best of my knowledge, it was Montana 12 state -- recollection is Montana state court. 13 Q. What was the -- as best you can recall, 14 what was the basis upon which they moved to exclude 15 you? 16 A. I don't recall the details, and I recall 17 notification from the retaining attorney that it was 18 not -- that it wasn't a successful or didn't receive a 19 successful judgment in that time. 20 Q. Do you know if it was an attempt to exclude 21 you in full or just portions of your opinions? 22 A. If I recall correctly, it was portions of 23 my opinion. 24 Q. Okay. 25 A. I don't recall the details.</p>	<p style="text-align: right;">Page 25</p> <p>1 understand? 2 A. No. I had a previous -- I have previous 3 experience doing that. 4 Q. And there aren't very many people that can 5 say you play a paramedic by day and a paramedic on 6 screen, but you've played a paramedic in different 7 movies and TV shows? 8 A. Yes, I have. 9 Q. When was the last time that you acted? 10 A. Approximately three years ago, to the best 11 of my knowledge. 12 Q. All right. 13 So let's talk about your CV. 14 The CV that I have, and I'll just note for 15 the record and we can make it an exhibit, is Schwartz 16 549 to 552. 17 Do you have that in front of you? I don't 18 know if you have Bates stamped copies of CVs. 19 A. Yes, I don't have the Bates stamped copy of 20 the CV in front of me, but I am going to pull up my 21 copy of it. 22 Q. Is this -- the copy that was attached to 23 your report, is that the -- an updated copy of your CV? 24 A. As I don't have a copy that was Bates 25 stamped and attached to my report, I'm unable to give</p>

<p style="text-align: right;">Page 26</p> <p>1 you an affirmative answer as to whether that's the most 2 updated copy. However, the most updated copy should 3 have reference to my work as a -- at Moorpark College 4 related to the health sciences department. Is that the 5 copy that you have? 6 Q. Yes. That's the first entry under 7 experience. 8 A. Okay. Yes, I'm going to agree that that is 9 most likely the most updated. 10 Q. Did you work for the City of Fillmore? 11 A. Yes. I'm a paramedic firefighter with 12 them. 13 Q. Is that listed on that version of your 14 report -- of your CV, excuse me? 15 And I'll tell you, I'm not trying to trick 16 you here. 17 A. I appreciate that. 18 Q. I don't see it listed here, but I 19 understand that you do work for the City of Fillmore. 20 A. Yes. Thank you. That's correct, I do. 21 The copy I have has it listed. And -- but yes, that's 22 true. 23 Q. All right. 24 You're not a certified flight paramedic; 25 correct?</p>	<p style="text-align: right;">Page 28</p> <p>1 would have been able to work in that role while 2 achieving my FP-C within, I believe, the first six 3 months of my employment. 4 Q. So you would have agreed to obtain that 5 licensure to keep a job if you were hired? 6 A. I'm sorry, I couldn't hear you. Could you 7 repeat? 8 Q. You would need to obtain the FP-C licensure 9 to keep your job if you were hired by REACH? Would you 10 agree? 11 A. I believe that was what their expectation 12 was, yes. 13 Q. And you're also not a -- are you familiar 14 with the term critical care paramedic certification? 15 A. Yes, I am. 16 Q. What is that -- what is your understanding 17 as to what that certification is? 18 A. Much like the flight paramedic 19 certification, they are reemphasized portions of the 20 paramedic standard of care that we received in 21 paramedic school, that apply to specific job functions. 22 Q. And you do not hold that certification; 23 correct? 24 A. Yes, correct. I do not. 25 Q. You do not; right?</p>
<p style="text-align: right;">Page 27</p> <p>1 A. Yes. Correct. I'm not. 2 Q. And you've never been a certified flight 3 paramedic; correct? 4 A. Yes. That's correct. I have not. 5 Q. And if I call that -- I'll probably call it 6 certified flight paramedic but it's also known as an 7 FP-C. Would you agree? 8 A. Yes, that's my understanding. 9 Q. And that's the licensure that Barry 10 Bartlett had, was a certified flight paramedic. Would 11 you agree? 12 A. I don't recall that he had the flight 13 paramedic certification or if he had been granted 14 authority by the state of Nevada to operate as an air 15 ambulance paramedic. 16 Q. Sorry. This Zoom thing drives me crazy 17 because I can't tell when you're done as well as I 18 could if we were in person. Sorry to interrupt you. 19 Do you know if he had a certified flight 20 paramedic license in the state of California? 21 A. Yes, I recall reading that. 22 Q. Based on your current licensure, would you 23 have been qualified to work in the same role that Barry 24 Bartlett did at REACH? Do you know? 25 A. According to the REACH policies, yes. I</p>	<p style="text-align: right;">Page 29</p> <p>1 A. Yes. Correct. I do not. 2 Q. Sorry, it cut out. 3 Do you still work for AMR? 4 A. I do not. 5 Q. Do you know if AMR owns REACH? 6 A. American Medical Response does not own 7 REACH. My understanding is Global Medical Response, 8 which is the parent company that oversees all of those 9 assets, owns REACH. 10 Q. Does GMR own AMR? 11 A. Yes. 12 Q. When did you stop working for AMR? 13 A. I estimate 20 -- I believe it was the 14 beginning of 2020. Yes, it would have been the 15 beginning of 2020. 16 Q. So the copy of your CV that we have -- 17 we'll mark -- we've marked as Exhibit 1, it says you 18 worked there 2018 to the current. I know you had 19 earlier jobs as a supervisor in 2007 to the current as 20 a paramedic. 21 So that part is outdated as well? 22 A. Let me pull up a copy to verify. I think 23 I'm getting my years confused. 24 Q. And I can -- I can screen share with you, 25 too, so that you can see what I'm looking at.</p>

<p style="text-align: right;">Page 30</p> <p>1 A. Thank you, yes. It would have been -- it 2 would have been right after receiving my employment at 3 Moorpark College. So I believe it's 2020, which is 4 what I represented in my CV, beginning in 2020. 5 Q. So just so that you and I are talking 6 apples to apples, I'm going to share my screen over 7 here. 8 Are you able to see my mouse over here? 9 A. Now I can, yes. 10 Q. All right. 11 Do you see down here how it says that this 12 is current -- this is current, that those are outdated; 13 right? 14 A. Yes, that's correct. 15 Q. Currently, is the City of Fillmore -- is 16 that the only place where you actually treat patients 17 as a paramedic? 18 A. Yes. 19 Q. When you worked for AMR, what was the 20 geographic area where you worked generally? 21 A. Ventura -- I'm sorry, I cut you off. 22 Q. No, sorry. I added that wording a little 23 late. 24 A. I worked for AMR of Ventura County. 25 Q. And does AMR of Ventura County have</p>	<p style="text-align: right;">Page 32</p> <p>1 Q. All right, scene call. That's a better way 2 to say it. I'll use your terminology. 3 And an interfacility transfer, would you 4 agree that's taking a patient from hospital A to 5 hospital B? 6 A. That would represent one type of 7 interfacility transfer, yes. 8 Q. What other types of interfacility transfers 9 are there? 10 A. Transportation to other nonprimary care 11 facilities, like residential care facilities, for 12 instance. There's transportation to other locations 13 that would be associated with an airport that would be 14 part of the -- a certain type of interfacility 15 transport, regarding the transportation of a patient in 16 totality. 17 There may be different segments of that 18 process, for instance, but an interfacility transfer is 19 generally qualified as transportation from a primary 20 caregiver, or definitive care facility, to an 21 alternative location. 22 Q. And that alternative location does not have 23 to be to another care provider? 24 A. I'm sorry. You were a little low volume. 25 Q. Is it always to another primary care</p>
<p style="text-align: right;">Page 31</p> <p>1 aircraft as part of its options to transport patients? 2 A. Yes. 3 Q. How many aircraft do they have? 4 A. We have county providers of aircraft 5 transportation and we have private providers of 6 interfacility aircraft transportation available to us. 7 Q. Are those helicopters and fixed-wing 8 aircraft? 9 A. We have both. So we also have a local 10 airport that is routinely used for fixed-wing Air 11 Medical transportation. 12 Q. And in Ventura County did AMR -- does it 13 offer interfacility transfer services? 14 A. Yes. 15 Q. And is this different -- would you say that 16 interfacility transfers, or IFTs, are different than 17 on-scene transfers? 18 A. In what regard, please? 19 Q. Would you agree that an on-scene transfer 20 is there's a car accident, a helicopter flies to it, 21 picks up a patient and takes the patient to the 22 hospital? 23 Can we agree that's an on-scene transfer? 24 A. The definition of those two would be a 25 scene call versus an interfacility transfer, yes.</p>	<p style="text-align: right;">Page 33</p> <p>1 provider, or is there always a primary care provider on 2 the receiving end of an IFT? 3 A. There is not always a primary care provider 4 on the receiving end of the same level of medical 5 direction or qualification. In an interfacility 6 transport that is between two hospital facilities, then 7 there are two coordinating physicians or discharge 8 staff members that are coordinating the interfacility 9 transportation. 10 Q. Are you familiar with the phrase 11 "convalescent transfer"? 12 A. Yes. 13 Q. Is that different from an interfacility 14 transfer? 15 A. No. 16 Q. Would you use those -- would convalescent 17 transfer, in your view, be under the umbrella of an 18 interfacility transfer? 19 A. That would be inclusive, yes, based on the 20 definitions within the standard of care. 21 Q. All right. 22 So with your -- with respect to your 23 experience specifically, while working for AMR, did you 24 participate in interfacility transfers using aircraft, 25 not using ground transport?</p>

<p style="text-align: right;">Page 34</p> <p>1 A. Yes.</p> <p>2 Q. Did you do this in the context of critical</p> <p>3 care transports in the -- as an interfacility</p> <p>4 transport?</p> <p>5 A. Yes.</p> <p>6 Q. Approximately how many interfacility</p> <p>7 transports in the critical care realm do you think you</p> <p>8 did?</p> <p>9 A. Critical care transports? I would estimate</p> <p>10 hundreds.</p> <p>11 Q. Give me an example of what one would be.</p> <p>12 A. An example would be picking up a patient</p> <p>13 from a local emergency department at a preceding</p> <p>14 hospital with a nurse, and coordinating the treatment</p> <p>15 and transportation of that patient to an alternative</p> <p>16 specialized facility, that might be a cardiac care</p> <p>17 facility, or a trauma facility, or some other</p> <p>18 definitive care facility.</p> <p>19 Q. In that way, did you ever take a patient</p> <p>20 from a rural hospital to a higher level of care</p> <p>21 hospital?</p> <p>22 A. The term "rural" might apply to some of our</p> <p>23 locations. Certainly, hospitals that had a lower level</p> <p>24 of service that they could provide for the patient at</p> <p>25 the time, that required the transport of the patient to</p>	<p style="text-align: right;">Page 36</p> <p>1 that Ronnie Lyons was in a more superior position of</p> <p>2 authority over Barry Bartlett on their team, would you</p> <p>3 not?</p> <p>4 A. Superior position related to -- of</p> <p>5 authority related to medical education, or in what</p> <p>6 capacity?</p> <p>7 Q. All right.</p> <p>8 Let me phrase it this way: When you're</p> <p>9 working on a team -- let me step back. Not Ronnie</p> <p>10 Lyons, not Barry Bartlett.</p> <p>11 In Ventura County, you're on an aircraft</p> <p>12 with a nurse. Does the nurse have higher decision</p> <p>13 authority than you or do you have equal decision</p> <p>14 authority with respect to patient care?</p> <p>15 A. Medical authority for patient care comes</p> <p>16 from medical direction. And the person providing the</p> <p>17 care may be the nurse and the doctor.</p> <p>18 And you clarified via aircraft. I want to</p> <p>19 make sure that we understand each other.</p> <p>20 The critical care transports I'm talking</p> <p>21 about were by ground.</p> <p>22 Q. I asked you earlier -- and I'm glad you</p> <p>23 clarified that. I thought I asked you earlier, if I</p> <p>24 didn't, I apologize.</p> <p>25 Did you ever provide critical care</p>
<p style="text-align: right;">Page 35</p> <p>1 a different definitive care facility.</p> <p>2 Q. You would agree, wouldn't you, that in</p> <p>3 Ventura County there are hospitals that you would</p> <p>4 consider rural hospitals, would you?</p> <p>5 A. The term "rural" as a specific definition?</p> <p>6 Yes, I would consider at least one of our hospitals to</p> <p>7 be a community hospital versus a larger definitive care</p> <p>8 facility.</p> <p>9 Q. On the transfers that you did, were you the</p> <p>10 medic in charge or were you assisting the nurse on</p> <p>11 these critical care transports?</p> <p>12 A. I believe the best way to answer that</p> <p>13 question is that we were part of a critical care team,</p> <p>14 working together to treat a patient and provide the</p> <p>15 transportation.</p> <p>16 Q. Well, and that's not my question.</p> <p>17 My question -- let me rephrase my question.</p> <p>18 Was the nurse your supervisor or were you</p> <p>19 the nurse's supervisor, or neither?</p> <p>20 A. In those situations, neither.</p> <p>21 Q. Did the nurse have higher medical training</p> <p>22 than you?</p> <p>23 A. Yes.</p> <p>24 Q. Let me put it in the context of Barry</p> <p>25 Bartlett and Ronnie Lyons. Who was -- you would agree</p>	<p style="text-align: right;">Page 37</p> <p>1 transport using either a helicopter or a fixed-wing</p> <p>2 aircraft while working for AMR in Ventura County?</p> <p>3 A. Not on the aircraft, no.</p> <p>4 Q. So all of your transports were via</p> <p>5 ambulance or some type of -- I don't want to say car</p> <p>6 because I know an ambulance is not a car, but on the</p> <p>7 ground?</p> <p>8 A. A transport vehicle on the ground, yes,</p> <p>9 that's right.</p> <p>10 Q. Have you ever in your career provided a --</p> <p>11 or assisted in a critical care interfacility transport</p> <p>12 using an aircraft?</p> <p>13 A. My answer previously was yes, with</p> <p>14 clarification that we routinely transported patients</p> <p>15 from hospitals to the local airport with fixed-wing and</p> <p>16 rotor-wing transports.</p> <p>17 Q. All right, but you said earlier -- I asked</p> <p>18 you, I said, "Did you ever provide critical care</p> <p>19 transport using either a helicopter or a fixed-wing</p> <p>20 aircraft while working for AMR?"</p> <p>21 And you said, "No, not in the aircraft."</p> <p>22 A. Yes. That's correct.</p> <p>23 Q. So I guess I'm not understanding.</p> <p>24 How did you provide critical care transport</p> <p>25 but not using -- it seems like you're giving two</p>

<p style="text-align: right;">Page 38</p> <p>1 different answers and I'm sure I'm misunderstanding. 2 A. That's quite all right. 3 Because AMR doesn't have helicopters, 4 there's the clarification, in Ventura County. So the 5 transportation I provided is with the sheriff's 6 department aviation unit. We had several patients 7 which we transported, critical burn patients, for 8 example, or diving accidents from one facility to 9 another so that they could receive care. 10 So there was the experience I was referring 11 to. 12 With regard to the fixed and rotor wing and 13 the transportation of patients with a critical care 14 team, there was that experience also. And then AMR has 15 ground transportation resources in Ventura County, in 16 which I've transported patients routinely in 17 interfacility transports alongside aides. 18 Q. So let me be specific. How many times in 19 your career have you gone to a facility, picked up a 20 patient who is a critical care patient, and transported 21 them via any type of aircraft to another facility for a 22 higher level of care? 23 A. Approximately ten. 24 Q. When were those -- or let me make it 25 easier. When was the last time you did that?</p>	<p style="text-align: right;">Page 40</p> <p>1 critical care team. 2 Q. Do you understand the acronym BLS? 3 A. Yes. 4 Q. And do you also understand the acronym 5 ACLS? 6 A. Yes. 7 Q. What level of care is used between those 8 two on a critical care transport? 9 A. You may use all levels of care in a 10 critical care transport. 11 Q. Fair enough. 12 On a critical care transport, you would 13 agree that you use BLS; right? 14 A. Yes. 15 Q. And also ACLS? 16 A. I believe you're confusing the two terms. 17 ACLS is advanced cardiac life support with 18 the American Heart Association program. And ALS is 19 advanced life support, the umbrella by which all 20 paramedics operate. 21 Q. Yes, and I've been asking for the base ALS. 22 ALS is what I'm referring to. 23 A. Yes. Correct. ALS and BLS care, correct. 24 Q. Thank you. Too many health care cases, too 25 many acronyms.</p>
<p style="text-align: right;">Page 39</p> <p>1 A. Approximately 20 years ago. 2 Q. Was this part of your search and rescue 3 days? 4 A. Yes. 5 Q. And that was in partnership with AMR and 6 Ventura County; right? 7 A. When you say "a partnership," can you be 8 more specific? 9 Q. You were basically borrowed -- that sounds 10 bad, but you were loaned to Ventura County Search and 11 Rescue as an AMR employee; correct? 12 A. For a period of time, yes. And then for a 13 period of time, no. That program ended. 14 Q. And the aircraft you used, that was a 15 Ventura County Search and Rescue aircraft; correct? 16 A. It was a Sheriff's Department aircraft. It 17 wasn't designated only for search and rescue. 18 Q. Was it a helicopter or an airplane? 19 A. Helicopter. 20 Q. If you had to describe what critical care 21 transport, how would you describe that? What's your 22 definition? 23 A. My definition of critical care transport is 24 the interfacility transport of patient from one 25 definitive care facility to another, utilizing a</p>	<p style="text-align: right;">Page 41</p> <p>1 The transport to Ventura County, were those 2 under ALS protocol or BLS? 3 A. Both. 4 Q. You describe yourself as a flight paramedic 5 with Ventura County in your CV. Do you agree? 6 A. Yes. 7 Q. Do you have any actual flight paramedic 8 certification that would allow you to use that name, or 9 is that just a name that you chose? 10 A. It was our title as paramedics on the 11 flight crew. We were flight paramedics. 12 Q. Who gave you that title? 13 A. That was a title given to us I believe both 14 by AMR and by the Sheriff's Department aviation unit. 15 Q. You would agree that search and rescue is 16 different than interfacility transfer? Agree? 17 A. Yes. 18 Q. And even search and rescue, where you 19 transport a patient that you actually rescued, that's 20 different than interfacility transfer; right? 21 A. The nature of the call is different, yes. 22 Q. So if you hoist somebody off a mountainside 23 or pluck them out of the ocean, I don't know what you 24 do with search and rescue, that's not an interfacility 25 transfer; right?</p>

<p style="text-align: right;">Page 42</p> <p>1 A. Yes, that's correct, that is not. 2 Q. Were there flight paramedics with Ventura 3 County who were not ALS trained? 4 A. No. 5 Q. Every flight paramedic was ALS trained? 6 A. Yes. 7 Q. Have you ever transferred a patient on a 8 fixed-wing aircraft or airplane? 9 A. No. 10 Q. When you were with Ventura County -- let me 11 back up. 12 You're familiar with the term RSI? 13 A. Yes. 14 Q. Rapid sequence induction? 15 A. Yes. 16 Q. When you were working with Ventura County 17 search and rescue as a flight paramedic, did you ever 18 perform an RSI? 19 A. I never performed the administration of the 20 medications. That was outside of the policies and 21 procedures of Ventura County. 22 Q. All right. 23 Did you ever actually perform the procedure 24 of a rapid sequence induction while working as a flight 25 paramedic for Ventura County?</p>	<p style="text-align: right;">Page 44</p> <p>1 rapid sequence intubation {sic}. 2 A. Rapid sequence induction, as we just 3 agreed, is the RSI term. 4 Q. Sorry. 5 A. The process of administering medications, 6 no. I would estimate that there were less than ten, 7 approximately five times in my career, in which there 8 was a flight nurse on the helicopter with us for the 9 Sheriff's Department aviation unit that would have 10 administered medications. And I would have passed the 11 tube or performed the intubation. 12 Q. While working for AMR in Ventura County, 13 did you ever perform a rapid sequence induction? 14 A. No. 15 Q. So in your life, in total, how many times 16 would you say you've performed an RSI, in any context, 17 in any situation? And let me back up. 18 Not including training, not on a mannequin, 19 not on a cadaver, on an actual real live patient. 20 A. I would estimate ten times. 21 Q. Do you recall approximately the last time 22 you did that? Was this 20 years ago? 23 A. Yes. 24 Q. Okay. 25 Have you ever done an RSI on an airplane?</p>
<p style="text-align: right;">Page 43</p> <p>1 A. The rapid sequence induction portion is the 2 administration of the medications. That's what I'm 3 referring to. And no, I did not. That was not within 4 the protocols. 5 Q. Are there other portions of the RSI besides 6 the administration of the medications? 7 A. Yes, the actual passing of the tube and 8 intubation of the patient. 9 Q. Did you ever perform that portion of an RSI 10 while working as a flight paramedic for Ventura County? 11 A. Yes. 12 Q. Approximately how many times? 13 A. I would estimate less than ten. 14 Q. Give me one second. Let me ask the 15 question this way. 16 At any point, while you were working as a 17 paramedic for Ventura County, did you perform a rapid 18 sequence intubation {sic}? 19 A. Ventura County AMR or Ventura County 20 Aviation? 21 Q. No, not AMR, not Ventura County AMR, but 22 Ventura County, the flight paramedic. 23 A. The administration of the drugs, no, I did 24 not. 25 Q. Well, I'm asking you if you performed a</p>	<p style="text-align: right;">Page 45</p> <p>1 A. No. 2 Q. And you already testified you've never 3 pushed the drugs for an RSI as a paramedic; correct? 4 A. That's correct. 5 Q. And you've never administered Rocuronium; 6 correct? 7 A. That's correct. 8 Q. And you've never administered Ketamine; 9 correct? 10 A. That's correct. 11 Q. Back when you were working for AMR, how 12 much of your work was prehospital work? Let me back 13 up. 14 When you say -- in your report oftentimes 15 you talk about prehospital, or your resumé, your CV 16 uses that phrase, "prehospital," what do you understand 17 that phrase to mean? 18 A. Seeing calls for those patients that are 19 not in a definitive care facility. 20 Q. All right. Under that definition, how much 21 of your work was spent, when you were working for AMR, 22 on prehospital patient care versus interfacility 23 transfers or patients that had already been admitted 24 somewhere? 25 A. I would estimate 60/40, approximately,</p>

<p style="text-align: right;">Page 46</p> <p>1 scene calls versus interfacility transports. 2 Q. Of your interfacility transfers that you 3 participated in while working for AMR, what percentage 4 were ground transports and what percentage were air 5 transports? 6 A. As I qualified earlier, all of them would 7 have been ground transports for AMR, and moving of 8 patients with an air crew or the movement of patients 9 with a nurse or with another paramedic. 10 Q. And that's when you were working for AMR; 11 correct? 12 A. Yes, that's correct. 13 Q. When you're doing a ground interfacility 14 transport, when do you consider you to have assumed 15 control of the patient? 16 A. The transfer and care process involves 17 control of the patient care. So at the moment that I 18 introduce myself to a patient, retain the records for 19 that patient, move the patient over to my gurney and 20 receive an off-going report, those things in 21 combination create a transfer of care. 22 Q. Going back to -- I want to get back to the 23 patient control issue. 24 When you were doing interfacility 25 transports, what percentage of your transports were</p>	<p style="text-align: right;">Page 48</p> <p>1 Q. And if phlebotomy needs to come to draw my 2 blood, I'm also the patient of a phlebotomist; correct? 3 A. Yes. 4 Q. And if I need to run down to radiology to 5 get my x-ray on my broken arm, I'm a patient of the 6 radiology tech doing the x-ray as well; correct? 7 A. Yes. 8 Q. And if I need to be transported to a higher 9 level facility, I also become the patient of the flight 10 crew that's transporting me; correct? 11 A. Yes. 12 Q. And so what I want to -- and those 13 relationships can exist at the same time; correct? 14 A. Those being all of the ones you just listed 15 or specific ones? 16 Q. I'll be more specific. 17 The patient relationship can exist amongst 18 the doctor, the nurse and the flight crew at the same 19 time in certain circumstances; correct? 20 A. The patient relationship? Is that what you 21 asked me? 22 Q. Yes. 23 A. A patient caregiver relationship can be 24 amongst multiple caregivers. 25 Q. All right.</p>
<p style="text-align: right;">Page 47</p> <p>1 critical care versus convalescent transport? 2 A. I would estimate about 40 percent of our 3 transports that I participated in were critical care. 4 Approximately 60 percent would have been convalescent 5 care facilities. 6 Q. Going back to the patient control issue, 7 you would agree that a patient being treated in the 8 hospital, the emergency department, is the patient of 9 multiple providers, would you not? 10 A. Could you ask me that question again, 11 please. 12 Q. Sure, and I'll be more specific. 13 A patient in the ED is the patient of the 14 attending physician, or the physician that's attending 15 to the patient; correct? 16 A. They are part of the attending personnel, 17 if that's what you're referring to. 18 Q. No. I'm asking specifically, if I'm in the 19 emergency department being treated by a physician, I'm 20 that physician's patient; correct? 21 A. Yes. 22 Q. And if that physician has a nurse assisting 23 him or her, I'm also the patient of that nurse; 24 correct? 25 A. Yes.</p>	<p style="text-align: right;">Page 49</p> <p>1 So let's be specific. Let me give you a 2 hypothetical, which obviously you're an expert, I'm 3 allowed to do that. 4 If I'm in the emergency department and I 5 need to be transported to a high level of care, when 6 the flight crew arrives, prior to the introduction of 7 the flight crew to the patient, you would agree I'm the 8 patient of the attending physician and the nurse; 9 correct? 10 A. Correct. 11 Q. The flight crew comes in and says, "Hey, my 12 name is John." I then start to establish a patient 13 relationship with that flight crew; correct? 14 A. Yes. Correct. 15 Q. But I haven't yet given up my patient 16 relationship with the physician; correct? 17 A. Based on the introduction hypothetically, 18 that -- in giving up -- I think that's the hard part 19 for me, is the "giving up" term. 20 Q. All right. 21 The physician is still my doctor; correct? 22 A. Yes. 23 Q. And the nurse is still my nurse; correct? 24 A. Yes. 25 Q. So my question for you is: When is the</p>

<p style="text-align: right;">Page 50</p> <p>1 point in time where the flight crew assumes sole 2 patient care of the patient, when they arrive at an 3 emergency department to transport a patient for an IFT? 4 A. I think there are several steps to that 5 process. 6 Q. Explain each of them to me, please. 7 A. First would be, as I outlined, the 8 introduction. 9 Q. And let me back up. 10 I just want to know -- I don't want to know 11 when it starts a transition. I want to know what is 12 the point in time where that relationship is now solely 13 with the flight crew? 14 A. I think my best answer in this case is 15 related to when the flight crew believed it was their 16 patient. 17 Q. I'm not asking -- I'm not making it 18 specific to the Schwartz case. I'm saying in general. 19 Is it when they arrive at the hospital at 20 the introduction, when they push the patient down the 21 hall, when they exit the hospital doors, when they 22 actually get on the rig and start driving away? At 23 what point is it? 24 A. At the point in time in which there is the 25 introduction, the transfer of documentation, the</p>	<p style="text-align: right;">Page 52</p> <p>1 discharge order is? 2 A. It's a consent for transportation. It's an 3 outline of documentation to be provided to the 4 transport crew, a destination location and the 5 statement of a receiving physician at the receiving 6 facility. 7 Q. So I want to ask you a -- present a 8 hypothetical. 9 Let's assume you've done -- let's see, what 10 did you call it? You called it the "off-going report." 11 Let's assume you've done the off-going report, or 12 received it, sorry. Got the approval from the 13 attending and the patient is good to go. You're 14 walking down the hall towards the door, pushing the 15 patient on the stretcher, and the patient arrests. 16 Do you continue on to the receiving 17 facility or turn right back around and go to the ED? 18 A. The patient would no longer be eligible for 19 air transportation or ground transportation. They 20 would stay within the emergency department and be 21 treated by the staff. 22 Q. What if you were in the parking lot, 23 between the door of the hospital and the door of the 24 ambulance, and the patient arrests, would you turn back 25 around and go into the emergency department?</p>
<p style="text-align: right;">Page 51</p> <p>1 off-going report by the treating or attending staff, 2 and the patient is moved over to your transportation 3 equipment. That is the transfer of care. 4 Q. What is the off-going report? 5 A. An off-going report would be the nature of 6 the illness or the mechanism of injury, and nature of 7 the treatment provided to the patient prior to the 8 arrival of the transport crew. And the ongoing care 9 that's anticipated to be provided to the patient in the 10 medical documentation. 11 Q. Sorry. I didn't mean to interrupt you. 12 As part of the off-going report, is there 13 an approval from the attending physician that the 14 patient is ready for transport? 15 A. Yes. 16 Q. And so if the physician never approves 17 transport of the patient, I mean he is ready to go, you 18 can go out the door, the flight crew hasn't assumed 19 control of the patient yet; correct? 20 A. That may not be the case as outlined in 21 this case. 22 Q. Again, I'm speaking generally. 23 You're familiar with discharge orders? 24 A. Yes. 25 Q. What's your understanding of what a</p>	<p style="text-align: right;">Page 53</p> <p>1 A. Yes. I believe you're asking my questions 2 related to EMTALA. I believe there's an expert that's 3 going to offer an opinion related to EMTALA. So 4 without offering opinions that are contrary or lack 5 sufficient facts and information, my understanding of 6 EMTALA is that that patient would still belong to the 7 hospital, but they would need to then reenter that 8 patient into their system as the patient would already 9 have been discharged. 10 Q. All right. 11 Let's talk about your testimony log. 12 I only see one case where there's a Nevada 13 case, and I think the firm's name is listed wrong. 14 It says Kemp Thord & Coulthard. Is that 15 supposed to be Kemp Jones & Coulthard? 16 A. It may be. 17 Q. Do you know which attorneys you worked with 18 at that firm? 19 A. I don't recall. 20 Q. In that case, it looks like you only did a 21 deposition. 22 A. If that's what it's listing; correct. I 23 don't recall testifying in court on the case. 24 Q. And I'll represent to you it says "depo." 25 Are you aware of any other cases, and I</p>

<p style="text-align: right;">Page 54</p> <p>1 realize this only goes back four years, any other cases 2 where you provided expert opinions in Nevada -- or 3 sorry, expert testimony in Nevada? 4 A. No, there are no other cases I provided 5 expert testimony in Nevada. 6 Q. This case and one other case? 7 A. Yes. That's correct. 8 Q. All right. 9 Let's -- I don't know exactly how long 10 we've been going but it seems like it's more than an 11 hour. Do you want to keep going or do you want to -- 12 MR. BURTON: Or does anyone else need a 13 break? 14 MS. BLAZICH: I never turn down a break. 15 MR. BURTON: Let's take a five-minute break 16 just to stretch our legs. 17 (Recess taken from 3:40 p.m. to 3:51 p.m.) 18 BY MR. BURTON: 19 Q. Mr. Everlove, are you ready? 20 A. Yes, I am. 21 Q. Mr. Everlove, would you agree that being 22 hit by a car going 35 miles an hour is an emergency? 23 MS. BLAZICH: Objection. Calls for 24 speculation. 25 BY MR. BURTON:</p>	<p style="text-align: right;">Page 56</p> <p>1 chest. They placed him in spinal immobilization as a 2 precaution and then transported him to the hospital. 3 Q. Are you aware of any specific injury that 4 Mr. Schwartz received because of being hit by the car? 5 A. In the hospital it was determined that he 6 had rib fractures and a pneumothorax of a small 7 percentage. 8 Q. Do you know how many rib fractures he had? 9 A. My initial recollection was three rib 10 fractures. I don't recall the exact number. 11 Q. Are you familiar with the term "flail 12 segment"? 13 A. Yes, I am. 14 Q. What is your understanding of what a flail 15 segment is? 16 A. It's two or more ribs fractured in two or 17 more places that creates an isolated moving portion of 18 the ribcage, independent of the other portion of the 19 ribcage. 20 Q. In your opinion, is a rib fracture with a 21 flail segment -- is that a traumatic injury? 22 A. Yes, it is. 23 Q. In your opinion, having three fractures, is 24 that a traumatic injury after being hit by a car? 25 A. Yes. It's an injury that is secondary to</p>
<p style="text-align: right;">Page 55</p> <p>1 Q. Go ahead. 2 A. In this situation, regarding Mr. Schwartz; 3 is that correct? 4 Q. No, just generally. 5 Would you agree that if a pedestrian gets 6 hit by a car and the car is traveling 35 miles an hour, 7 that that's an emergency situation? 8 MS. BLAZICH: Objection to the form of the 9 question. Calls for speculation. 10 THE WITNESS: We use the term "a 11 significant mechanism of injury." And yes, it's a 12 significant mechanism of injury. 13 BY MR. BURTON: 14 Q. What is your understanding, now specific to 15 this case, as to the injuries that Mr. Schwartz 16 received from being hit by a car going 35 miles an 17 hour, approximately 35 miles an hour? 18 A. My understanding of the injuries as 19 determined by the hospital or injuries that were 20 initially determined on scene of the incident? 21 Q. You can give me both. 22 A. Initial impact location, when the ground 23 paramedics arrived on scene, they found Mr. Schwartz 24 with musculoskeletal complaints of pain and initially 25 described difficulty breathing due to the pain from his</p>	<p style="text-align: right;">Page 57</p> <p>1 trauma. 2 Q. But it's -- okay. Sorry. 3 What about a pneumothorax? Is a 4 pneumothorax that comes about as the result of a motor 5 vehicle/pedestrian accident, is that a traumatic 6 injury? 7 A. And I'm using the term secondary to trauma. 8 In this case, yes, it was secondary to the traumatic 9 injury. 10 Q. What do you mean by the term, and I 11 appreciate that clarification, secondary to trauma? 12 A. It means that the causation of the injury 13 was a traumatic injury, or a traumatic event rather. 14 Q. So in this incident, to be more specific, 15 the traumatic event was the car hitting Mr. Schwartz? 16 A. Or Mr. Schwartz hitting the ground 17 secondary to being struck by the vehicle. I don't 18 recall a specific denotation between the two. 19 Q. Fair enough. 20 And the injuries were secondary to those 21 events? 22 A. That is my understanding, yes. 23 Q. Okay. 24 Do you draw a distinction between what you 25 consider a traumatic injury and a critical injury?</p>

<p style="text-align: right;">Page 58</p> <p>1 A. I believe the terms you're using are 2 related to Mr. Schwartz, that he suffered a traumatic 3 injury. And the distinction is whether it was a mild, 4 moderate or severe injury or, in this case, a critical 5 injury that required critical intervention. I believe 6 that's what you're asking me. 7 Q. Yes. My question, though, is with those -- 8 I mean in your report, you use the phrase "traumatic 9 injury." You also use the phrase "critical injury." 10 Are those different? 11 A. Yes. Any injury can be a traumatic injury. 12 In this case, this was an injury secondary to traumatic 13 event. And in this case, the denotation between what 14 was critical and not critical, as far as Mr. Schwartz's 15 presentation, secondary to the trauma event. 16 Q. So you would agree that Mr. Schwartz's 17 injuries were secondary to trauma? 18 A. Yes. 19 Q. But your report says they were not 20 critical, is that right, not critical injuries? 21 A. Yes. 22 Q. Why were Mr. Schwartz's injuries not 23 critical? 24 A. Based on his presentation, he was in stable 25 condition, not in a critical condition that required</p>	<p style="text-align: right;">Page 60</p> <p>1 testimony is, Mr. Everlove. Let me be more specific. 2 If this case goes to trial, do you intend 3 to offer any opinion regarding whether or not 4 Mr. Schwartz should have been transferred to Salt Lake 5 City? 6 A. I intend to offer the opinion that I just 7 gave you regarding whether he was critical or not, 8 based on the injuries that he sustained. 9 Q. And that's not my question. My question is 10 very specific. 11 If this case goes to trial, do you intend 12 to offer any opinion as to whether or not Mr. Schwartz 13 should have been transferred to Salt Lake City from 14 Northeastern Nevada Regional Hospital? 15 A. I believe I've given you my best answer. 16 Q. Go ahead and give me your answer to that 17 question. 18 A. Which would be the same as the previous 19 question that you asked, which is: That that may be 20 based on the standard of care for Dr. Garvey and under 21 the scope of practice for a physician, of which there 22 are other opinions being offered. But that I would 23 offer the opinion that Mr. Schwartz did not have 24 critical injuries at the time of his -- secondary to 25 the traumatic event.</p>
<p style="text-align: right;">Page 59</p> <p>1 immediate intervention by the paramedics that 2 transported Mr. Schwartz to the hospital. And his 3 condition did not change while he was at the hospital. 4 Even with the benefit of definitive diagnostic testing, 5 there were no critical injuries noted. 6 Q. Do you have an opinion as to whether or not 7 Mr. Schwartz should have been transferred to the 8 University of Utah as a result of his traumatic 9 injuries? 10 A. I believe those opinions were -- would be 11 based upon Dr. Garvey's decision and the standard of 12 care for an emergency department physician. And as 13 I've already stated, I don't intend to offer those 14 opinions. 15 Q. Do you believe that the transfer, the 16 requested transfer of Mr. Schwartz, is appropriate or 17 not? 18 A. I believe I just answered the question to 19 the best of my ability. 20 Q. So is the answer no, or yes? 21 A. My answer is -- 22 MS. BLAZICH: Objection. Misstates the 23 testimony. 24 BY MR. BURTON: 25 Q. I'm trying to figure out what your</p>	<p style="text-align: right;">Page 61</p> <p>1 Q. And that's not an answer to my question. 2 This is -- you don't intend to offer any opinions that 3 Mr. Schwartz should or should not have been 4 transferred; correct? 5 A. I believe I've given you my best answer. 6 Q. All right. 7 Let me ask that question again: You do not 8 intend to offer any opinions that Mr. Schwartz should 9 or should not have been transferred when this case goes 10 to trial; correct? 11 MS. BLAZICH: Objection. Asked and 12 answered. 13 BY MR. BURTON: 14 Q. Go ahead. 15 A. I believe I've given you my best answer. 16 Q. Okay. 17 That's not an answer to my question. This 18 is a yes-or-no question. I'm entitled to know today 19 what opinions you intend to offer at trial. You would 20 agree with that; correct? 21 A. Yes. 22 Q. And so do you intend to offer an opinion at 23 trial regarding the appropriateness of Mr. Schwartz 24 being transferred or not? 25 MS. BLAZICH: Objection. Asked and</p>

<p style="text-align: right;">Page 62</p> <p>1 answered.</p> <p>2 THE WITNESS: I believe I've given you my</p> <p>3 best answer regarding the scope of my opinions.</p> <p>4 BY MR. BURTON:</p> <p>5 Q. Okay.</p> <p>6 And is your opinion that you're going to</p> <p>7 offer an opinion regarding whether he should have been</p> <p>8 transferred or not? It's just a yes or no. Are you</p> <p>9 going to tell the jury he shouldn't have been</p> <p>10 transferred or are you going to tell the jury he should</p> <p>11 have been transferred? It's a simple question.</p> <p>12 A. I plan to offer the opinion to the jury</p> <p>13 that Mr. Schwartz was not a critical patient.</p> <p>14 Q. And, therefore, because he's not critical,</p> <p>15 should he have not been transferred?</p> <p>16 A. My opinion will remain that he was not a</p> <p>17 critical patient. What decisions the jury draws from</p> <p>18 that testimony will be up to them.</p> <p>19 Q. So if I asked you at trial, "Okay, you say</p> <p>20 he's not a critical patient. Should he have not been</p> <p>21 transferred," are you going to answer that question at</p> <p>22 trial?</p> <p>23 A. I would offer you the same answer that I'm</p> <p>24 offering now and refer to the scope of the opinions for</p> <p>25 the physicians that made the decision related to</p>	<p style="text-align: right;">Page 64</p> <p>1 scope of my opinions related to a physician treatment</p> <p>2 decision, but that Mr. Schwartz at the time of the</p> <p>3 transport request was not critical.</p> <p>4 Q. Can you just say no, you don't intend to</p> <p>5 offer that opinion? Wouldn't that just make this a lot</p> <p>6 easier?</p> <p>7 MS. BLAZICH: He's answered your question,</p> <p>8 James, so you're badgering the witness at this point.</p> <p>9 MR. BURTON: I'm not badgering the witness.</p> <p>10 BY MR. BURTON:</p> <p>11 Q. Am I badgering you, Mr. Everlove?</p> <p>12 A. I appreciate your consideration of me, and</p> <p>13 I would offer the same answer to the previous question.</p> <p>14 That is, in an effort to be very clear about what my</p> <p>15 opinions will be, that I plan to testify to the jury</p> <p>16 that at the time of the transfer request, Mr. Schwartz</p> <p>17 was not critical as evident by his condition on scene</p> <p>18 and at the hospital.</p> <p>19 Q. In the hospital setting, whose</p> <p>20 determination is it as to whether or not the patient's</p> <p>21 injuries are critical?</p> <p>22 A. The in-the-hospital scenario is the</p> <p>23 physician of record and the treatment physician, in</p> <p>24 combination with the other staff members, such as the</p> <p>25 nurses and primary care providers.</p>
<p style="text-align: right;">Page 63</p> <p>1 Mr. Schwartz's transfer.</p> <p>2 Q. Is it your opinion that Mr. Schwartz could</p> <p>3 have been adequately treated at Northeastern Nevada</p> <p>4 Regional Hospital?</p> <p>5 A. I was not asked to offer that opinion. I</p> <p>6 believe that falls under the scope of the physicians</p> <p>7 that made the decision regarding the transfer of care</p> <p>8 and that would be outside of my scope of practice.</p> <p>9 Q. So you do not intend to offer an opinion as</p> <p>10 to whether or not he could have adequately been treated</p> <p>11 and stayed at Northeastern Nevada Regional Hospital?</p> <p>12 A. I believe I just gave you my best answer to</p> <p>13 that question.</p> <p>14 Q. Just yes or no. Do you intend to offer an</p> <p>15 opinion as to whether or not Mr. Schwartz could have</p> <p>16 been treated adequately at Northeastern Nevada Regional</p> <p>17 Hospital and not been transferred?</p> <p>18 MS. BLAZICH: Objection. Asked and</p> <p>19 answered.</p> <p>20 THE WITNESS: I believe I've given you my</p> <p>21 best answer.</p> <p>22 BY MR. BURTON:</p> <p>23 Q. You can't give a yes-or-no answer to that?</p> <p>24 A. I believe I've given you the best answer,</p> <p>25 and that answer is that that would fall outside of a</p>	<p style="text-align: right;">Page 65</p> <p>1 Q. Meaning the physician gathers input from</p> <p>2 others, but ultimately, the physician determines if the</p> <p>3 patient is critical or not; correct?</p> <p>4 A. Yes. That's my understanding.</p> <p>5 Q. And obviously, on scene, the paramedics can</p> <p>6 make a determination if they think the patient is</p> <p>7 critical or not; correct?</p> <p>8 A. They can give an opinion regarding patient</p> <p>9 severity, yes.</p> <p>10 Q. But once we get into the hospital, the</p> <p>11 ultimate decision as to whether or not a patient is</p> <p>12 critical does not rest with the paramedics; correct?</p> <p>13 A. The paramedics that transport the patient</p> <p>14 to the hospital or the paramedics and flight crew or</p> <p>15 staff members that are responsible for the</p> <p>16 transportation of the patient from the hospital?</p> <p>17 Q. Fair question. I'll break it down.</p> <p>18 Once the paramedics that transport to the</p> <p>19 hospital transport the patient, they no longer make the</p> <p>20 determination if he's critical because the attending</p> <p>21 would make that determination; correct?</p> <p>22 A. Yes. That's correct.</p> <p>23 Q. And the nurse doesn't make the</p> <p>24 determination if the patient is critical; correct?</p> <p>25 They may give input, but they don't make the</p>

<p style="text-align: right;">Page 66</p> <p>1 determination; correct?</p> <p>2 A. I'm sorry, in beginning to answer your</p> <p>3 question I cut off. Could you please repeat?</p> <p>4 Q. Yeah.</p> <p>5 And I think we took turns cutting each</p> <p>6 other off so my apologies. I think I actually cut you</p> <p>7 off first.</p> <p>8 The nurse may give input as to the status</p> <p>9 of the patient, whether he or she is critical, but</p> <p>10 ultimately, the determination if the patient is</p> <p>11 critical lies with the physician; correct?</p> <p>12 A. Determination is a difficult word because</p> <p>13 there may be critical lab values, critical findings</p> <p>14 that are denoted by another physician, as you pointed</p> <p>15 out, a radiologist or someone else in the care of the</p> <p>16 patient that may find something critical that another</p> <p>17 physician does not. So that's why I clarified, the</p> <p>18 determination is a combination of opinions potentially,</p> <p>19 or one opinion from one of the treatment or care</p> <p>20 providers.</p> <p>21 Q. Fair enough.</p> <p>22 The decision as to whether or not a patient</p> <p>23 is critical, the ultimate decision, that lies with the</p> <p>24 physician; right?</p> <p>25 A. I believe I've just given you the best</p>	<p style="text-align: right;">Page 68</p> <p>1 BY MR. BURTON:</p> <p>2 Q. Well, you read Dr. Garvey's transcript,</p> <p>3 didn't you?</p> <p>4 A. Yes, I did.</p> <p>5 Q. And you know that he called the University</p> <p>6 of Utah after Mr. Schwartz came to the hospital; right?</p> <p>7 A. Yes. I'm aware of that.</p> <p>8 Q. And the receiving physician at the</p> <p>9 University of Utah said that he would accept transfer.</p> <p>10 Do you agree with that?</p> <p>11 A. I recall that testimony, yes.</p> <p>12 Q. And Dr. Garvey decided to proceed with the</p> <p>13 transfer, you would agree with that?</p> <p>14 A. Yes.</p> <p>15 Q. All right.</p> <p>16 Let's talk about transfer. In your report</p> <p>17 you say that the -- that -- I don't want to put words</p> <p>18 in your mouth -- that the transport from the scene to</p> <p>19 the hospital was without lights and sirens.</p> <p>20 Do you recall that?</p> <p>21 A. Yes. I recall that statement.</p> <p>22 Q. Are you using that statement as support for</p> <p>23 the fact that this was not a critical injury?</p> <p>24 A. Not by itself. But yes, that was part of</p> <p>25 my evaluation.</p>
<p style="text-align: right;">Page 67</p> <p>1 answer to the same question.</p> <p>2 Q. In your experience, do hospitals routinely</p> <p>3 transfer patients for whom they're able to adequately</p> <p>4 provide health care?</p> <p>5 MS. BLAZICH: Objection. Calls for</p> <p>6 speculation.</p> <p>7 THE WITNESS: The term "adequate" may be</p> <p>8 subject to interpretation, and there are numerous</p> <p>9 reasons why facilities transport patients from one</p> <p>10 facility to another.</p> <p>11 BY MR. BURTON:</p> <p>12 Q. All right. Let's be specific then.</p> <p>13 In this setting, would you agree that</p> <p>14 Dr. Garvey made the determination that he needed to</p> <p>15 transfer Mr. Schwartz because they couldn't provide him</p> <p>16 adequate care at Northeastern Nevada Regional Hospital?</p> <p>17 MS. BLAZICH: Objection. Assume facts not</p> <p>18 in evidence. Lacks foundation.</p> <p>19 THE WITNESS: As this was not part of my</p> <p>20 opinion and evaluation, I'm reluctant to give you an</p> <p>21 off-the-cuff answer. I don't recall whether that was a</p> <p>22 sole decision, a collaborative decision between</p> <p>23 receiving facility, and how exactly that determination</p> <p>24 was made, or conversation with radiologists and other</p> <p>25 care providers.</p>	<p style="text-align: right;">Page 69</p> <p>1 Q. Have you ever in your -- how many ambulance</p> <p>2 runs do you think you've done in your career?</p> <p>3 A. I would estimate a few thousand.</p> <p>4 Q. Have you ever transported a critical</p> <p>5 patient not using lights and sirens?</p> <p>6 A. Not to the best of my recollection.</p> <p>7 Q. I want you to think about it. Think back.</p> <p>8 I know you've got a long career. Can you think of any</p> <p>9 time where you had a critical patient and you didn't</p> <p>10 turn your lights on or your sirens?</p> <p>11 A. Specifically, a critical patient like the</p> <p>12 scenario with Mr. Schwartz; correct.</p> <p>13 Q. No. I'm saying critical based on your</p> <p>14 earlier definition of critical.</p> <p>15 A. As I sit here, I don't recall any scenario</p> <p>16 like that.</p> <p>17 Q. Do you know how far -- or how much time is</p> <p>18 saved on average using lights and sirens versus not</p> <p>19 using lights and sirens?</p> <p>20 A. That's a broad hypothetical. It depends on</p> <p>21 the location and the availability of resources.</p> <p>22 Q. Are you aware of any studies that analyze</p> <p>23 that question, whether lights and sirens actually save</p> <p>24 time when transporting a patient?</p> <p>25 A. In regards to policies and procedures for</p>

<p style="text-align: right;">Page 70</p> <p>1 Nevada or generalized studies? 2 Q. Generalized. 3 A. Generalized studies, I know that there have 4 been studies. I don't recall related to the transport 5 of patients to facilities. I do recall studies related 6 to the initial response of resources, in a 911 7 environment, that there are certain circumstances where 8 they do not increase survivability. 9 Q. Do you know how far it was from the scene 10 to Northeastern Nevada Regional Hospital? 11 A. The records, I believe for Elko Ambulance, 12 I would have to review them to verify the exact 13 distance. 14 Q. As you sit here, and this isn't a test and 15 I just want -- do you have any approximation of how far 16 it is? 17 A. I don't recall the exact mileage, but I 18 know it's listed in the patient care report for Elko 19 Ambulance. 20 Q. Do you know if there were -- how many 21 stoplights there were between the scene and the 22 hospital? 23 A. I don't recall that, no. 24 Q. Have you ever looked on a map to see what's 25 located between the restaurant where Mr. Schwartz was</p>	<p style="text-align: right;">Page 72</p> <p>1 sirens would have been used? 2 A. Saved any time? That's a broad reference. 3 Certainly, lights and sirens would enable somebody to 4 get to a location more quickly, even if they were able 5 to come in contact with one vehicle that yielded to 6 them. So any, yes. I would offer the opinion lights 7 and sirens are there for a purpose, to save time in 8 transportation of patients to the hospital. 9 Q. Have you reviewed the Elko County EMS 10 protocols as to when they should or should not use 11 lights and sirens? 12 A. I don't recall specifically Elko. I recall 13 reviewing the Nevada protocols related to the priority 14 transportation of patients. And as part of it -- 15 Q. Sorry. Go ahead. 16 A. As part of the standard of care in all of 17 the educational materials, that the utilization of 18 lights and sirens is for transporting priority or 19 critical patients. 20 Q. But you have not reviewed Elko's policies, 21 correct, Elko EMS? 22 A. I don't recall. 23 Q. And you've not reviewed Elko's policies as 24 to what constitutes a critical versus noncritical 25 patient?</p>
<p style="text-align: right;">Page 71</p> <p>1 hit and the hospital? 2 A. I do recall looking at the map. I don't 3 recall the distance. 4 Q. Have you ever been to Elko, Nevada? 5 A. I have not. 6 Q. You're going to get a chance it sounds like 7 in this case. 8 Do you know if it's a busy metropolitan 9 area? 10 A. To the best of my knowledge, it is not. 11 Q. Do you know if it has a lot of traffic at 12 8:30 at night? 13 A. I couldn't speak to that. I don't think it 14 would be appropriate since I -- I'm not familiar with 15 the traffic patterns at 8:30 at night in Elko. 16 Q. Do you have an opinion as to how much time 17 would have been saved if lights and sirens would have 18 been used versus not lights and sirens in transporting 19 Mr. Schwartz? 20 A. I have an opinion that that's not part of 21 the policy consideration as it relates to using 22 emergency systems to rapidly transport patients that 23 are critical or priority and unstable. 24 Q. But you don't have an opinion as to whether 25 or not it would have saved any time if lights and</p>	<p style="text-align: right;">Page 73</p> <p>1 A. Yes. That's correct. 2 Q. Let's talk about Dr. Garvey's role. 3 Is it your opinion that Dr. Garvey was 4 functioning as the REACH medical director on call when 5 Mr. Schwartz was brought to the emergency department in 6 June of 2016? 7 A. I believe the testimony was that he was not 8 functioning as an assistant medical director for REACH. 9 Q. And in fact, if there was a reportable 10 incident, Dr. Garvey would not be who the REACH crew 11 would have called then; correct? 12 A. Correct. Yes. They would have contacted 13 the medical director or assistant medical director on 14 call, and done that through their operation center. 15 And I believe there was a notification made, but I 16 don't recall seeing any report related to that 17 notification. 18 Q. In your report you indicate that Dr. Garvey 19 was the attending and the REACH medical director. Was 20 there some reason why you listed him also as the REACH 21 medical director? 22 A. Because he identified that in his 23 testimony, as part of his roles and responsibilities. 24 If I recall -- 25 Q. Sorry, the pause, every time I think you're</p>

<p style="text-align: right;">Page 74</p> <p>1 done. I'm not trying to interrupt you.</p> <p>2 A. I appreciate that and I understand it is a</p> <p>3 challenge, so thank you. No problem.</p> <p>4 It's my recollection of the testimony that</p> <p>5 Mr. Garvey -- I'm sorry, Dr. Garvey was the attending</p> <p>6 physician, and also listed as his employment the</p> <p>7 assistant medical director position. Therefore, I</p> <p>8 utilized it as a reference in my report, that he was</p> <p>9 aware of or at least familiar with the policies and</p> <p>10 procedures related to REACH.</p> <p>11 Q. Other than his awareness of the REACH</p> <p>12 policies, procedures and protocols, is the fact that</p> <p>13 Dr. Garvey was a REACH medical director significant in</p> <p>14 any other way for purposes of your opinions?</p> <p>15 A. If your questions related to the legal</p> <p>16 distinction as to who was in charge of the patient,</p> <p>17 then my listing wasn't referring to that portion. It</p> <p>18 was referring more to a -- an enhanced understanding of</p> <p>19 the nature of the roles and responsibilities for the</p> <p>20 REACH medical team, transportation providers and the</p> <p>21 responsibilities related to the policies and</p> <p>22 procedures.</p> <p>23 Q. What is your understanding of</p> <p>24 Mr. Bartlett's -- prior to this event, his work</p> <p>25 experience as a flight paramedic?</p>	<p style="text-align: right;">Page 76</p> <p>1 based on the records that I've reviewed, my opinion is</p> <p>2 that he was under the evaluation of Ronnie Lyons. He</p> <p>3 was a trainee of Mr. Lyons. And he was being trained</p> <p>4 on REACH policies, procedures, protocols and the</p> <p>5 medical transportation tasks of REACH Air Medical.</p> <p>6 Q. All right.</p> <p>7 Would you agree that Mr. Bartlett has</p> <p>8 significantly more flight paramedic experience than you</p> <p>9 do?</p> <p>10 A. Yes.</p> <p>11 Q. Let's talk about airway assessments.</p> <p>12 Do you train students? Like EMT, paramedic</p> <p>13 students; right?</p> <p>14 A. Yes, I have.</p> <p>15 Q. What type of visual assessment of a patient</p> <p>16 do you instruct your students to do when encountering a</p> <p>17 patient? Focusing on the phrase "visual assessment."</p> <p>18 A. The standard of care calls for an</p> <p>19 assessment of the patient's airway prior to any</p> <p>20 advanced airway procedures. That assessment includes</p> <p>21 the visual inspection, a patient opening their mouth,</p> <p>22 being able to do a Mallampati visual assessment. There</p> <p>23 are also several assessments related to the mnemonics,</p> <p>24 that I used, Mr. Byrd used, related to LEMON and DOPE.</p> <p>25 And I believe all of those are consistent with a visual</p>
<p style="text-align: right;">Page 75</p> <p>1 A. He had extensive work experience.</p> <p>2 Q. Would you say he was qualified, had</p> <p>3 experience as a certified flight paramedic?</p> <p>4 A. I don't know that that would be an opinion</p> <p>5 that I would offer. I recognize from his resumé that</p> <p>6 he had significant experience.</p> <p>7 Q. Do you remember how many RSIs Mr. Bartlett</p> <p>8 had performed over the course of his career?</p> <p>9 A. I don't recall his testimony specifically</p> <p>10 to RSIs, but I remember him stating something to the</p> <p>11 effect of thousands of intubations, if I recall</p> <p>12 correctly.</p> <p>13 And to clarify the distinction between the</p> <p>14 two, again, as a paramedic, the placement of an</p> <p>15 endotracheal tube can be on those patients that are</p> <p>16 unconscious, unresponsive, not related to the</p> <p>17 medication administration. RSI is the administration</p> <p>18 of the medications by another provider. So from a</p> <p>19 paramedic's perspective, the procedure is unchanged.</p> <p>20 Q. In your report you refer to Mr. Bartlett as</p> <p>21 a trainee. You're not saying that he was</p> <p>22 inexperienced, he just was in a training role at REACH,</p> <p>23 would you agree?</p> <p>24 A. When you use the term "inexperienced," that</p> <p>25 could apply to a lot of different things. I think,</p>	<p style="text-align: right;">Page 77</p> <p>1 inspection.</p> <p>2 Some involved the introduction of fingers</p> <p>3 into a patient's mouth to also measure distances, to</p> <p>4 determine whether a patient is a difficult airway or</p> <p>5 not.</p> <p>6 Q. So I used to be an EMT and I remember in my</p> <p>7 training that they would tell us, "The moment you walk</p> <p>8 in, you start your visual observation of the patient.</p> <p>9 How they're interacting, how they're responding, how</p> <p>10 they're verbalizing, how they're moving."</p> <p>11 Would you agree that that's part of the</p> <p>12 training?</p> <p>13 A. Yes. That is part of the EMT training</p> <p>14 specifically related to scene size-up and most often</p> <p>15 applies to on-scene calls. It includes forming a</p> <p>16 general impression of the patient, which is that visual</p> <p>17 assessment of cues from the environment, and their</p> <p>18 presentation that helps determine initially what may be</p> <p>19 wrong with the patient.</p> <p>20 Q. Let's talk specifically in a hospital</p> <p>21 setting.</p> <p>22 If a crew comes in, a flight crew, it's a</p> <p>23 flight paramedic, and they know they're going to come</p> <p>24 in and intubate a patient prior to transport, would you</p> <p>25 agree that part of their assessment is a visual</p>

<p style="text-align: right;">Page 78</p> <p>1 assessment of how is the patient talking, how does his 2 anatomy work, does he have any injuries, things of that 3 nature? 4 A. So I think I'd like to back up to your 5 hypothetical. 6 If I understand you correctly, a flight 7 crew comes in with a ground transport unit, is going to 8 transport a patient by air and they intend to intubate 9 the patient, that's a very difficult hypothetical. 10 I don't recall being in a situation where a 11 patient required treatment and transportation, via air 12 or ground, that the primary transport providers were 13 the ones that were going to intubate the patient. 14 Q. So you would agree that's generally the 15 fact scenario we have in this case? And I'm not trying 16 to play word games or trick you. I'm trying to create 17 a hypothetical that's similar to our case here. 18 A. Thank you. I appreciate that, nor am I 19 trying to be evasive, but I don't recall that the REACH 20 Air Medical team knew when they walked in that they 21 were going to be intubating the patient. 22 Q. All right, but at some point they knew. 23 I'm not saying that they knew on the drive over that 24 dispatch says, "Hey, you're going to intubate the 25 moment you get there." That's not what I'm saying.</p>	<p style="text-align: right;">Page 80</p> <p>1 A. In a training role as a paramedic trainee, 2 then yes, we routinely performed intubations in the 3 hospital. 4 Q. Let's talk about in a critical care 5 transport, where you were taking a patient from one 6 hospital to another hospital. Have you ever intubated 7 a patient prior to transport from the sending hospital? 8 A. Absolutely not. 9 Q. Okay. 10 In your report you use the phrase 11 "comprehensive primary assessment" and "comprehensive 12 secondary assessment." 13 What is the difference between the two? 14 A. The primary assessment involves the 15 evaluation of immediate life threats, airway, 16 breathing, circulation. Some of those may be obtained 17 by the scene size-up as you described, when you first 18 walk in, to visualizing a patient. 19 The secondary assessment is the more 20 detailed assessment that would be applicable to a 21 patient that's going to be under your care. 22 The primary and secondary assessment don't 23 differentiate between a scene call or an interfacility 24 transport. They're the responsibility for any medical 25 provider that is going to assume care of a patient.</p>
<p style="text-align: right;">Page 79</p> <p>1 They become aware that they're going to 2 intubate the patient. Would you agree, that in that 3 scenario, part of the assessment includes a visual 4 assessment of the patient, the anatomy, how's the 5 patient talking, are there any deformities, anything 6 that we need to be worried about, without physically 7 touching the patient? 8 A. I appreciate your hypothetical, and I 9 understand you're asking me specifics related to the 10 intubation airway assessment within the standard of 11 care, but the premise that they were going to be the 12 ones intubating the patient is a significant hurdle I 13 can't clear. 14 Q. Okay. 15 A. The fact that they were going to be the 16 ones performing a surgical intervention on a patient, 17 because that patient needed to be stabilized for 18 transport, is a difficult part of this fact pattern for 19 the hypothetical and I'm maybe complaining to. 20 Q. Let's talk about your experience. 21 In all of your experience, have you ever 22 intubated a patient in the hospital setting? 23 A. Yes. In a training role, I have absolutely 24 intubated patients in a hospital setting. 25 Q. What do you mean by "in a training role"?</p>	<p style="text-align: right;">Page 81</p> <p>1 Q. All right. 2 Let's talk about -- do you intend to offer 3 any opinion at trial that Dr. Garvey did not obtain 4 consent for the intubation of Mr. Schwartz? 5 Let me make it more specific. I think it 6 will be easier for you to answer. 7 Do you intend to offer any opinion at trial 8 that Dr. Garvey did not obtain consent for him to do an 9 intubation of Mr. Schwartz? 10 A. I don't intend to offer an opinion 11 regarding Dr. Garvey. 12 Q. In your report you talk extensively about 13 the use of REACH equipment and the use of REACH 14 medications. Is the use of REACH equipment or 15 medications, is that a significant fact for purposes of 16 your opinions? 17 A. It is part of the fact pattern that is 18 significant. It includes the movement of the patient 19 over to REACH's transportation gurney, or in this case, 20 the transportation gurney that was going to be used to 21 move Mr. Schwartz by ground to the aircraft. 22 And the utilization of their equipment, 23 because Mr. Schwartz was hooked up to their equipment, 24 at the time that they were asked to perform this 25 procedure or intervention.</p>

<p style="text-align: right;">Page 82</p> <p>1 Q. And how is that significant for purposes of 2 your opinions? 3 A. It denotes a transfer of care. 4 Q. A total transfer, or the start of a 5 transfer of care? 6 A. It denotes a transfer of care. The 7 patient's been moved to a transportation gurney. And 8 in this case, documentation was provided to them, an 9 off-going report was provided to them, according to the 10 nursing staff. And they had retained care of the 11 patient and the transfer of care, again, to the best of 12 my understanding of the document, had taken place. 13 Q. So when you say REACH retained care of the 14 patient, had Dr. Garvey given up care of the patient at 15 that point? 16 A. Based on my understanding of the records, 17 yes. 18 Q. So at what point -- be very specific here. 19 At what point did Dr. Garvey give up care of the 20 patient in your opinion? 21 A. Based on my review of the transport consent 22 form that was signed, the documentation that was 23 furnished to Mr. Lyons, Mr. Lyons had received an 24 off-going report from the nurse, primary caregiver, to 25 Mr. Schwartz, and the patient was moved over to their</p>	<p style="text-align: right;">Page 84</p> <p>1 Q. Are familiar with the phrase "procedural 2 timeout"? 3 A. Yes. 4 Q. Have you participated ever in a procedural 5 timeout in a hospital setting? 6 A. Yes, I have. 7 Q. How do those generally work in your 8 experience? 9 A. In my experience, there is a discussion 10 prior to the interventions about risks, complications, 11 needs of the procedure, and assignment of roles and 12 responsibilities, ensuring equipment is available, and 13 ensuring that all of the parties involved in the care 14 are familiar with their -- with the expectations. And 15 also, an understanding of what is going to be a cutoff 16 point and when decisions are going to be made to alter 17 the course based on a change in patient condition. 18 Q. Based on your experience, you would agree 19 that these procedural timeouts usually occur 20 immediately prior to a procedure; correct? 21 A. "Usually" is a difficult term. I can't 22 quantify usually, but the timeout is indicated within 23 the standard of care prior to performing interventions. 24 Q. And you're not talking three hours prior 25 to, but very soon before the invention is performed;</p>
<p style="text-align: right;">Page 83</p> <p>1 gurney, REACH's gurney. That was the transfer of care. 2 All of that took place in the context of the transfer 3 of care. 4 Q. But you would agree that after this point 5 in time that you talk about, care was still provided to 6 Mr. Schwartz by the hospital staff; correct? 7 A. Yes. That's correct. 8 Q. And care was still provided to Mr. Schwartz 9 after this point by Dr. Garvey; correct? 10 A. Yes. That's correct. 11 Q. So help me understand, then, what -- how 12 could Dr. Garvey have given up care of the patient 13 while still providing care? 14 A. That is a challenge to the fact pattern. 15 There are really two scenarios. 16 One scenario is that transfer of care took 17 place, Dr. Garvey came in with a new request and did 18 not take back the care of Mr. Schwartz. 19 The second scenario is that the REACH 20 medical crew was providing care without consent from 21 Mr. Schwartz, and the care was provided by Dr. Garvey 22 and both of those crew members. 23 And I'm unable to come up with a third 24 scenario, but those appear to be the two scenarios in 25 the fact pattern.</p>	<p style="text-align: right;">Page 85</p> <p>1 correct? 2 A. It is in close context, yes. 3 Q. When a procedural timeout is called, people 4 don't say, "Hey, hold on, I'm going to go eat lunch and 5 I will be back and we'll do this procedure," in your 6 experience; right? 7 A. I have not had that happen. 8 Q. Meaning we do the procedural timeout and 9 proceed to the procedure. That's been your experience; 10 correct? 11 A. Yes. 12 Q. Are you aware if a procedural timeout 13 occurred in this case? 14 A. I understand there's conflicting testimony 15 as to whether that occurred or not. According to 16 Mr. Lyons, it did not, and it did not meet the 17 procedural timeout as I described to you in the 18 standard of care. I understand that term was used, 19 though, by Dr. Garvey, and if I recall correctly, or 20 another caregiver in the room. 21 Q. So it's your testimony, based on your 22 understanding of the records, that Ronnie Lyons 23 testified that a procedural timeout did not occur, is 24 that what you're telling me? 25 A. My testimony is that a procedural timeout,</p>

<p style="text-align: right;">Page 86</p> <p>1 as I just outlined to you, based on my experience and 2 my familiarity with the standard of care, did not 3 occur. 4 Q. And you reviewed Ronnie Lyons's deposition 5 transcript; correct? 6 A. Yes. 7 Q. Do you recall if he was asked if a 8 procedural timeout occurred? 9 A. I recall the testimony. I don't recall the 10 specific questions. 11 Q. I want you to assume that a procedural 12 timeout occurred. 13 Would you have any -- is there anything 14 from the record that tells you that in a procedural 15 timeout, Dr. Garvey, in this instance, didn't say, "I'm 16 going to go do a chest tube and Barry Bartlett's going 17 to do the intubation"? Anything in the record that 18 supports that that discussion did not occur? 19 A. I believe the procedural timeout term is 20 very specific in its definition in the standard of 21 care. The statements that you just read to me are my 22 recollection of what took place. I don't connect those 23 two as being equal. One is not a procedural timeout. 24 The other, as I described, with all the detail that I 25 described, is a procedural timeout and the standard of</p>	<p style="text-align: right;">Page 88</p> <p>1 anybody voiced concerns during the procedural timeout 2 regarding the proposed procedure? 3 A. I recall that line of questioning or that 4 testimony. I don't recall the specifics of it. 5 Q. So if a procedural timeout occurred, how do 6 you square that? 7 I want you to assume that one occurred. If 8 a procedural timeout occurred and nobody voiced 9 objections, how does that square with your testimony 10 that Dr. Garvey never instructed the REACH crew what 11 they were doing? 12 A. I believe my answer earlier regarding what 13 a procedural timeout is is different, significantly 14 different, and within the standard of care, versus 15 Dr. Garvey looking at the REACH crew and saying, You 16 intubate and I'll place a chest tube. I'm 17 paraphrasing, but something along those lines. 18 Q. Do you recall if Ronnie Lyons was asked to 19 give a definition of what a procedural timeout was? 20 A. I recall the questions. I don't recall 21 the -- something along those lines. I don't recall his 22 testimony. 23 Q. Would it surprise you that his answer was, 24 "A procedural timeout is where everybody comes to a 25 stop. They focus on the person in charge. He then</p>
<p style="text-align: right;">Page 87</p> <p>1 care. 2 Q. Do you recall if Ronnie Lyons was asked if 3 a procedural timeout was an opportunity to voice any 4 concerns regarding the proposed procedure? 5 A. I don't recall that exact question, but I'm 6 going to believe that you're looking at the transcript 7 right now and asking me a question based on the 8 information you already have. Therefore, I -- 9 Q. I'm asking for your recollection. 10 A. Yes. 11 I recall that there was a conversation 12 regarding a role for the REACH crew and Dr. Garvey's 13 role related to placement of a chest tube and 14 intubation. 15 Q. My question was more specific. 16 Do you recall if Ronnie Lyons was asked if 17 a procedural -- sorry. 18 Do you recall if Ronnie Lyons was asked -- 19 let me totally start over. 20 Do you recall if Ronnie Lyons was asked if 21 a procedural timeout was the opportunity to voice any 22 concerns regarding the specific procedures? 23 A. I don't recall the exact question but I 24 recall testimony along those lines. 25 Q. Do you recall if Ronnie Lyons was asked if</p>	<p style="text-align: right;">Page 89</p> <p>1 tells you who the patient is, what the planned 2 procedures will be and everyone has to be in agreement. 3 Everyone has to have their equipment ready to proceed 4 before the next step is taken." 5 Does that sound like a definition of a 6 procedural timeout? 7 A. My definition is based on the records and 8 documents regarding the standard of care. And the 9 educational materials include several pieces that are 10 missing in that statement. Specifically -- 11 Q. Sorry. Go ahead. 12 A. Specifically related to risks, 13 complications, and also, what do you do when something 14 is not going as initially intended regarding a medical 15 procedure. 16 It also squares away, as you had stated, 17 the specific roles and responsibilities for medical 18 health caregivers in an environment that are all within 19 the context of consent. I believe that in this case, 20 the procedural timeout was also related to a transport 21 crew being involved in surgical interventions on a 22 patient that they didn't have a consent to treat. 23 Q. Is it your testimony that an intubation is 24 a surgical intervention? 25 A. It is an advanced intervention.</p>

<p style="text-align: right;">Page 90</p> <p>1 Q. I'm being specific as to surgical. You 2 used the phrase "surgical." 3 Is the intubation -- is that a surgical 4 intervention? Yes or no? 5 A. It could specifically be a surgical 6 intervention, yes, when it relates to a failed airway 7 that requires a cricothyrotomy. That's a surgical 8 intervention. 9 So when you're talking about the context of 10 intubation, and you lay out risks and complications, 11 that is a potential end point that you would get to and 12 it's a surgical procedure, as evidenced by the standard 13 of care that paramedics, physicians, nurse anesthetists 14 are isolated in the procedure of advanced airway 15 placement using intubation. 16 Q. But you would also agree that the 17 intubation is successful on the first attempt, when it 18 goes in, tube goes in, patient is intubated, that's not 19 a surgical intervention; correct? 20 A. As it stands alone, I don't recall whether 21 that was termed surgical. It is advanced airway 22 placement that involves surgical procedures. 23 Q. Do you know when in time the procedural 24 timeout described by Ronnie Lyons occurred with respect 25 to when did it occur in relation to the first</p>	<p style="text-align: right;">Page 92</p> <p>1 A. Yes, that's correct, it is not. 2 Q. But you -- have you ever seen a chest tube 3 inserted? 4 A. Yes. 5 Q. Have you ever seen it done in a hospital 6 setting? 7 A. Yes. 8 Q. Have you ever seen it done in a nonsterile 9 environment, as far as the one performing the chest 10 tube is not sterilized and the area is not sterilized? 11 A. When you say "not sterilized," so an OR -- 12 I'll give you my definition of what sterilized is. 13 An OR surgical suite or surgical operating 14 room would be sterile with certain procedural contexts 15 for that. 16 A surgical procedure, like the insertion of 17 a chest tube, requires sterile -- local sterilization 18 of the -- of the patient prior to insertion. So I 19 guess -- and it requires that the physician use sterile 20 gloves versus traditional exam gloves, and other types 21 of sterile instruments and surgical instruments that 22 have to be sterilized. So I -- 23 Q. Let me see if I can be more specific. I 24 was watching an episode of Chicago Med the other day. 25 A patient comes in, crashing, and boom, cut, the tube</p>
<p style="text-align: right;">Page 91</p> <p>1 intubation attempt? 2 A. My -- 3 Q. Sorry. I interrupted you there. 4 A. That's okay. I do take a minute to pause 5 and think about my answer to make sure that I'm 6 answering it to the best of my ability and that pause 7 throws people off. So I apologize. 8 The recollection I have is that it was a 9 procedural timeout using his definition or what he 10 believed to be a procedural timeout at the time prior 11 to the intubation attempt. 12 Q. Can you put any time to it? Was it 13 seconds? Minutes? Hours? 14 A. I don't recall a specific time. 15 Q. Do you recall if Dr. -- from your review of 16 the records -- I realize you weren't there. 17 From your review of the records, was 18 Dr. Garvey prepared to proceed with the chest tube when 19 he called the procedural timeout? 20 A. Prepared? I recall there was a sequential 21 order to it and there was intubation and prepping 22 Mr. Schwartz for chest tube placement. So prepared 23 versus prepping, I don't recall specifically. 24 Q. A chest tube is not within your scope of 25 practice; correct?</p>	<p style="text-align: right;">Page 93</p> <p>1 goes in. 2 That's not the scenario we have with 3 Mr. Schwartz. He's relatively stable. Do you have any 4 understanding, from your review of the record, that 5 Dr. Garvey did not take appropriate steps to sterilize 6 the area where the chest tube would be inserted and to 7 appropriately put on protective gear for himself that 8 would keep the area sterile? 9 A. Yeah, I agree that Mr. Schwartz was stable. 10 I agree with the observation regarding that he was 11 being prepped for a chest tube. Regarding the 12 procedural aspect of that, I don't intend to offer an 13 opinion regarding Dr. Garvey. 14 Q. I'm not asking you to offer an opinion. I 15 mean you've reviewed the record. Based on your 16 understanding, did Dr. Garvey take the steps to provide 17 a sterilized or safe chest tube insertion? 18 A. I don't recall evaluating the records for 19 that detail. 20 Q. Based on your review or your experience 21 with procedural timeouts, do you have any reason to 22 believe that Dr. Garvey, during the procedural timeout, 23 didn't say, "I'm going to do the chest tube. I'm ready 24 to go. Mr. Bartlett is going to do the intubation. 25 Everybody's got their equipment. Let's proceed,"</p>

<p style="text-align: right;">Page 94</p> <p>1 something along those lines? Not verbatim but that 2 general idea. 3 A. If what you're representing to me is what 4 happened, then that would be below the standard of care 5 for procedural timeouts. 6 And, it also offers the opportunity for the 7 REACH crew to say, "This is absolutely not something 8 that we can do without consent, without further 9 consideration of the risks, the consequences, the 10 cutoff points," as we discussed. And if the patient is 11 on their transport gurney, that is a surgical procedure 12 being performed on their transport gurney. And then an 13 intubation or advanced airway placement, which is a 14 high-risk event and procedure on their transport 15 gurney, clearly, there has been some discussion between 16 them and Dr. Garvey. This would all have been within 17 the context of a procedural timeout. 18 Q. Not my question. It's a long answer but I 19 would move to strike if we were at trial. My question 20 is very specific. 21 Is it really your opinion that the medical 22 team treating Mr. Schwartz in the ED did not know that 23 Barry Bartlett was the one who would attempt the 24 intubation? 25 A. It is my opinion from the records that the</p>	<p style="text-align: right;">Page 96</p> <p>1 If Dr. Garvey had been the one to attempt 2 the intubation, you don't disagree that he had consent 3 to do that; correct? 4 A. If that was the exact question that you 5 asked me, I agree that he had spoken to a family member 6 regarding the procedure of intubation. Consent would 7 be expressed and formed and require details to the 8 conversation that are disputed based on the facts. 9 Q. But there are facts that demonstrate -- and 10 I realize you can pick and choose which facts you want 11 to believe, but there are facts that say that 12 Dr. Garvey explained the process and got permission to 13 do it. 14 You would agree with that; correct? 15 A. So I would not parse the facts. Explaining 16 the process didn't give detail as to what that meant. 17 Therefore, understanding that you had asked me earlier 18 whether I intend to offer an opinion regarding 19 Dr. Garvey, if I assume for a hypothetical that full, 20 complete, expressed, informed consent was obtained for 21 the procedure by Dr. Garvey, then that hypothetical 22 would apply, yes, he received the consent. 23 Q. I'm not asking for a hypothetical. I'm 24 asking specifically, based on your review of the 25 records, did Dr. Garvey receive informed, expressed</p>
<p style="text-align: right;">Page 95</p> <p>1 REACH crew was asked to perform the intubation and a 2 decision was made that Barry Bartlett would do it. If 3 I remember the context of the testimony Ronnie Lyons 4 offered, he had delegated that or the procedure had 5 been delegated to Barry Bartlett. 6 Q. Who asked the REACH crew to do the 7 intubation? 8 A. My recollection is it was Dr. Garvey. 9 Q. In your report you say, "According to 10 Bartlett, he had no conversation with Dr. Garvey 11 regarding who was going to perform the intubation." 12 So is that characterized strictly -- you're 13 taking that from Mr. Bartlett's testimony or from the 14 testimony of everyone at large? 15 A. I believe Mr. Bartlett testified to that. 16 Mr. Lyons testified to the crew being asked to perform 17 it. Hence, the reason I included it in my report. 18 Q. You earlier agreed that Dr. Garvey had 19 consent. If he would have performed the intubation, he 20 had consent to do that; correct? 21 MS. BLAZICH: Objection. Misstates the 22 testimony. 23 BY MR. BURTON: 24 Q. I'm not trying to misstate your testimony. 25 I asked you a question earlier.</p>	<p style="text-align: right;">Page 97</p> <p>1 consent for intubation? 2 A. And I believe those are facts in dispute. 3 Q. So is that a no, he did not receive 4 consent, or yes, he did? 5 A. I'm not a trier of fact. I'm offering the 6 opinion that those facts are in dispute. 7 Q. So be more specific. When you say "those 8 facts are in dispute," are you saying that there is not 9 testimony where Dr. Garvey explained the process and 10 got permission to do the process? 11 A. That wasn't my answer and that wasn't the 12 question. The question was: Did he receive expressed, 13 informed consent? And my answer was that there is 14 testimony that he did and testimony that he didn't. 15 It's a dispute of the facts. 16 Q. Okay. That's helpful. 17 Tell me what you mean by "expressed and 18 informed consent." 19 A. Actually, to give it, I'd rather give you 20 the definition within the documentation. 21 Q. I'm just asking for your understanding of 22 what expressed and informed consent is. 23 A. It's based on my understanding of the 24 standard of care related to consent. And it is defined 25 very specifically, so I'd like to read it if I could.</p>

<p style="text-align: right;">Page 98</p> <p>1 Q. What are you reading from? It looks like 2 you have something other than your binder in front of 3 you. 4 A. Yes, that's correct. This is one of the 5 textbooks that I referenced in my report as being 6 supporting documentation. It's a paramedic textbook. 7 Specifically, it's the Mosby's textbook, 4th edition. 8 It's states, "Informed consent is patient 9 consent that signifies the individual knows, 10 understands and agrees to the care rendered. This 11 consent is given based on full disclosure of the 12 information. Verbal or written consent to the 13 treatment is called expressed consent. 14 "Implied consent is different," and then it 15 goes on to discuss it. So informed, expressed consent 16 is, therefore, a full understanding of the risks, 17 benefits and acknowledgment of those risks and benefits 18 with authorization for anyone who treats the patient. 19 Q. All right. 20 I want you to assume that Dr. Garvey had 21 express and informed consent. Are you with me? 22 A. Yes, I am. 23 Q. If Dr. Garvey had expressed and informed 24 consent to perform the intubation -- if he had assigned 25 that intubation to be done by a respiratory therapist,</p>	<p style="text-align: right;">Page 100</p> <p>1 as to what an RT would do. 2 BY MR. BURTON: 3 Q. You can go ahead and answer. 4 A. My best answer is it depends. It depends 5 on the -- the scenario that you provided has a lot of 6 issues related to the relationship between the staff 7 and the RT or any of the caregivers in the hospital 8 environment. 9 Q. Let me ask it this way: Is there a 10 scenario where the express -- again, assume the 11 informed consent of Dr. Garvey. 12 Is there a scenario where that consent, 13 expressed and informed, would apply to a hospital 14 employee, meaning the hospital employee would not need 15 to get additional consent? 16 A. And my best answer is it depends. It 17 certainly wouldn't apply to a medical transportation 18 team. 19 Q. And that's not my question. 20 A. That's the part that I reviewed. 21 Q. That's not my question. 22 My question is: Give me a scenario where a 23 doctor who has expressed, informed consent to perform 24 an intubation can delegate that to a hospital employee, 25 another hospital employee, and that hospital employee</p>
<p style="text-align: right;">Page 99</p> <p>1 employed by the hospital, would the informed and 2 express consent obtained by Dr. Garvey had applied -- 3 would that apply to the RT as well? 4 A. It may or it may not, depending on the role 5 of the RT within the hospital system, and whether the 6 respiratory therapists were part of the employees of 7 the hospital or, as by hospital policy, fall under the 8 consent of the emergency department physician. 9 There are subcontracted roles and 10 responsibilities that isolate specific issues related 11 to consent. And for the support of that opinion, if 12 you were to go to get an x-ray, for instance, as you 13 discussed earlier, depending on the nature of that, 14 that may require a separate consent for that procedure. 15 Q. I'm not -- I'm being very specific. 16 I want you to assume Dr. Garvey has 17 expressed, informed consent and the RT is an employee 18 of the hospital. Does that RT -- and that RT is asked, 19 by Dr. Garvey, to do the intubation. 20 Does that RT need to say, "I can't do it 21 until I re-explain to the patient the risks, the 22 procedure, and I get their verbal approval based on a 23 full understanding of the process"? Does the RT need 24 to do that? 25 MS. RIES-BUNTAIN: Objection. Foundation</p>	<p style="text-align: right;">Page 101</p> <p>1 does not need to go get their own separate expressed 2 and informed consent. Does that make sense to you? 3 A. I believe I understand the question that 4 you're asking me. So in that case, yes, it makes 5 sense. But regarding the hypothetical, there are so 6 many different environments where there would need to 7 be separate consents for a procedure or for a caregiver 8 within that environment -- 9 Q. That's not my question. 10 Sir, my question is this: Give me a 11 scenario where that hospital employee would not need to 12 go get their own separate consent. I understand there 13 are lots where it would be problematic. I want you to 14 give me an example where they wouldn't need to, if you 15 can. And if you can't, that's fine. I'll move on. 16 MS. BLAZICH: I'm just going to object that 17 this is outside the scope of his expert opinions. 18 MR. BURTON: It's not. It's squarely 19 within the scope of his informed consent opinions. 20 BY MR. BURTON: 21 Q. Go ahead. 22 A. I wasn't finished with my earlier answer. 23 Q. Well, I want you to answer the question I'm 24 actually asking. 25 A. I appreciate that.</p>

<p style="text-align: right;">Page 102</p> <p>1 So in answer to your question, it depends. 2 Q. Can you give me a scenario where a hospital 3 employee would not need to go get their own separate 4 informed consent? Can you do that? 5 MS. RIES-BUNTAIN: Objection, foundation. 6 MS. BLAZICH: Join, and same objection as 7 before. 8 THE WITNESS: It is a broad hypothetical 9 that I can't give a blanket answer to. 10 BY MR. BURTON: 11 Q. Can you give any specific answer? I'm not 12 asking for a blanket answer. I'm asking, can you give 13 any example, based on your years of experience and your 14 expertise, where a doctor's informed consent would 15 apply to a separate hospital employee who would then 16 not need to go get their own informed and expressed 17 consent? 18 MS. BLAZICH: Same objection. 19 MS. RIES-BUNTAIN: Join. 20 THE WITNESS: Again, it depends. The 21 hypothetical is too broad. I would need more 22 specifics. 23 BY MR. BURTON: 24 Q. All right. What if it was an attending and 25 a resident? The attending gets the expressed, informed</p>	<p style="text-align: right;">Page 104</p> <p>1 into the room and say, "You know what, I already got 2 your approval. I'm actually going to have the resident 3 do that, are you okay with it?" 4 A. That's a different hypothetical than you 5 just asked me. My answer to the previous hypothetical 6 was that the attending physician is responsible for the 7 resident physician. And that if the attending 8 physician and resident physician aren't there at the 9 same time, to obtain informed, expressed consent in 10 written or verbally expressed form, then both have an 11 obligation to get that consent before the procedure. 12 And if I may, also, again, you're asking me 13 questions regarding a resident in a training capacity 14 related to a training hospital, which -- with which a 15 patient would sign a consent at the moment they come 16 into the hospital, acknowledging it's a training 17 hospital and allowing them to be treated by students. 18 Q. If the resident was standing in the room 19 when the attending received the informed, expressed 20 consent, you wouldn't need to get a separate informed, 21 expressed consent for the resident to do it; correct? 22 A. I believe I've given you my best answer, 23 which includes that portion of the hypothetical. 24 Q. Would you need -- 25 A. Generally speaking --</p>
<p style="text-align: right;">Page 103</p> <p>1 consent to do the intubation and delegates it to 2 resident. Does the resident need to go in and say, "I 3 need to go get my own informed consent to do the 4 procedure"? 5 MS. BLAZICH: Same objection. 6 THE WITNESS: In that scenario, there's a 7 training relationship and the resident is a trainee as 8 identified under the hospital policies and procedures, 9 or for the institution with which they're being 10 educated. That would require consent from the 11 overseeing physician or primary care provider for the 12 training physician, and the training physician would 13 still need to reiterate the procedure to the patient 14 and receive their own informed consent. Understanding 15 that the issues to consent, as you describe, are not 16 applicable in the same way to the medical 17 transportation crew scenario that is related to the 18 Schwartz case. 19 BY MR. BURTON: 20 Q. I'm not asking about that. 21 So is it your testimony -- and I'm not 22 trying to misstate your testimony. I'm trying to 23 understand. 24 Is it your testimony, in a resident 25 hypothetical, that the attending would need to go back</p>	<p style="text-align: right;">Page 105</p> <p>1 Q. Would you or would you not need the 2 additional consent? 3 A. I believe I gave you the best answer I just 4 could give you. And generally speaking, when you're 5 performing high-risk interventions, such as advanced 6 airway management secondary to sedation and paralytics, 7 you must obtain consent for that as you would other 8 treatments. 9 Q. What if it was a nurse, experienced in 10 intubation, and the physician had obtained consent and 11 the nurse was in the room when the consent was 12 obtained? 13 Would the physician need to specifically 14 say, "I'm giving your consent for the nurse to do it," 15 or is he just getting consent for the procedure? 16 A. Consent includes informed patient 17 understanding of the procedure, which would include who 18 is performing the procedure. 19 Q. And in every scenario it's your testimony 20 that the patient -- that the patient is always informed 21 who specifically will be performing the procedure; is 22 that your testimony? 23 A. My testimony to your hypothetical was that, 24 yes, if there's a procedure being performed on a 25 patient, that requires expressed and informed consent.</p>

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1 The informed consent would include the caregiver
2 performing the procedure.
3 Q. Have you ever been in an emergency
4 department and given a hand to the care that's being
5 provided to some patient in the ED?
6 A. I don't understand what you mean by "giving
7 a hand." Could you be more specific?
8 Q. You really -- you don't know what I mean
9 when I say "giving a hand"?
10 A. Mr. Burton, I'm asking you to clarify what
11 you mean by "giving a hand," because that could fall
12 under many categories.
13 Q. All right, I'll be specific. I'm sorry you
14 didn't understand what giving a hand means.
15 Have you ever assisted in patient care in
16 the emergency department?
17 A. Yes.
18 Q. Have you ever assisted in patient care in
19 the emergency department on a patient that you did not
20 just transport into the hospital?
21 A. Yes.
22 Q. Have you ever assisted on patient care in
23 the emergency department on a patient that you didn't
24 just transfer in or that you don't intend to transfer
25 out?

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1 A. Yes.
2 Q. So, for example, the hospital -- the ED is
3 busy and someone says, "Hey, can you go start a line
4 for me?"
5 A. Yes.
6 Q. And then I assume you've done that many
7 times over the course of your career.
8 A. I wouldn't say many times, no.
9 Q. How many times do you think you've done
10 that?
11 A. I don't think I could estimate, but I would
12 say maybe 20 times in my career, that's happened.
13 Q. In the 20 times that you did that, did you
14 always fill out a trip report with your EMS agency for
15 that care that you assisted on in the emergency
16 department, on the patient you hadn't just transported
17 or you weren't intending to transport, because the ED
18 was busy?
19 A. Well, the scenario wasn't necessarily that
20 the ED was busy.
21 Q. All right, take out the busy part.
22 A. But yes, I did not always complete a
23 patient care report for starting an IV on a patient in
24 the hospital. I instead was --
25 Q. Well -- sorry.

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1 A. I instead was included in the patient care
2 report for the hospital and I achieved informed,
3 expressed consent for me to operate in that capacity,
4 notified my employer that I was operating within the
5 hospital to assist them in this particular instance I'm
6 referring to, performing CPR and starting IV for triage
7 patients related to a multi-casualty event.
8 Q. So in every scenario prior to providing
9 care, you would call your dispatcher or your employer
10 and say, "I've been asked to start a line. I've been
11 asked to help with CPR, just FYI," and then go do the
12 care?
13 A. Yes.
14 Q. Even in an emergent situation?
15 A. If I'm in the emergency department doing
16 something specifically in partnership with the hospital
17 that was care, yes, absolutely, I did that. And they
18 were very rare related to, again, multi-casualty
19 incidents.
20 And the other scenario I can recall is
21 providing CPR. In fact --
22 Q. Sorry, I thought you were done.
23 A. In fact, just this weekend I responded on a
24 call that required a patient to receive rapid sequence
25 induction in the emergency department, a patient I

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1 treated and transported. And I absolutely did not
2 provide any care in that scenario because I'm not a
3 licensed caregiver in that capacity, except in disaster
4 events.
5 Q. The times where you provided assistance in
6 the ED, did you document your care in the hospital
7 record?
8 A. Yes.
9 Q. Let's talk about informed -- staying on the
10 issue of informed consent.
11 You're aware that nurses change shifts?
12 A. Yes.
13 Q. So oftentimes, it's 7:00 to 7:00 or -- you
14 know, pick a timeframe. And a new -- old nurse goes
15 off and a new nurse comes on. Would you agree?
16 A. Yes.
17 Q. Is it your opinion that in that situation,
18 when an oncoming nurse assumes care of the patient,
19 that she needs to -- he or she needs to get informed
20 consent -- express and informed consent prior to
21 providing any patient care?
22 MS. BLAZICH: Objection. It's outside the
23 scope of his expert opinions.
24 BY MR. BURTON:
25 Q. Go ahead.

<p style="text-align: right;">Page 110</p> <p>1 A. Could you ask the question again, please. 2 Q. Yeah. 3 Oncoming nurse, prior to providing any care 4 to a patient in an ED, does that nurse need to go in 5 and get express and informed consent prior to providing 6 any patient care? 7 MS. BLAZICH: Same objection. 8 THE WITNESS: I don't know that I feel 9 comfortable offering an opinion in that hypothetical. 10 BY MR. BURTON: 11 Q. Do you have any opinion at all in that 12 scenario, or regarding that scenario? 13 MS. BLAZICH: Same objection. 14 THE WITNESS: My answer is I don't know 15 that I feel comfortable offering an opinion regarding 16 that hypothetical. 17 BY MR. BURTON: 18 Q. I think I asked you earlier how many RSIs 19 you've done during patient transport. I don't know if 20 I asked that specifically. Let me ask it specifically. 21 Knowing that you've done -- I think you 22 said, and don't let me put words in your mouth, but 23 you've done 15 to 20 RSIs. I might be forgetting that. 24 Is that accurate? Is that what you said? 25 A. Yes. In the hospital environment, in the</p>	<p style="text-align: right;">Page 112</p> <p>1 in front of me and I'm going to refer to it real 2 quickly. 3 Q. That's fine. 4 A. (Witness reviews document.) The -- 5 Q. Just refer to what page you're reading 6 from. 7 A. Yes. Thank you. The Bates stamp number is 8 188. 9 Q. Okay. 10 A. It's the patient care report. It states 11 that, "At 0018, it was Ronnie Lyons that administered 12 the Ketamine, 180 milligrams intravenously." And I 13 believe -- I'm reviewing it for a time stamp. 14 It says that in the report, there was a 15 sixty-second pause for effect in the patient care 16 report. I believe my opinions related to Ronnie Lyons 17 and Barry Bartlett's testimony, that after giving the 18 Ketamine, they initiated the intubation. 19 Q. It's not your testimony that it happened 20 immediately; correct? 21 Let me rephrase. I'll withdraw that 22 question. 23 You dispute that a sixty-second pause for 24 effect occurred? 25 A. I'd have to review all of the testimony</p>
<p style="text-align: right;">Page 111</p> <p>1 context of the question you asked, I believe it was -- 2 in my career, it was hospital environment, training 3 environment, related to my paramedic work, yes. 4 Q. And it was about 15 to 20? 5 A. Yes. Approximately. 6 Q. And that's -- again, to make sure we're not 7 taking past each other, that's total in any scenario; 8 correct? 9 A. Yes. That's correct. 10 Q. Have you ever done an RSI mid-transport, 11 whether ground or air or any -- where you're moving 12 with the patient, you're not at a scene or in a 13 hospital? 14 A. No, I have not. 15 Q. In your report you talk about how -- and 16 I'll quote you from it. 17 You say that, "Barry Bartlett administered 18 Ketamine." And then you say, "Immediately after the 19 medication was administered REACH Paramedic Bartlett 20 initiated the intubation." 21 Is it your opinion that Mr. Bartlett did 22 not wait 60 seconds before -- after administering 23 Ketamine before -- or after the Ketamine was 24 administered before attempting intubation? 25 A. If I may, I've got the patient care report</p>	<p style="text-align: right;">Page 113</p> <p>1 from Ronnie Lyons and from Barry Bartlett, whether they 2 used the term immediately or not. But in the patient 3 care report, it states there was a sixty-second pause 4 for effect. 5 Q. Okay. 6 MR. BURTON: I don't know how long we've 7 been going. Do you want to take a break or are you 8 doing okay? I know that -- or does anybody else want a 9 break? 10 THE WITNESS: Out of courtesy and 11 consideration for everyone else, I'll be happy to take 12 a break. 13 MR. BURTON: All right. Thanks. 14 (Recess taken from 3:59 p.m. to 4:06 p.m.) 15 BY MR. BURTON: 16 Q. Do you have an opinion on what constitutes 17 an intubation attempt? 18 A. Yes. 19 Q. What is that opinion? 20 A. The attempt is the visualization of the 21 airway with the intent to pass the tube. I understand 22 that there are some differing opinions that have been 23 offered by opposing experts, and so I relied on 24 Mr. Lyons's representation of an intubation attempt. 25 Q. When you say "visualization of the airway,"</p>

<p style="text-align: right;">Page 114</p> <p>1 is that visualizing the cords? What are you 2 visualizing? Is it opening of the mouth? What are you 3 talking about? 4 A. Utilizing the laryngoscope, or in this case 5 the airway visualization device. 6 Q. Does it have to -- can you have an 7 intubation attempt without the instrument entering the 8 patient's mouth? 9 A. The instrument being the laryngoscope or 10 visualization device? 11 Q. Yes. 12 A. Yes, that would not be an attempt. 13 Q. So for example, I can visualize a patient's 14 airway with just their mouth open, but that's not an 15 intubation attempt; correct? 16 A. That is correct. 17 Q. Are you aware if Nevada has any specific 18 law on what constitutes an airway attempt -- or excuse 19 me, not airway, intubation attempt? 20 A. I don't recall reading something specific 21 related to Nevada in intubation attempts. Again, I've 22 used my context, the standard of care context, and then 23 Mr. Lyons's representation of an intubation. 24 Q. But you would agree -- let me ask you, do 25 you know if there are states that specifically</p>	<p style="text-align: right;">Page 116</p> <p>1 intubation attempts occurred with respect to 2 Mr. Schwartz? 3 A. Yes. 4 Q. What is that? 5 A. I've reviewed Mr. Lyons's testimony. He 6 represented there were at least 11. 7 Q. Was that -- is your opinion based on a 8 review of the records or based on Mr. Lyons's 9 testimony? 10 A. I relied on Mr. Lyons's testimony as a 11 review of the records and my review of the records came 12 up with similar numbers. 13 Q. Similar or identical? 14 A. Similar, because there is some discrepancy 15 as to the possibility of them being more than 11. 16 Q. How many CRIC have you done in your career? 17 A. My career? In my training, I've performed 18 them if I recall, but in the field environment, I have 19 not performed a cricothyrotomy, certainly not in an 20 interfacility transfer. 21 Q. And you've never performed it in the 22 hospital, I assume? 23 A. When we say hospital, interfacility 24 transfer; that's correct. 25 Q. I'm talking about have you ever</p>
<p style="text-align: right;">Page 115</p> <p>1 describe, for that state, what constitutes an 2 intubation attempt? 3 A. There may be, yes. 4 Q. I'm asking if you know. I'm not -- not if 5 there may be. Do you know, as you sit here today, if 6 there are attempts at -- if there are states that 7 specifically define what constitutes an intubation? 8 A. States -- I'm not aware of a state 9 definition. 10 Q. Have you ever missed when trying to 11 intubate a patient? 12 A. Yes. 13 Q. How many times do you think you've missed? 14 A. In my career, I would estimate a handful of 15 times, in the beginning of my training. 16 Q. And I'm not talking about on a dummy or a 17 cadaver, but on a real live patient. 18 Let me ask you this: If somebody told you 19 that has done intubations that they've never missed, 20 would you believe them? Isn't it common that people 21 miss? 22 A. I don't think the word "common" is 23 appropriate, but it would be uncommon if people haven't 24 missed in their career. 25 Q. Do you have an opinion as to how many</p>	<p style="text-align: right;">Page 117</p> <p>1 performed -- I'll be more specific. 2 Have you ever performed a cricothyrotomy in 3 an emergency department? 4 A. In my training, in the beginning of my 5 career, I recall doing it but not since. 6 Q. Were you doing it or were you assisting in 7 it being done? 8 A. I was part of doing the procedure. I was 9 not the only one part of doing the procedure. 10 Q. Were you the one doing the actual cutting? 11 A. Yes. 12 Q. Okay. 13 When was that training? 14 A. It would have been at the beginning of my 15 paramedic career, so '91, '92. 16 Q. And you've never done one in the field; 17 correct? 18 A. That's correct. 19 Q. And you've never done one on an aircraft; 20 correct? 21 A. Yes, that's correct. 22 Q. And you've never done one in the back of an 23 ambulance? 24 A. Yes, that's correct. 25 Q. And you haven't done one in approximately</p>

<p style="text-align: right;">Page 118</p> <p>1 30 years, however long ago 1991 was? 2 A. Yes. Correct. 3 Q. In this case, do you intend to offer an 4 opinion as to when a cricothyrotomy should have 5 occurred? 6 A. Yes. 7 Q. What is that opinion? 8 A. According to REACH policies and procedures, 9 it is after -- it's considered within line of the crash 10 airway or failed airway. And within the standard of 11 care for patients with advanced airway failures, it's 12 after the third attempt. 13 Q. Do you have an opinion as to whether or not 14 a CRIC would have been successful if it would have been 15 tried after the third failed airway attempt? 16 A. Standard of care for paramedics related to 17 performing that procedure doesn't denote a guaranteed 18 outcome. So regarding the believing of -- belief or 19 opinion as to whether it would have been successful 20 wasn't within the policies and procedures for REACH Air 21 Medical transport. So, therefore, I don't intend to 22 offer an opinion as to its likelihood of its success. 23 Q. Do you intend to offer any opinion as to 24 how the outcome for Mr. Schwartz could have been 25 different if the CRIC would have been tried after the</p>	<p style="text-align: right;">Page 120</p> <p>1 done a CRIC after the third attempt, that they no 2 longer could try endotracheal intubation or suction 3 through the mouth; correct? 4 A. Who is "they," please? 5 Q. The crew. Those treating Mr. Schwartz in 6 the ED, the medical team. 7 A. Well, the medical team to me is the REACH 8 Air Medical crew. I want to make sure, that's why I 9 ask. 10 Q. I'll be more specific. 11 All in the ED that were providing care for 12 Mr. Schwartz, any provider; Dr. Garvey, nursing staff, 13 the REACH team, whoever else is there. 14 The moment the CRIC occurs, they couldn't 15 have tried endotracheal intubation; correct? 16 A. I don't intend to offer an opinion 17 regarding Dr. Garvey. 18 Q. I'm not -- 19 A. I don't intend to offer an opinion 20 regarding the nurses within the hospital environment. 21 I intend to offer an opinion related to the REACH crew, 22 that that was the policy and procedures that was 23 applicable to them at the time and within the standard 24 of care, that the cricothyrotomy was the indicated 25 intervention for them.</p>
<p style="text-align: right;">Page 119</p> <p>1 third failed attempt? 2 A. That sounds like a causation opinion to me. 3 Q. I assume you're not offering any causation 4 opinions. 5 A. That is correct. 6 Q. Okay. 7 That would have been a better way to ask 8 that question. You've done this before I can tell. 9 Let me ask you this: Could you attempt 10 intubation after a CRIC has been performed? 11 A. Can you attempt intubation? There is the 12 passing of an endotracheal tube that can be done 13 through a tracheotomy opening, using an inducer, 14 basically a guide. So endotracheal intubation using 15 the visualization of a laryngoscope after a 16 cricothyrotomy procedure, I'm not familiar with that 17 being done within the standard of care. 18 Q. And I should have been more specific. I 19 was talking about endotracheal. 20 Once -- once you attempt a CRIC, you don't 21 attempt to go through the mouth anymore; correct? 22 A. I have not heard of a scenario like that, 23 nor have I seen that within the standard of care 24 documents. 25 Q. So you would agree if -- if they would have</p>	<p style="text-align: right;">Page 121</p> <p>1 Q. Not my question. I'll make it a different 2 question. See if we can get an answer to this one 3 actually. 4 In a hypothetical situation, patient's 5 being treated in the emergency department. A 6 cricothyrotomy is attempted but unsuccessful. 7 Can the medical team providing care to that 8 patient then attempt additional attempts for 9 endotracheal intubation? Yes or no? 10 A. Can -- I don't know what can be done by a 11 higher level of medical care providers, like 12 anesthesiologist or, in this case, Dr. Garvey. 13 I don't know what was available to them, 14 but for the REACH medical crew -- 15 Q. I'm not asking -- this is a hypothetical, 16 not specific to REACH. I want you to answer that 17 question. 18 A. Specifically related to a hypothetical, 19 where you have two separate entities, the providers of 20 different levels of medical training, I can't offer you 21 an answer to what they can do. Related to the standard 22 of care, it would be outside of the standard of care to 23 intubate someone repeatedly, or attempt to, and not do 24 the cricothyrotomy indicated policies and procedures 25 and in the medical journals and documentation.</p>

<p style="text-align: right;">Page 122</p> <p>1 Q. And I'm not sure why this is such a 2 struggle, Mr. Everlove. If it's on my part, I 3 apologize. That's not at all my question. I'll try to 4 be very specific and simple. 5 If the doctor tries a CRIC, in a hospital 6 setting, in an emergency department, and the CRIC is 7 unsuccessful, can the doctor, subsequent to the 8 unsuccessful CRIC, attempt endotracheal intubation? 9 Yes or no? 10 MS. BLAZICH: I'm just going to object that 11 I think it's outside the scope of his expert opinions. 12 MR. BURTON: Well, a lot of it's outside of 13 his scope but he's happy to go there. 14 BY MR. BURTON: 15 Q. Go ahead and answer. 16 MS. BLAZICH: Well, you're asking the 17 questions, James. 18 BY MR. BURTON: 19 Q. Go ahead, Mr. Everlove. Do you understand 20 my question or do I need to simply it for you? 21 A. I appreciate your question. I understand 22 that you're now asking it related to the physician and 23 I would feel uncomfortable offering an opinion 24 regarding the scope of practice for the physician in 25 that hypothetical.</p>	<p style="text-align: right;">Page 124</p> <p>1 of care to subsequently attempt an endotracheal 2 intubation after a failed CRIC? 3 A. I don't have knowledge that that's the 4 case. I have not encountered a situation like that, 5 nor have I encountered documentation related to a 6 failed cricothyrotomy and the alternatives or 7 opportunities to place an advanced airway past that, 8 absent of a tracheostomy. 9 Q. Let me ask you this: In specific to 10 Mr. Schwartz, once the CRIC failed, what were the 11 options of the team, the REACH team? 12 MS. BLAZICH: Objection. Outside the 13 scope. Well, maybe not if you're asking about the 14 REACH team. 15 BY MR. BURTON: 16 Q. Go ahead. 17 A. I'm sorry, can you ask your question again, 18 please. 19 Q. Once they were unable to secure an airway 20 through a cricothyrotomy, what were the options to 21 secure an airway available to the REACH team? 22 A. To the best of my knowledge, that was their 23 option. Dr. Garvey or the hospital staff may have had 24 other options, like the tracheostomy procedure. But 25 within the policies and procedures that REACH had, that</p>
<p style="text-align: right;">Page 123</p> <p>1 Q. Well, go ahead. And you have experience 2 with airway management. Go ahead and answer my 3 question. 4 A. I don't believe it would be appropriate for 5 me to do that, because I don't understand -- I'm sorry. 6 I understand your question. I don't have the 7 applicable scope of practice, knowledge, to know what a 8 physician can do in that situation. 9 Q. So are you refusing to answer my question? 10 MS. BLAZICH: Objection. It's 11 argumentative. He has answered your question. It's 12 asked and answered. 13 BY MR. BURTON: 14 Q. Go ahead, Mr. Everlove. Are you refusing 15 to answer my question? 16 MS. BLAZICH: Same objections. 17 THE WITNESS: I'm offering you my best 18 answer, under the penalty of perjury, as I sit here, to 19 not answer a question for which I'm unfamiliar with the 20 scope of practice. 21 BY MR. BURTON: 22 Q. All right, I'll make it more specific to 23 you. 24 If a paramedic attempts a CRIC and is 25 unsuccessful, would a paramedic be within the standard</p>	<p style="text-align: right;">Page 125</p> <p>1 was their option. 2 Q. Meaning there was no subsequent option 3 after that? 4 A. For the REACH team, I don't see anything 5 within their policies and procedures of how to manage a 6 failed cricothyrotomy. 7 Q. And so what do you do in that scenario? 8 You've attempted intubation but it's unsuccessful. You 9 attempt a CRIC, it's unsuccessful. What do you do 10 then, as the REACH crew? 11 A. In this case specifically, you never put 12 yourself in that position. It would be a primary care 13 provider in a high-risk environment, for a patient that 14 is in the emergency department and needs further 15 interventions, such as a surgical intervention or 16 advanced airway placement. 17 Q. All right, they're in that situation. What 18 were their option after a failed CRIC? Were there any 19 additional medical procedures or steps that the REACH 20 crew could take after a failed CRIC? 21 A. Related to the advanced airway placement, I 22 don't know that there were any. 23 Q. Would you agree that Mr. Schwartz was 24 REACH's patient? You've already agreed to that; 25 correct?</p>

<p style="text-align: right;">Page 126</p> <p>1 A. Yes.</p> <p>2 Q. I'm now going to focus on your opinions.</p> <p>3 Explain to me what your first opinion is.</p> <p>4 Summarize your first opinion for me, please. I don't</p> <p>5 want you to read it word for word. I want just kind of</p> <p>6 a summary of what it is.</p> <p>7 A. Mr. Schwartz was under the patient care of</p> <p>8 REACH personnel and hospital staff during the subject</p> <p>9 event.</p> <p>10 Q. You identified all factual support for your</p> <p>11 first opinion within your report?</p> <p>12 A. That's correct. I listed all the materials</p> <p>13 I reviewed in developing my opinions.</p> <p>14 Q. But I'm being more specific.</p> <p>15 Under your actual opinion section, where</p> <p>16 you have number one, have you identified all the</p> <p>17 factual support upon which you're relying for that</p> <p>18 opinion?</p> <p>19 A. I see. You're referring to the statements,</p> <p>20 not necessarily the documents themselves.</p> <p>21 Q. Yes. The actual -- on page 10 of your</p> <p>22 report, starting with line 11. Is that the totality of</p> <p>23 your opinion and the support for your opinion for</p> <p>24 number one?</p> <p>25 A. It is at the time of this report, yes.</p>	<p style="text-align: right;">Page 128</p> <p>1 A. They're directly caring for the patient.</p> <p>2 Q. So are there indirect health care providers</p> <p>3 as well?</p> <p>4 A. I believe the term I used was based on that</p> <p>5 direct patient care scenario. I don't know that I</p> <p>6 quantified what indirect would have been, but</p> <p>7 specifically related to this opinion, they were</p> <p>8 directly providing primary care to Mr. Schwartz.</p> <p>9 Q. Identify for me all people who were direct</p> <p>10 providers -- direct health care providers of</p> <p>11 Mr. Schwartz during the intubation attempts.</p> <p>12 A. The direct caregivers were -- in personnel</p> <p>13 were the REACH personnel, Ronnie Lyons and Barry</p> <p>14 Bartlett. They were the REACH transportation crew that</p> <p>15 were providing direct patient care to Mr. Schwartz as</p> <p>16 it relates to the advanced airway procedure, while</p> <p>17 Dr. Garvey was providing the care related to the chest</p> <p>18 tube or the intervention of chest tube.</p> <p>19 An indirect care provider may have been a</p> <p>20 nurse or ancillary staff member who is assisting with</p> <p>21 going to get medications and bring them to the room,</p> <p>22 but may not be directly performing a patient</p> <p>23 intervention.</p> <p>24 MR. BURTON: Sorry. I've got the cleaning</p> <p>25 crew to come in to get my trash. Come on in, please.</p>
<p style="text-align: right;">Page 127</p> <p>1 However, Dr. Osborn's deposition, for instance,</p> <p>2 reinforces the fact that this was a patient under the</p> <p>3 care of REACH.</p> <p>4 Q. Well, but you would agree Dr. Osborn's</p> <p>5 testimony was not that the patient was under the sole</p> <p>6 control of REACH; correct?</p> <p>7 A. Yes. That is correct, and my opinion</p> <p>8 reflects similar findings that Dr. -- I'm sorry,</p> <p>9 Mr. Schwartz was under the care of Northeastern Nevada</p> <p>10 Regional Hospital staff and REACH Air Medical Services</p> <p>11 personnel.</p> <p>12 Q. All right.</p> <p>13 Have you told me -- is there any other</p> <p>14 factual support for your opinion number one, besides</p> <p>15 what you've testified to during today's deposition?</p> <p>16 A. Outside the reference I just made, the</p> <p>17 other documents that are available to me since this</p> <p>18 report, no, not that I can think of.</p> <p>19 Q. In your report you talk about -- in your</p> <p>20 opinion, sorry, number one, you use the phrase "direct</p> <p>21 healthcare providers."</p> <p>22 Do you recall that phrase?</p> <p>23 A. Yes, I do.</p> <p>24 Q. What does that mean, "direct healthcare</p> <p>25 provider"?</p>	<p style="text-align: right;">Page 129</p> <p>1 BY MR. BURTON:</p> <p>2 Q. Can you identify every individual who</p> <p>3 attempted intubation on Dr. -- on Mr. Schwartz?</p> <p>4 A. Every individual? No. I can identify the</p> <p>5 REACH Air transport crew and I can identify Dr. Garvey.</p> <p>6 Q. Do you know, as you sit here today, if</p> <p>7 there were others that also attempted intubation of</p> <p>8 Mr. Schwartz?</p> <p>9 A. The record shows that at some point, an</p> <p>10 Elko ambulance paramedic also attempted an intubation.</p> <p>11 Q. Was he a direct -- I don't know he or she,</p> <p>12 I don't know if it was a man or a woman.</p> <p>13 Was that person a direct health care</p> <p>14 provider of Mr. Schwartz?</p> <p>15 A. Using that procedure, yes.</p> <p>16 Q. Dr. Garvey, when he attempted the</p> <p>17 intubation, was he a direct health care provider?</p> <p>18 A. He was a -- yes, he was the direct health</p> <p>19 care provider for the hospital.</p> <p>20 Q. And isn't it fair to say anybody who was</p> <p>21 attempting intubation, under your definition, would be</p> <p>22 a direct health care provider to Mr. Schwartz?</p> <p>23 A. For the purposes of that specifically, yes.</p> <p>24 However, I am aware that there's a legal definition in</p> <p>25 the state of Nevada related to a health care provider.</p>

<p style="text-align: right;">Page 130</p> <p>1 And so --</p> <p>2 Q. I'm only asking in the context of your --</p> <p>3 MS. BLAZICH: Let him answer the question.</p> <p>4 MR. BURTON: No. No. I'm tired of going</p> <p>5 off on a tangent. That's not responsive to my</p> <p>6 question.</p> <p>7 MS. BLAZICH: It is responsive to your</p> <p>8 question, and let the record reflect that you're</p> <p>9 cutting off the witness and not letting him finish his</p> <p>10 answer.</p> <p>11 MR. BURTON: What I'm -- I'm not doing</p> <p>12 that. What I'm asking is, I'm not asking for Nevada's</p> <p>13 definition. My question -- I want him to be responsive</p> <p>14 to my question.</p> <p>15 MS. BLAZICH: He is being responsive to</p> <p>16 your question and you are cutting him off.</p> <p>17 BY MR. BURTON:</p> <p>18 Q. Under your definition, this is your phrase,</p> <p>19 "direct healthcare provider," anybody who assisted with</p> <p>20 the intubation would be considered a direct health care</p> <p>21 provider as you use that phrase in your report;</p> <p>22 correct?</p> <p>23 A. Assisted, no. That's not what I've said.</p> <p>24 Q. Attempted. I meant to say "attempted."</p> <p>25 A. Attempted, yes.</p>	<p style="text-align: right;">Page 132</p> <p>1 Q. Billing with a B. Billing.</p> <p>2 A. I've worked for billing departments? I</p> <p>3 have not.</p> <p>4 Q. Okay.</p> <p>5 A. Worked in conjunction with billing</p> <p>6 departments, recognizing that when a bill is submitted</p> <p>7 to a patient and when --</p> <p>8 Q. Move to strike this narrative</p> <p>9 nonresponsiveness, I want you to answer my question and</p> <p>10 not go off --</p> <p>11 MS. BLAZICH: He is answering your</p> <p>12 question. Let the record reflect you're cutting him</p> <p>13 off.</p> <p>14 MR. BURTON: No. My question was specific,</p> <p>15 how many departments and you said none. I'm moving on</p> <p>16 to my next question.</p> <p>17 MS. BLAZICH: After cutting him off, go</p> <p>18 ahead and move on.</p> <p>19 MR. BURTON: Well, the witness is not being</p> <p>20 responsive. He's obfuscating --</p> <p>21 MS. BLAZICH: Then object that it's</p> <p>22 nonresponsive, but you don't get to cut him off and</p> <p>23 pretend like he doesn't have opinions, because he does.</p> <p>24 MR. BURTON: Well, obviously, he does.</p> <p>25 BY MR. BURTON:</p>
<p style="text-align: right;">Page 131</p> <p>1 Q. Okay. That was my question.</p> <p>2 How many --</p> <p>3 A. Now, in relation --</p> <p>4 Q. How --</p> <p>5 A. In relationship to the understanding that</p> <p>6 there is a different connotation of that, yes, for the</p> <p>7 purposes of my medical opinion, that is correct. I</p> <p>8 understand that there may be a legal connotation and in</p> <p>9 actuality, the state of Nevada lists the REACH Air</p> <p>10 Medical crews, the Elko Ambulance crews, and any of</p> <p>11 those personnel as attendants, not as health care</p> <p>12 providers.</p> <p>13 Q. But you're not going to offer legal</p> <p>14 opinions to the jury; right? That's outside the scope</p> <p>15 of your expertise?</p> <p>16 A. It is outside of the scope of my expertise,</p> <p>17 but it certainly applies to a term that may have some</p> <p>18 legal connotation to it. And, therefore, I wanted to</p> <p>19 make sure that my -- the record is clear and my report</p> <p>20 is clear.</p> <p>21 Q. How many billing departments have you</p> <p>22 worked in for different EMS providers in your life, in</p> <p>23 your career?</p> <p>24 A. Did I understand you to say "billing</p> <p>25 departments"?</p>	<p style="text-align: right;">Page 133</p> <p>1 Q. Let's go to your second opinion,</p> <p>2 Mr. Everlove.</p> <p>3 Do you know what a physician extender is?</p> <p>4 A. I'm familiar with the term that was brought</p> <p>5 up by Dr. Osborn. I don't -- I'm not familiar with the</p> <p>6 context with which she used it. So when you say do I</p> <p>7 know what it is, as if it's a universal definition, my</p> <p>8 answer would be no.</p> <p>9 Q. You've never heard the phrase before</p> <p>10 reading Dr. Osborn's deposition?</p> <p>11 A. I have heard the phrase before. My answer</p> <p>12 was, as it relates to a universal understanding of that</p> <p>13 term, no, I don't understand what she means in regards</p> <p>14 to a physician extender for Mr. Schwartz.</p> <p>15 I am familiar with the term as it applies</p> <p>16 to the standard of care in its -- what I believe to be</p> <p>17 the appropriate use of that term or connotation.</p> <p>18 Q. What is your understanding, your</p> <p>19 understanding, of what a physician extender is?</p> <p>20 A. As paramedics, we are physician extenders</p> <p>21 into the field for a medical director that oversees the</p> <p>22 on-line and off-line medical direction of care for</p> <p>23 patients in a nonclinical environment. It is done</p> <p>24 through policy and procedure. It may be standard</p> <p>25 orders, it may be a written form, or it may be in the</p>

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1 connotation of making a phone call to a physician to
2 receive medical direction on how to treat patients in
3 the field.
4 Q. Is a nurse a physician extender of a
5 physician?
6 A. My understanding of the physician extender
7 relationship is based on what I just described to you.
8 A nurse may have a different connotation related to
9 that aspect of the standard of care.
10 Q. So can you answer that yes or no? Is a
11 nurse a physician extender of a physician? Do you
12 know?
13 MS. BLAZICH: He's answered the question.
14 MR. BURTON: Then I'll move on.
15 BY MR. BURTON:
16 Q. If you don't know, I'll move on.
17 Do you know if a nurse is a physician
18 extender of a physician?
19 A. I just gave you my best answer.
20 Q. All right.
21 You would agree that the care provided by
22 the REACH crew was not prehospital emergency medical
23 services; correct?
24 A. That is correct.
25 Q. All right.

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1 Why, in your report, do you say that REACH
2 deviated from the standard of care for prehospital
3 emergency medical services?
4 A. Because paramedics and nurses in the
5 medical transportation provider role are the
6 prehospital services. They were not employed within
7 the hospital, operating as an entity of the hospital.
8 Q. So is there no difference between -- is
9 interfacility transfer, is that still considered
10 prehospital, even if you're picking up a patient from
11 the hospital?
12 A. It is considered part of the emergency
13 medical services and prehospital care, which they also
14 get. Interfacility transports are part of a
15 prehospital medical transportation role. And in this
16 case, they were not agents of the hospital. Therefore,
17 the term I used was prehospital.
18 Q. And --
19 A. Based on their primary employment.
20 Q. And you believe that that term,
21 "prehospital," is appropriate for the care here by the
22 REACH crew?
23 A. It was the term I used to describe
24 everything I just answered to you, that they were
25 employed by a prehospital provider and performed scene

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1 calls and interfacility transports.
2 Q. That's not my question.
3 My question was: Do you believe that the
4 term "prehospital" is appropriate to the care provided
5 by the REACH crew here, prehospital?
6 MS. RIES-BUNTAIN: Hold on, Mr. Everlove,
7 sorry. I got a text. Keith I think has been muted by
8 the host so he hasn't been able to maybe unmute himself
9 to place an objection or make some other statement on
10 the record.
11 MS. BLAZICH: Keith, are you involuntary
12 muted?
13 MR. BURTON: It worked.
14 THE COURT REPORTER: Are you able to unmute
15 now, Keith?
16 (No audible response.)
17 (Discussion held off the record.)
18 MR. WEAVER: I do have a question. I was
19 trying to ask a question or a clarification a moment
20 ago. I missed the answer as to whether or not the
21 witness considers a nurse to be a physician extender.
22 I just didn't hear what the answer was. If it's an
23 issue, I don't want to go back over it. I just didn't
24 hear the answer.
25 MR. BURTON: I'll ask the question again.

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1 BY MR. BURTON:
2 Q. Mr. Everlove, do you consider a nurse to be
3 a physician extender?
4 MS. BLAZICH: Objection. Foundation.
5 THE WITNESS: I think the best way for me
6 answer that is to have the court repeater read my
7 answer back.
8 BY MR. BURTON:
9 Q. I'm entitled to ask it to you again,
10 Mr. Weaver has asked.
11 So my question to you is: Do you consider
12 a nurse to be a physician extender?
13 MS. HUETH: Objection. It's asked and
14 answered.
15 BY MR. BURTON:
16 Q. Go ahead.
17 MS. BLAZICH: Same objection. Foundation.
18 THE WITNESS: The physician extender
19 question was related to a term that applies within the
20 standard of care for a prehospital environment. As it
21 relates to paramedics specifically, I'm unaware of how
22 the standard of care or scope of practice may be
23 affected for a nurse in that environment.
24 BY MR. BURTON:
25 Q. In your report, in opinion number two, you

<p style="text-align: right;">Page 138</p> <p>1 call it a "gross deviation from the standard of care." 2 Is there any significance to that word 3 "gross," the phrase "gross deviation" focusing on 4 "gross"? 5 A. There is significance to it that it was an 6 extreme departure of the standard of care. 7 I also understand that there are legal 8 terms that have legal merit, and as an expert witness 9 it would be inappropriate for me to try to enter those 10 legal terms in my report. 11 Q. Are you aware if there are any punitive 12 damages claims that are at issue in this case? 13 A. I have not discussed anything with 14 Ms. Blazich related to the nature of the claims, 15 amounts, or anything of that nature. 16 Q. Is there, in your mind -- and this is your 17 phrase, gross deviation, whatever you intend it to 18 mean, is that different from just plain old regular 19 deviation from the standard of care? 20 A. Yes. 21 Q. What is the difference? 22 A. The difference is, in this case, that the 23 failure to obtain informed consent related to the 24 nature of the high-risk procedure being performed by 25 the REACH medical crew was a gross deviation of the</p>	<p style="text-align: right;">Page 140</p> <p>1 determines that the REACH crew -- this is what we're 2 going to argue, that the REACH crew was a physician 3 extender of Dr. Garvey. 4 Are you with me so far? 5 A. I understand that's what you state you're 6 going to argue. 7 Q. No, I'm asking you to assume that. 8 A. Oh, okay. All right. That's an 9 assumption -- that isn't what you're going to argue, 10 but it's an assumption for the hypothetical. 11 Q. I want you to assume that the jury 12 determines that the REACH crew is a physician extender 13 of Dr. Garvey. 14 Do you understand? 15 A. I understand. 16 Q. And I want you to then tell me -- you 17 already determined that Dr. Garvey -- that you have an 18 opinion -- let me rephrase that. 19 Based on my assumption, what I'm asking you 20 to assume, was the REACH crew then authorized to 21 perform the intubation if they're determined to be 22 physician extenders of Dr. Garvey? 23 A. I don't understand what you mean by the 24 word "authorized." You mean does it negate the 25 standard of care for them? Does it negate the consent</p>
<p style="text-align: right;">Page 139</p> <p>1 standard of care. It was an extreme departure in the 2 standard of care. 3 Q. If the jury determines that the REACH crew 4 was a physician extender of Dr. Garvey, would you agree 5 that they had consent, the REACH crew, to perform the 6 intubation? 7 MS. BLAZICH: Objection. Asked and 8 answered. 9 MR. BURTON: I haven't asked that question. 10 BY MR. BURTON: 11 Q. Go ahead. 12 A. I do not have an opinion as to what the 13 jury's decision will mean related to my opinions. I 14 will let the jury be the trier of fact to decide. 15 Q. But your job -- you would agree, your job 16 as an expert is to be helpful to the jury; correct? 17 A. My job as an expert is to offer an 18 unqualified, unbiased opinion. 19 Q. For purposes of assisting the jury; 20 correct? 21 A. That is part of it, yes. 22 Q. So if the jury -- and I'm entitled to ask 23 you hypotheticals. I'm entitled to ask you to assume 24 things. That's what comes with being an expert. 25 I want you to assume that the jury</p>	<p style="text-align: right;">Page 141</p> <p>1 aspect? I don't understand what you're referring to. 2 Q. You don't understand the word "authorize"? 3 A. If I understand with clarity, I don't ask. 4 And in this case, authorized could mean several 5 different things. Are we talking about authorized 6 related to the clinical care? Authorized to deviate 7 from the REACH policies? Authorized regarding consent? 8 It just -- those things are all a factor -- or at 9 issue, rather, within the fact pattern. 10 Q. I'm sorry that you don't understand the 11 term "authorized." I'll try to pick a different word 12 that hopefully you'll understand. 13 Under my assumption, Dr. Garvey -- if the 14 REACH crew is determined to be a physician extender of 15 Dr. Garvey, are you with me? 16 A. Yes. Thank you. 17 Q. Do you have any objection to the REACH crew 18 not having consent to perform the intubation? 19 A. Any objection to the REACH crew not -- I'm 20 going to ask you to rephrase the question, please. 21 Q. What don't you understand about my 22 question? 23 A. You're saying something related to not -- 24 it's a double negative. I want to make sure I 25 understand what you're asking me. So if you would,</p>

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1 please, I want to give you a fair answer.
2 Q. If Dr. Garvey had authorization to do the
3 intubation, and the REACH crew is considered to be a
4 physician extender, do you -- will it be your testimony
5 that the REACH crew still did not have consent to do
6 the intubation?
7 A. I'm going to testify to the jury that they
8 did not have consent to perform the intubation. And
9 that the nature of the term "physician extender" is a
10 unique term in an interfacility transport process of
11 this case. And that I'm unclear as to what that means,
12 and that it's my opinion that that does not pertain to
13 the fact pattern leading to the intubation.
14 Q. So even if the jury determines that
15 Dr. Garvey had consent, are you with me?
16 A. Yes.
17 Q. And even if the jury determines that the
18 REACH crew is a physician extender, are you with me?
19 A. Yes.
20 Q. You still won't agree that the REACH crew
21 then was appropriate to do the intubation?
22 A. I don't know what situation that I would be
23 asked to offer an opinion after a jury decision like
24 that. So I'm -- I'm having trouble with how the
25 hypothetical would apply.

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1 Q. And I'm sorry that you're having so many
2 troubles. Maybe it's a Friday. Maybe it's my
3 questions and I apologize, but you would agree that I
4 could ask you those questions at trial, and if the jury
5 makes that determination, that he's a physician
6 extender, you will not agree today or at trial that,
7 therefore, the REACH crew was appropriate to do the
8 intubation? Is that your testimony?
9 A. My testimony to the jury will be exactly
10 what I described earlier.
11 And if I may, out of great respect for the
12 jury and their ability to determine facts, I would
13 not -- I would not be put in a position to offer a
14 secondary opinion after a verdict or decision by the
15 jury like that.
16 Q. In your report you talk about, in your
17 second opinion, how Mr. Schwartz could not have been
18 informed of the potential risk and complications of the
19 procedure.
20 Do you see that?
21 A. Which line, please?
22 Q. This is page 11, line 14.
23 A. Yes. It refers to the -- several lines
24 above it, in which there was not consent obtained by
25 Mr. Schwartz by the REACH Air Medical Services

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1 personnel.
2 Q. Is it your testimony that Dr. Garvey did
3 not properly inform Mr. Schwartz of the potential risks
4 and complications of the procedure?
5 A. That was a question you asked me earlier
6 and I believe it relates to the disparaging facts and
7 testimony related to whether it was or was not
8 appropriate or informed or fully informed, and my
9 answer remains the same.
10 Q. I want you to assume that Dr. Garvey did
11 adequately inform Mr. Schwartz, to use your words, of
12 the potential risks and complications of the procedure.
13 Are you with me?
14 A. Yes.
15 Q. The REACH crew wouldn't, then, need to
16 reinform Dr. -- Mr. Schwartz of the same potential
17 risks and complications; correct?
18 A. Absolutely, they would.
19 Q. For what purpose?
20 A. For the purpose of meeting the standard of
21 care. For a legal consent. They're a separate entity.
22 They're a medical transportation crew.
23 So as in your examples earlier of
24 interfacility transport of patients for -- you know, to
25 a convalescent home, that still requires consent.

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1 Any time I touch a patient, it requires
2 consent. If it weren't the case, then Mr. Schwartz
3 would not have had to receive any additional
4 information regarding any care, because the Elko
5 Ambulance crews' consent would have applied in totality
6 to all of the caregivers.
7 That's not the case. They're two separate
8 entities, specifically related to this high-risk
9 procedure. If they're asked to do this procedure,
10 first they should have said no, and secondarily, they
11 should have received consent.
12 Q. Well, in the context of your report you
13 characterized it for purposes of making Mr. Schwartz
14 aware.
15 And I understand what you're saying, that
16 your opinion is -- and obviously, I disagree with you
17 and I think the standard disagrees with you, that they
18 needed to get it for purposes of their participation.
19 But I'm asking, from the lens of Mr. Schwartz's
20 awareness, getting the same story from REACH wouldn't
21 make Mr. Schwartz any more aware because they already
22 got it from Dr. Garvey; right?
23 A. That's not the standard of care in facts
24 specifically related to the consent. It is not just
25 awareness, it's expressed and informed consent, which

<p style="text-align: right;">Page 146</p> <p>1 is what I read earlier.</p> <p>2 Q. And I'm not talking about consent. You</p> <p>3 used the word "aware" in your report. Mr. Schwartz</p> <p>4 would have been no more aware of the risks in</p> <p>5 procedures if the REACH crew came in and just repeated</p> <p>6 what Dr. Garvey had already said; correct?</p> <p>7 MS. BLAZICH: Objection. Calls for</p> <p>8 speculation.</p> <p>9 THE WITNESS: I don't know that I can agree</p> <p>10 with that.</p> <p>11 BY MR. BURTON:</p> <p>12 Q. All right.</p> <p>13 Give me the elements for false imprisonment</p> <p>14 in Nevada.</p> <p>15 A. That I believe is a legal conclusion</p> <p>16 related to the state of Nevada so I don't know that I'd</p> <p>17 be comfortable doing that, but the standard of care</p> <p>18 related to paramedic care universally, within the</p> <p>19 United States, is the national standard for us applying</p> <p>20 the consent laws to providing medical care. And it's</p> <p>21 specifically outlined in the standard of care as to how</p> <p>22 that's quantified.</p> <p>23 Q. And I'll move to strike your nonresponsive</p> <p>24 answer. My question is very specific. I'll make it</p> <p>25 more specific to help.</p>	<p style="text-align: right;">Page 148</p> <p>1 A. Based on Nevada law, no, I can't.</p> <p>2 Q. All right.</p> <p>3 Is there anything else with respect to your</p> <p>4 second opinion that is not contained in your report?</p> <p>5 A. Just clarification that could not have been</p> <p>6 aware of the potential risks and complications, I think</p> <p>7 we covered that.</p> <p>8 And the connection related to false</p> <p>9 imprisonment, assault and/or battery is clearly</p> <p>10 outlined in the standard of care, which was the</p> <p>11 reference.</p> <p>12 Q. But that's not listed in your report;</p> <p>13 correct?</p> <p>14 A. The standard of care related to what part?</p> <p>15 Q. The standard of care for false</p> <p>16 imprisonment, assault or battery, that's not listed in</p> <p>17 your report; correct?</p> <p>18 A. It is, page 11, line 15 through 17.</p> <p>19 Q. And this is, "The paramedics who fail to</p> <p>20 obtain consent"? That's what you're saying, that's the</p> <p>21 totality of your opinion?</p> <p>22 A. Yes, as it relates to the materials that</p> <p>23 I've cited. Specifically, for instance, "False</p> <p>24 imprisonment may be charged by a patient who is</p> <p>25 transported without consent or is restrained without</p>
<p style="text-align: right;">Page 147</p> <p>1 Can you identify the elements of false</p> <p>2 imprisonment in the state of Nevada? Yes or no? Can</p> <p>3 you identify them?</p> <p>4 A. I cannot.</p> <p>5 Q. Can you identify the elements of assault in</p> <p>6 the state of Nevada?</p> <p>7 A. I cannot.</p> <p>8 Q. Can you identify the elements for battery</p> <p>9 in the state of Nevada?</p> <p>10 A. I cannot.</p> <p>11 Q. Based on Nevada law, can you identify what</p> <p>12 would make the REACH crew liable for false</p> <p>13 imprisonment? Again, based on Nevada law. Can you?</p> <p>14 A. I'm sorry, say that again, please.</p> <p>15 Q. Based on Nevada law, can you identify what</p> <p>16 would make the REACH crew liable for false</p> <p>17 imprisonment?</p> <p>18 A. Based on Nevada law, I cannot.</p> <p>19 Q. And same question with respect to assault</p> <p>20 and for battery. Based on Nevada law, can you identify</p> <p>21 what would make the crew liable for assault or battery?</p> <p>22 A. Correct. I cannot.</p> <p>23 Q. Based on Nevada law, can you identify any</p> <p>24 difference between false imprisonment and assault or</p> <p>25 battery?</p>	<p style="text-align: right;">Page 149</p> <p>1 proper justification or authority. It is defined as</p> <p>2 intentional and unjustifiable detention of a person</p> <p>3 without consent, or the legal authority, and may result</p> <p>4 in civil or criminal liability."</p> <p>5 Q. You're not a lawyer; right?</p> <p>6 A. That's correct, I am not.</p> <p>7 Q. And you've not played one in all of your</p> <p>8 acting roles either; right?</p> <p>9 A. It wouldn't apply if I did, correct. I'm</p> <p>10 not a lawyer.</p> <p>11 Q. Opinion number three, have you fully</p> <p>12 explained your third opinion in your report?</p> <p>13 A. Yes.</p> <p>14 Q. Fully identified all support for your third</p> <p>15 opinion in your report?</p> <p>16 A. Yes, as outlined in the materials reviewed.</p> <p>17 Q. How would the care of Mr. Bartlett been</p> <p>18 different -- sorry, I just read the word Bartlett.</p> <p>19 How would the care of Mr. Schwartz been</p> <p>20 different if the REACH crew had done the assessment</p> <p>21 that you say they didn't do?</p> <p>22 MS. BLAZICH: Objection. Calls for</p> <p>23 speculation. Lacks foundation.</p> <p>24 MR. BURTON: Well, let me back up. I'll be</p> <p>25 glad to lay some foundation here.</p>

<p style="text-align: right;">Page 150</p> <p>1 BY MR. BURTON: 2 Q. This is your opining as an expert. 3 You say, "It was a gross deviation from the 4 standard of care for prehospital emergency medical 5 services personnel when REACH failed to assess 6 Mr. Schwartz's airway anatomy prior to initiating the 7 high-risk procedure of oral endotracheal intubation." 8 Do you see that? 9 A. Yes, I do. 10 Q. So if they'd done that, how would things 11 have been different? 12 MS. BLAZICH: Same objection. 13 THE WITNESS: The standard of care calls 14 for following the policies and procedures, based on the 15 clinical medical evidence. I think what you're asking 16 me is a causation statement, and I believe that would 17 be outside of my scope. 18 BY MR. BURTON: 19 Q. So again, with respect to opinion three, 20 you don't intend to offer any causation testimony; 21 correct? 22 A. That's correct. 23 Q. In fact, you don't intend to offer any 24 causation testimony for any of your opinions; is that 25 right?</p>	<p style="text-align: right;">Page 152</p> <p>1 other experts that are offering that opinion. 2 Q. It's a question that's -- I mean I'm not 3 asking if you're going to be asked that question. I'm 4 asking if you're going to provide that opinion. 5 Do you intend to provide the opinion at 6 trial whether or not Mr. Schwartz should have been 7 intubated? 8 A. I do not intend to offer that opinion. 9 Q. Okay. 10 Do you have any opinion regarding whether 11 or not Mr. Schwartz's anatomy made his airway 12 difficult? 13 Sorry, that came out half the way I meant 14 for it to. 15 Do you have any opinion as to whether or 16 not Mr. Schwartz's anatomy made it obtaining an airway 17 difficult? 18 A. I don't intend to offer an opinion related 19 to information that wasn't determined at the time of 20 the intubation. And my opinion is there was no 21 assessment of Mr. Schwartz's anatomy sufficient to 22 making a judgment as to whether it would interfere with 23 intubation or not. 24 Q. In your report you said, "They determined 25 that Mr. Schwartz's airway anatomy is difficult to</p>
<p style="text-align: right;">Page 151</p> <p>1 A. Yes. That's correct, understanding the 2 connection between the opinions related to the standard 3 of care as they may impact an impression of causation, 4 but I do not intend to offer a direct causation 5 opinion; that's correct. 6 Q. Do you intend to offer a direct causation 7 opinion? 8 A. Only what I just described, where I 9 understand my opinions have a component to them related 10 to the deviations of the standard of care that may 11 connect to causation, but I'm not offering a causation 12 opinion. 13 Q. In your opinion, did Mr. Schwartz need to 14 be intubated? 15 A. I don't know that that was within the scope 16 of my opinions that I was asked to offer. And, 17 therefore, it's not a part of my report. 18 Q. All right. 19 So I must be very specific so I can pin you 20 down on this. 21 At trial, do you intend to offer any 22 opinion as to whether or not Mr. Schwartz should have 23 been intubated? 24 A. I don't believe that will be a question 25 that I will be asked to offer. I believe there are</p>	<p style="text-align: right;">Page 153</p> <p>1 properly place an advanced airway." 2 What about Mr. Schwartz's anatomy made it 3 difficult? 4 A. I believe the testimony -- and I'm trying 5 to recall exactly what Mr. Bartlett said or Mr. Lyons 6 said. I believe it was Mr. Bartlett that talked about 7 once attempting the intubation, that Mr. Schwartz had a 8 difficult -- had an anatomy that made intubation 9 difficult. 10 Q. Was it an anatomy or laryngospasms? 11 A. I don't recall specifically clarifying 12 between the two. I recall the term "anatomy." 13 Q. Was it the anatomy or was it the vomit that 14 made it difficult to obtain an airway? 15 A. Again, I'm referring to Mr. Bartlett's 16 testimony and I recall him using the word "anatomy." 17 Certainly, vomitus makes airway management more 18 difficult. 19 Q. Is it your testimony that REACH was 20 operating under its policies, protocols and procedures 21 while in the emergency department at Northeastern 22 Nevada Regional Hospital? 23 A. My answer to your question, it goes back to 24 the two scenarios. Either they were operating under 25 their policies and procedures, in which they violated</p>

<p style="text-align: right;">Page 154</p> <p>1 the standard of care, or they were not operating under 2 their policies and procedures and deviated from the 3 standard of care, violating the standard of care. 4 So in answer to your question, whether they 5 were or were not, I think that's a dispute of fact. 6 Q. What trumps, policies and procedures or the 7 direction of a physician? 8 A. Direction of a physician outside of the 9 scope of practice is the part of the hypothetical that 10 applies here. 11 Q. Let me ask if you agree with this 12 statement: "The standard of care calls for adherence 13 to policies, procedures and protocols. Exceptions to 14 the adherence of policies, procedures and protocols 15 requires medical direction." 16 Do you agree with that statement? 17 A. I do, specifically in the context of what 18 medical direction is. 19 Q. Okay. 20 A. In the statement that you just read, that's 21 a very familiar term to me in the literature. And it 22 relates specifically to on-line or off-line medical 23 direction that we discussed in a prehospital 24 environment or in that scene environment that we talked 25 about.</p>	<p style="text-align: right;">Page 156</p> <p>1 specifically relates to obtaining consent and having 2 physicians on scene of medical calls that may be asking 3 you to do something different than what's within your 4 policies or procedures. 5 Q. Is intubation outside of a paramedic's 6 scope of practice? 7 A. When performed properly with consent, no, 8 it is not. 9 Q. All right. 10 Let's be very specific to this case. 11 Was Dr. -- was the REACH crew acting 12 appropriately when they followed the instructions of 13 Dr. Garvey during the failed intubation attempts? 14 A. In the hypothetical that they were 15 following the direction of Dr. Garvey? 16 Q. Well, it's not a hypothetical, but go 17 ahead. 18 A. In the multiple intubation attempts, I 19 believe it's a dispute of the facts as to whether they 20 were following Dr. Garvey's direction to continue to 21 try to intubate. That's what I'm referring to. 22 However, following Dr. Garvey's request for 23 an advanced airway intervention, for a patient that is 24 on their gurney, yes, that was a violation of the 25 standard of care. And in context of what it takes to</p>
<p style="text-align: right;">Page 155</p> <p>1 Q. And it's not your opinion that it applies 2 in the hospital setting? 3 A. "It" being the standard of care related to 4 policies and procedures? 5 Q. No, meaning the exception can be medical 6 direction. Can that medical direction be received in 7 the hospital setting? 8 A. Exceptions related to the statement that 9 you just read would not apply in that environment that 10 the REACH crew found themselves in. In other words, 11 exceptions to the standard of care may -- I'm sorry, 12 exceptions to policies and procedures may apply to a 13 county that somebody is working in, but would have to 14 still be within the scope of practice for that 15 provider. 16 I wouldn't be able to have an exception to 17 a policy or procedure that asked me to do something 18 that was outside of my scope of practice or standard of 19 care. 20 Q. All right, let's be more specific to this 21 case. And that quote I'm reading is from a deposition 22 you gave in a different case. 23 A. That's why it's familiar to me, because 24 it's the same quote I highlighted for this case, but 25 it's actually part of a larger context. It</p>	<p style="text-align: right;">Page 157</p> <p>1 confirm placement of advanced airways and then a chest 2 tube, a surgical procedure on their gurney, 3 Mr. Schwartz would have had to have a post-intubation 4 x-ray performed to confirm placement. I find it 5 difficult to believe that that would have occurred on 6 the REACH Air Medical transport gurney as well. 7 Q. And that's -- but you would agree that a 8 post- intubation x-ray to confirm placement, that's far 9 afield from your experience or scope of practice? 10 A. In the interfacility transport realm, it is 11 within my scope of practice. In fact, it's often that 12 agencies will require it. And if they don't, that we 13 will require the post-intubation x-rays to confirm 14 placement based on the high-risk nature of transporting 15 patients that are intubated and the possibility of 16 esophageal -- I'm sorry, displacement of the 17 endotracheal tube. 18 Q. Let me ask you this: What, then, should 19 the REACH crew have done? Dr. Garvey says, "We're 20 going to intubate. You're going to intubate, Mr. 21 Bartlett," what should he have done? 22 A. Standard of care would have called for them 23 to say no. 24 Q. So it's your testimony you intend to tell 25 the jury that Mr. Bartlett should have said, "No, I'm</p>

<p style="text-align: right;">Page 158</p> <p>1 not going to do that"?</p> <p>2 A. Yes. It's my testimony that the standard</p> <p>3 of care called for Mr. Bartlett not to do that, that it</p> <p>4 is a high-risk procedure. They're within the hospital.</p> <p>5 It is fraught with significant complications. Without</p> <p>6 an airway, patients die. It's a known risk. And,</p> <p>7 therefore, the nature of that request should have been</p> <p>8 met with a "no."</p> <p>9 Q. Would you agree that of all the people in</p> <p>10 the room, the person with the most skill and the most</p> <p>11 experience in RSI intubation attempts was Barry</p> <p>12 Bartlett?</p> <p>13 MS. BLAZICH: Objection. Lacks foundation.</p> <p>14 MR. BURTON: All right, I'll back up.</p> <p>15 BY MR. BURTON:</p> <p>16 Q. Who in the room had attempted more RSIs</p> <p>17 than Mr. Bartlett? Do you know?</p> <p>18 A. Mr. Bartlett testified that he thought he</p> <p>19 had, but he wasn't sure because he didn't know how many</p> <p>20 Dr. Garvey had attempted.</p> <p>21 Q. You've now read Dr. Garvey's transcript.</p> <p>22 Between the two of them, who had done it more?</p> <p>23 A. Barry Bartlett asserts he had done it more.</p> <p>24 Q. Okay.</p> <p>25 I'm asking you, did Dr. Garvey -- did he</p>	<p style="text-align: right;">Page 160</p> <p>1 specific.</p> <p>2 Your testimony earlier was that the REACH</p> <p>3 protocol says three attempts, go to a cervical airway.</p> <p>4 That was your testimony; right?</p> <p>5 A. Yes. That's correct.</p> <p>6 Q. So if Dr. Garvey says, "No, we're going to</p> <p>7 try a fourth attempt," was it a violation of the</p> <p>8 standard of care for REACH to say, "No, we're going to</p> <p>9 go to a CRIC" -- or I'm sorry, for REACH to not say,</p> <p>10 "No, we're going to a CRIC"?</p> <p>11 A. I think your hypothetical again is</p> <p>12 predicated on the fact that they had already deviated</p> <p>13 from the standard of care by agreeing to perform the</p> <p>14 intervention without consent, in that moment. In that</p> <p>15 moment that they've done that, now finding themselves</p> <p>16 in a position the patient needs a surgical airway, that</p> <p>17 is something that they -- it's within their policies</p> <p>18 and procedures. So I guess the challenge for the</p> <p>19 hypothetical is which scenario applies?</p> <p>20 Q. All right.</p> <p>21 Let me ask you this: If the REACH crew had</p> <p>22 said, "No, Dr. Garvey, there's no way, we're not doing</p> <p>23 it. We're going to stand here and watch you do it,"</p> <p>24 and Dr. Garvey attempts an intubation and vomitus comes</p> <p>25 up, we have the same fact scenario that we have here.</p>
<p style="text-align: right;">Page 159</p> <p>1 give a number in his depositions as to how many he had</p> <p>2 attempted? Do you recall?</p> <p>3 A. I don't recall the exact number.</p> <p>4 Q. As you sit here today, do you have anything</p> <p>5 in your memory that says Dr. Garvey said he did it more</p> <p>6 than Mr. Bartlett?</p> <p>7 A. No, I don't have -- it's my recollection to</p> <p>8 the contrary, that Barry Bartlett said he had more</p> <p>9 experience than anyone else in the room.</p> <p>10 Q. And it's your testimony -- let's -- we've</p> <p>11 kind of bled over a little bit to your fourth opinion,</p> <p>12 and I think that they're very similar. I want to wrap</p> <p>13 up your third opinion on policies.</p> <p>14 Is it going to be your testimony at trial</p> <p>15 that the REACH crew acted inappropriately when they</p> <p>16 strayed from what their policies said because of</p> <p>17 physician direction?</p> <p>18 A. Again, going back to the two scenarios we</p> <p>19 discussed, straying from their policies is a deviation</p> <p>20 of the standard of care. They cannot deviate the</p> <p>21 standard of care based on a physician from another</p> <p>22 entity directing them to do so, and be within the</p> <p>23 standard of care.</p> <p>24 Q. All right.</p> <p>25 I understand that's your opinion. Let's be</p>	<p style="text-align: right;">Page 161</p> <p>1 Is it your testimony that the REACH crew should have</p> <p>2 stood against the wall the entire time and just</p> <p>3 watched?</p> <p>4 A. Well, it's my testimony that the REACH crew</p> <p>5 had an obligation to say no to the procedure. Playing</p> <p>6 out that hypothetical could go in multiple directions.</p> <p>7 Q. I want to be very specific, which direction</p> <p>8 it's going. They've already done what you said in this</p> <p>9 hypothetical. They've already said, "No, we're not</p> <p>10 going to do it." The next step is Dr. Garvey tries,</p> <p>11 the same result occurs and the patient vomits.</p> <p>12 And they attempt a couple of airways and</p> <p>13 Dr. Garvey turns to Barry Bartlett and he says, "Hey,</p> <p>14 you've done this a thousand times in the field, can you</p> <p>15 help?" In that scenario, should Barry Bartlett still</p> <p>16 have said, "No, Dr. Garvey, I'm going to stand here and</p> <p>17 watch you treat this patient"?</p> <p>18 MS. BLAZICH: Objection. Calls for</p> <p>19 speculation. Incomplete hypothetical.</p> <p>20 THE WITNESS: I don't feel giving you an</p> <p>21 off-the-cuff opinion on that.</p> <p>22 BY MR. BURTON:</p> <p>23 Q. What about that don't you understand?</p> <p>24 A. It's not a lack of understanding. It's</p> <p>25 actually a lack of understanding much more to your</p>

<p style="text-align: right;">Page 162</p> <p>1 hypothetical related to the standard of care or the 2 implications of that type of event, which isn't related 3 to the facts that I reviewed. 4 Q. I'll see if I can -- 5 A. I wouldn't give you an off-the-cuff 6 opinion, just based on the details related to that. 7 Q. Fine. Let me see if you can actually 8 answer this question. 9 My question is: Is there a scenario where 10 the REACH crew should have ever provided assistance in 11 the intubation attempt to Mr. Schwartz in Northeastern 12 Nevada Regional Hospital's emergency department? 13 A. I can't create a hypothetical -- or I'm 14 sorry, an answer to your scenario based on that 15 hypothetical. Simply based on the opinion that I 16 offered, which was they should not have accepted any 17 responsibility to perform critical interventions or 18 surgical -- assist with surgical procedures for 19 Mr. Schwartz. 20 Q. Give me just one second. I'm going to push 21 mute for one second. 22 Sorry about that. All right. 23 With respect to your third opinion, is it 24 fully contained within your report? 25 A. Yes.</p>	<p style="text-align: right;">Page 164</p> <p>1 A. Yes. He is a higher medical professional 2 than the REACH crew. 3 Q. What qualifies you, as a paramedic, to 4 second-guess -- you're not qualified as a paramedic to 5 second-guess the decisions of a physician; correct? 6 A. Yes, I am. 7 Q. But -- 8 A. In fact, it's a routine -- I shouldn't say 9 routine. 10 It is part of the responsibility, working 11 for a transport provider, that you understand what's 12 being asked of you is within your standard of care or 13 your scope of practice. 14 For example, there are times where we are 15 asked to transport patients that are either unstable or 16 patients that are on certain medications, and the 17 physician and the nurses may not know what the scope of 18 practice is for you as a prehospital care provider or 19 an interfacility transport provider in context of EMS. 20 And, therefore, we routinely have to have conversations 21 to clarify that that's not within our scope of practice 22 and, therefore, we can't do it. 23 Q. In your report you say that, "Mr. Schwartz 24 is at low risk for deterioration based on his 25 condition."</p>
<p style="text-align: right;">Page 163</p> <p>1 Q. And all the factual support is identified 2 in your report as well? 3 A. Yes, with the clarification about the 4 testimony that I think I referred to earlier from 5 Dr. Osborn. 6 Q. All right, we're almost done. 7 Your fourth opinion, how long had Dr. 8 Garvey been treating Mr. Schwartz before the REACH crew 9 arrived? 10 A. I would have to review the record to give 11 you an exact time. I don't recall the exact time, but 12 sufficient time to perform several diagnostic tests and 13 for him to develop an opinion regarding the diagnosis. 14 Q. Who was better informed to make the 15 decision regarding care of Mr. Schwartz, Dr. Garvey or 16 the REACH crew? 17 A. Dr. Garvey, which is exactly to support why 18 they should have said no. 19 Q. And you agree that Dr. Garvey had the 20 benefit of diagnostic testing and information? 21 A. Yes, he did. 22 Q. And also more training? 23 A. As it relates to the intubation or in 24 general medical training as a physician? 25 Q. Medical training.</p>	<p style="text-align: right;">Page 165</p> <p>1 Who's better to make that assessment, you 2 or Dr. Garvey? 3 A. Dr. Garvey was the treating physician and 4 had the benefit of the diagnostic tests. 5 Based on Mr. Schwartz's presentation for 6 being at the hospital, for the period of time that he 7 was, his condition had not changed. And, therefore, 8 the basis for my decision -- or I'm sorry, opinion, was 9 the low risk for deterioration based on that timeframe. 10 Q. That's not my question. 11 Who's in a better position to make that 12 determination, you or Dr. Garvey? 13 MS. BLAZICH: Objection. Asked and 14 answered. 15 BY MR. BURTON: 16 Q. Go ahead. 17 A. I think in the context of the opinions that 18 I have offered, it is a reasonable opinion. 19 Q. Are you not able to answer my question 20 whether you identified either yourself or Dr. Garvey as 21 to who is better positioned to make the determination 22 as to whether the patient was at low risk for 23 deterioration? 24 A. Certainly, Dr. Garvey is a doctor and I'm 25 not a doctor.</p>

<p style="text-align: right;">Page 166</p> <p>1 I agree that as a physician, he was in the 2 care and had all the benefits. Based on my analysis 3 after the fact, I'm offering the opinion that 4 Mr. Schwartz's condition had not changed over the 5 extended period of time. Therefore, the risk of 6 deterioration further at that point was not probable. 7 Q. Should the REACH crew have transferred 8 Mr. Schwartz without him being intubated first? 9 A. That is not an opinion that I'm offering. 10 Based on the lack of experience I have transporting 11 patients by air, I don't think it would be appropriate 12 for me to offer that opinion. However, because this 13 patient never left the hospital and it was a transfer 14 of care issue, it did not fall within my opinion. 15 Q. Would it have been better to have -- 16 realizing that neither is good, I want to say that for 17 the record, but would it have been better to have a 18 failed airway attempt in the ED or mid-flight? 19 A. Yes, I agree, neither one would be good. 20 And failed airway attempts are something you can 21 prepare for. Certainly, the policies and procedures 22 for REACH don't specify or differentiate between in 23 air, in ground or in the hospital. 24 Q. That's not even close to my question. 25 If you had to choose between a failed air</p>	<p style="text-align: right;">Page 168</p> <p>1 trying to perform that procedure as a two-man crew 2 working outside of your scope of practice. 3 Q. Okay. 4 Mr. Schwartz had a pneumothorax. You would 5 agree with that? 6 A. Yes, that's the diagnosis. 7 Q. Are you familiar with Boyle's law? I 8 assume you are as a flight paramedic. 9 A. Yes, I am. 10 Q. Explain to me what you understand Boyle's 11 law to be. 12 A. Changes in pressure affect oxygenation and 13 the ability for patients to oxygenate. And certainly, 14 with a pneumothorax, the ability for the lung to expand 15 or potentially effects in pressure on that 16 pneumothorax. 17 Q. And Boyle's law poses a potential problem 18 to a patient being transferred via an aircraft with a 19 pneumothorax, you would agree? 20 A. Yes, although clarifying the difference 21 between a pressurized aircraft and nonpressurized 22 aircraft and altitude. 23 Q. Well, even in a pressurized aircraft, 24 there's still a risk for expansion, wouldn't you agree? 25 A. Yeah. I believe this dovetails back into</p>
<p style="text-align: right;">Page 167</p> <p>1 attempt happening in the hospital or in a flight or in 2 an aircraft, where is the better location for that to 3 occur? 4 MS. BLAZICH: Objection. It calls for 5 speculation. 6 THE WITNESS: In this case or in a 7 hypothetical? 8 BY MR. BURTON: 9 Q. In a hypothetical. Let's start with that, 10 and then we'll be specific to this case. 11 Let me ask it this way: Isn't it true, 12 Mr. Everlove, that if you're going to have a failed 13 attempt, you're better to do it in the hospital, where 14 there are more hands to assist, more equipment, 15 multiple suction machines, multiple people that can 16 come in and switch people out, than in the back cramped 17 space of an aircraft, where you have two people and 18 limited equipment? 19 A. Absolutely. If you're the REACH crew, you 20 definitely want to do it in the hospital. However, as 21 I stated earlier, that's the REACH crew. It's actually 22 better to have a failed airway attempt when you have a 23 physician, an anesthesiologist or some other advanced 24 airway expert in the hospital or available to you, plus 25 a full support team to provide that care, and not</p>	<p style="text-align: right;">Page 169</p> <p>1 the opinion of whether Mr. Schwartz should have been 2 intubated or transferred. And I, again, understand 3 that that's an opinion being offered by other experts. 4 Q. And not by you? 5 A. Correct. I'm not offering it -- an opinion 6 as to whether Mr. Schwartz should have been 7 transferred. 8 Q. It's your opinion in your report that 9 Mr. Schwartz did not meet the criteria base for RSI. 10 Do you agree with that? 11 A. Yes. It's in my report; correct. 12 Q. What qualifies you as a paramedic to opine 13 on whether a hospital patient qualifies for RSI? 14 A. It's the transfer of the hospital patient 15 that qualifies me. And the transfer of care for 16 Mr. Schwartz, that if he required or qualified for RSI, 17 he would have been intubated prior to their arrival. 18 Had he qualified for RSI, it would have 19 been an intervention provided for the crew and not a 20 responsibility of the crew as a third-party entity. 21 Q. Who is more qualified to make the 22 determination whether he met the criteria for RSI, a 23 physician or a paramedic? 24 A. I think I just gave the answer, that it 25 would be the qualifications of the physician to</p>

<p style="text-align: right;">Page 170</p> <p>1 intervene and provide that intervention and treatment 2 prior to the flight medical crew arriving, and not the 3 responsibility of the flight crew to make that 4 determination. 5 Q. So is it your testimony in this case that 6 Mr. Schwartz should have been intubated before REACH 7 arrived? 8 A. It is my opinion and testimony that the 9 standard of care called for not having a medical 10 transportation provider, on an interfacility transport, 11 provide a critical intervention like airway management 12 in the context of the fact pattern of this case. 13 Q. In your years of experience, have you ever 14 refused a physician's order in the emergency 15 department? 16 A. Yes. 17 Q. Give me an example of when you did. 18 A. I've had physicians ask me to do things 19 that were outside of the scope of practice, like suture 20 patients. 21 I've had physicians that have asked me to 22 do things outside of the scope of practice or training, 23 like utilization of an airway device that wasn't within 24 our scope of practice. So a certain type like maybe 25 a -- maybe it was within our scope of practice</p>	<p style="text-align: right;">Page 172</p> <p>1 case; correct? 2 A. Yes. That's my understanding. 3 Q. Do you intend to offer any criticism of the 4 response to the vomit by Mr. Schwartz, by the REACH 5 crew at trial? 6 A. I do not. 7 Q. Okay. 8 Do you intend to offer any criticism at 9 trial regarding the decision to intubate, knowing 10 Mr. Schwartz for four or five hours earlier, when -- I 11 guess it would be about four hours earlier, had just 12 finished a meal? 13 A. I intend to offer the opinion that that was 14 not part of the assessment by Ronnie Lyons and Barry 15 Bartlett, in accordance with the standard of care prior 16 to performing an intervention, like advanced airway 17 management. 18 And if I may, to clarify, this is a very 19 unique situation in which your patient is alert, 20 oriented, responsive, has capacity and is communicating 21 effectively, such that you can get this information 22 prior to performing the intervention. Therefore, it 23 was an opportunity and within the standard of care for 24 them to do the relevant assessment, which would have 25 included that.</p>
<p style="text-align: right;">Page 171</p> <p>1 nationally, but not locally within our protocols. 2 Those are a couple of examples that, yes, 3 there is absolutely cases in which medical providers, 4 who aren't aware of your scope of practice or standard 5 of care, may ask you to do something that is in direct 6 deviation from the standard of care. 7 Q. Let me ask you this: Assume that Barry 8 Bartlett got what you view as informed and written 9 consent. Are you with me? 10 A. Yes. 11 Q. Is it your testimony it still would have 12 been improper for him to do the intubation in the 13 Northeastern Nevada Regional ED? 14 A. Yes. 15 Q. All right. 16 Have you ever had a patient vomit during an 17 intubation attempt? 18 A. Yes. 19 Q. How do you respond when a patient vomits 20 during an intubation attempt? 21 A. Generally speaking, you do the best you can 22 to clear that airway, which involves movement of the 23 patient, suctioning devices, and ensuring to the best 24 of your ability that the patient doesn't aspirate. 25 Q. Those are things that were done in this</p>	<p style="text-align: right;">Page 173</p> <p>1 Q. But they could get that information from 2 the nursing staff as well; correct? 3 A. Yes, they could get that information, but 4 as it relates to the procedure, if they were, in the 5 hypothetical, not in the emergency department and the 6 patient was able to answer them, that would be 7 information they would get. 8 In the scenario in which they are in the 9 emergency department, the nurses have the information, 10 as you've stated in the hypothetical, the doctor has 11 the information in the hypothetical. It is more 12 support for not performing advanced intervention 13 without sufficient information, to understand the 14 patient anatomy and risks and complications. 15 Q. And I'm not quite sure why you keep 16 qualifying all of this as a hypothetical, and that's 17 fine. 18 Let me ask it this way: Is there anything 19 in the record that supports the idea that Ronnie Lyons 20 and Barry Bartlett did not know that Mr. Schwartz had 21 eaten a meal immediately prior to being hit by a car? 22 A. I don't know when they knew that 23 information, prior to the intubation attempt, or during 24 the intubation attempt, or at some point in the 25 transfer of care. So when you say immediately, when he</p>

<p style="text-align: right;">Page 174</p> <p>1 had the meal, I don't know at what point they knew that 2 information related to Mr. Schwartz. 3 Q. Don't you teach all your students to assume 4 that a patient has a full stomach? 5 A. We teach all of our students to follow the 6 standard of care of assessment, which may include, in a 7 situation like this, being able to ask your patient 8 regarding meals. And we offer as reference the PO 9 versus NPO status of the patients that go in for 10 surgery, and the known complication to sedatives, other 11 pain medications and the administration of an airway 12 device into the patient that can stimulate vomiting. 13 So always teaching our students that, in 14 the context of all of the other standard of care items, 15 that is part of it. 16 Q. I remember from my experience, when I was 17 learning how to intubate, that we were taught to assume 18 that there was a full stomach because you want to be 19 prepared that there may be vomit. 20 Do you disagree with that? 21 A. I don't disagree. In fact, that's exactly 22 the type of information that's discussed in the -- the 23 -- the term is escaping me right now, but in the 24 timeout that was discussed, that's exactly the type of 25 information that's identified, this is high risk</p>	<p style="text-align: right;">Page 176</p> <p>1 Q. And you've identified all the factual 2 support knowing that you identified some additional 3 materials that you've read since your report? 4 A. Yes. That's correct. 5 Q. Have you -- are there any other opinions 6 that you intend to offer at trial that we have not 7 discussed today? 8 A. I intend to offer rebuttal opinions to 9 Mr. Byrd's report, specifically related to some of his 10 conclusions. 11 Q. All right. I want you to itemize all the 12 rebuttal opinions you intend to identify. 13 MR. BURTON: We've been going for another 14 hour. I know it's late, I'm happy to keep going, but 15 I'll let the group decide if they want to take a 16 five-minute break. 17 MS. BLAZICH: I'm okay, but I'll defer to 18 the rest. 19 MS. RIES-BUNTAIN: Yeah, I'd like to just 20 get it done. 21 MS. HUETH: Same. 22 MR. WEAVER: I agree. Thanks. 23 MR. BURTON: All right. 24 BY MR. BURTON: 25 Q. All right, Mr. Everlove, if you would,</p>
<p style="text-align: right;">Page 175</p> <p>1 because of these things. What will we do to intervene? 2 I think your training is absolutely 3 correct, that the advanced airway technique has a high 4 risk for complications and can compromise somebody's 5 ability to breathe regardless of their condition. 6 Q. In fact, the safest approach is to assume 7 that, so you have all of your equipment and training 8 and thought processes ready to go in case they do 9 vomit? 10 A. Actually, I would disagree that the safest 11 process is to not intubate patients that don't require 12 it. And to make sure that your procedural timeout is 13 well-informed, well-discussed, and that the caregivers 14 that are appropriately managing that procedure are the 15 ones that are in charge. 16 Q. Fair enough. 17 If you've made the determination to 18 intubate, the safest approach is to assume the patient 19 has a full stomach so you're prepared for vomitus? 20 A. That is part of what I had answered 21 earlier, yes. 22 Q. All right. 23 Have you fully identified all of your 24 opinions with respect to number four in your report? 25 A. Yes, I believe I have.</p>	<p style="text-align: right;">Page 177</p> <p>1 identify all the opinions that you intend to rebut in 2 Mr. Byrd's report. 3 A. Mr. Byrd offers the opinion, regarding my 4 qualifications to offer an opinion, he is incorrect. 5 And the lack of critical care transports, interfacility 6 transports, and specifically related to the transfer of 7 care and interventions provided during the Schwartz 8 subject event, the notations that he's made are 9 incorrect. 10 I think we've clarified a lot of those. 11 However, it is appropriate that Mr. Schwartz was on the 12 ground, in an emergency department, with a transfer of 13 care to a private transportation company, which is all 14 well within my area of expertise. 15 Mr. Byrd brings up my failure to note 16 legitimate possibility of decline. I think we've 17 covered that, but the opinions related to potential 18 decline didn't apply to the interventions, the lack of 19 informed consent or the care that was accepted by the 20 REACH crew that shouldn't have been under the subject 21 event. 22 And also, Mr. Byrd advocates that -- or 23 offers the opinion that the refusal to follow what 24 almost sounds like a direct order in a military 25 connotation request, outside of the standard of care by</p>

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1 a physician, would have been subject -- would have made
2 Ronnie Lyons and Barry Bartlett subject to some
3 regulatory or oversight agency disciplinary process, I
4 disagree.
5 In fact, it was within their standard of
6 care to refuse it, not to -- to follow any direction as
7 related in the fact pattern regarding a critical
8 intervention in a surgical procedure.
9 Q. Anything else, regarding your rebuttal to
10 Mr. Byrd's report? Sorry, Dr. Byrd.
11 A. Yeah, I apologize. That was my fault. I
12 referred to him as "Mr. Byrd." It is Dr. Byrd.
13 Q. He'll be all right.
14 A. I hope so.
15 He discusses the complication of airway
16 attempts related to vomiting. I concur that that is a
17 complication, but as you described in the training that
18 you received, and it is true, this is a known
19 complication for which it is predictable and
20 preventable to manage an airway for patients that have
21 vomited.
22 So as you described and we have discussed,
23 I've had plenty of cases in which those patients that
24 have vomited created an airway compromise that required
25 intervention. But the follow-up to that was, after

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1 suctioning and proper positioning and understanding
2 that that was going to be a potential risk, we were
3 able to be successfully manage the patient and intubate
4 them successfully.
5 Q. All right, let me ask you that, and I want
6 you to push pause.
7 How, then -- once the vomiting occurred,
8 what could the REACH crew have done differently to
9 secure the airway from -- or to secure Mr. Schwartz's
10 airway? And I understand you -- let me back up.
11 I understand you have a correlation, they
12 never should have done it, I have all that. I'm saying
13 the vomiting has started. What could the REACH crew
14 have done differently to secure the airway?
15 A. According to their policies and procedures,
16 it called for them to perform a cricothyrotomy --
17 Q. All right.
18 A. -- or for a CRIC to be performed on the
19 patient.
20 Q. And that was ultimately done, and I
21 understand you have a quarrel that it wasn't done after
22 the third attempt. If they would have done a CRIC
23 after the third attempt, do you intend to offer any
24 opinion that they would have successfully secured an
25 airway?

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1 A. I believe that goes back to the causation
2 conversation we had earlier. My opinions will relate
3 to the standard of care for policies and procedures,
4 not to causation.
5 Q. Which I understand that, but when you say,
6 "Listen, I've had patients vomit and I've been able to
7 secure an airway," that creates the presumption that
8 the REACH crew blew it because they couldn't secure the
9 airway here.
10 So do you intend to say that the REACH crew
11 blew it because once the vomit occurred, they could
12 have still secured the airway?
13 A. I appreciate the correlation. That wasn't
14 my intention.
15 Q. Okay.
16 A. It was partly that had they been more
17 prepared, in accordance with the standard of care, that
18 it would have included all of the things that we have
19 discussed over this last several hours.
20 Q. Okay.
21 Then tell me, if they would have been more
22 prepared under the standard of care, what should they
23 have had with them, once the vomiting occurred, to
24 secure the airway? Because, again, this is what -- I
25 understand you say you're not going to do causation,

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1 but every time you say this, you then say, "but if you
2 add this, it would have been different." So what could
3 they have done differently?
4 A. That wasn't my intent. It was merely that
5 we described several things related to the procedural
6 timeout and to the aspects of having all of the
7 equipment available within the standard of care.
8 That's what the procedural timeout in preparation and
9 assessment would have included, identifying that he may
10 have been too high risk for the procedure.
11 That's what my intent of the conversation
12 is. I don't intend to offer a causation opinion as to
13 the nature of the vomiting somehow related to
14 Mr. Schwartz's overall outcome.
15 Q. What equipment did they not have available
16 that they should have had available?
17 A. Well, again, it goes back to had they said
18 no in the first place, then that -- that's a whole
19 separate issue. But Dr. Garvey, in a hospital with
20 staff, with the additional crew member -- I'm sorry,
21 with the additional staff members, anesthesiologist,
22 that sort of thing, may have had additional equipment,
23 all I can speak to is the standard of care for the
24 management of a patient like Dr. Schwartz -- Mr.
25 Schwartz, rather, would have required all of those

<p style="text-align: right;">Page 182</p> <p>1 things to be in place.</p> <p>2 Q. But when they --</p> <p>3 A. So suction equipment was included. They</p> <p>4 attempted to use their suction equipment while</p> <p>5 Mr. Schwartz was being intubated by their personnel and</p> <p>6 their gurney and it was not successful.</p> <p>7 Q. But you also know, too, Mr. Everlove, very</p> <p>8 well, from reviewing the record, that they used</p> <p>9 multiple suction machines, that they were getting</p> <p>10 suction machines from other rooms. So when you say</p> <p>11 other equipment may have been available, what equipment</p> <p>12 wasn't available that you think would have made a</p> <p>13 difference?</p> <p>14 A. I was unclear in the records as to the</p> <p>15 availability of the cricothyrotomy or surgical airway</p> <p>16 trays necessary to perform the surgical airway</p> <p>17 intervention.</p> <p>18 Q. Any other equipment that you think should</p> <p>19 have been available that wasn't?</p> <p>20 A. I believe there are other opinions from</p> <p>21 other experts. I don't have other opinions related to</p> <p>22 that.</p> <p>23 Q. Okay.</p> <p>24 Any other -- and I kind of stopped you on</p> <p>25 the Byrd rebuttal stuff.</p>	<p style="text-align: right;">Page 184</p> <p>1 Mr. Everlove, and I appreciate your time.</p> <p>2 THE WITNESS: Thank you, Mr. Burton. I</p> <p>3 appreciate it.</p> <p>4 EXAMINATION</p> <p>5 BY MR. WEAVER:</p> <p>6 Q. Good afternoon, Mr. Everlove. My name is</p> <p>7 Keith Weaver. Do you understand I represent Dr. Garvey</p> <p>8 in this action?</p> <p>9 A. I do now. Good afternoon, Mr. Weaver.</p> <p>10 Q. Good afternoon.</p> <p>11 I'm thinking and hoping this is going to be</p> <p>12 quick and easy, and maybe hoping more than thinking,</p> <p>13 but as I understand your testimony, at least so far, at</p> <p>14 the time of trial, you don't intend to offer any</p> <p>15 opinions in any way, shape or form relating to</p> <p>16 Dr. Garvey's care and treatment of Mr. Schwartz or his</p> <p>17 medical judgments relating to Mr. Schwartz. Am I</p> <p>18 correct about that?</p> <p>19 A. Yes, you are correct about that.</p> <p>20 MR. WEAVER: I don't have any additional</p> <p>21 questions. Thank you, sir.</p> <p>22 THE WITNESS: Thank you, Mr. Weaver.</p> <p>23 MS. BLAZICH: Wow, that was easy, Keith.</p> <p>24 MR. WEAVER: I think that has probably</p> <p>25 been, in ten years, the first time I've only had one</p>
<p style="text-align: right;">Page 183</p> <p>1 Anything else on the Byrd rebuttal that you</p> <p>2 intend to offer as an opinion?</p> <p>3 A. No. I believe I've given you my opinions.</p> <p>4 Q. Have you had the chance to disclose all of</p> <p>5 the opinions that you intend to provide at trial?</p> <p>6 A. Yes, I have, as of today, given discovery</p> <p>7 materials I have available to me.</p> <p>8 Q. And have you had the chance today to fully</p> <p>9 disclose all factual support for the opinions you</p> <p>10 intend to offer at trial?</p> <p>11 A. Yes, I have.</p> <p>12 Q. And do you have any other opinions beyond</p> <p>13 those that you've identified today?</p> <p>14 A. No, I do not.</p> <p>15 Q. Do you have any other factual support</p> <p>16 beyond that which you've identified today?</p> <p>17 A. The materials I've identified, obviously,</p> <p>18 there are several points where I didn't read into the</p> <p>19 record all of the excerpts that I relied upon, but yes,</p> <p>20 I have all the materials available to me for the</p> <p>21 factual support and I have provided them to you.</p> <p>22 Q. All right.</p> <p>23 MR. BURTON: I have no further questions.</p> <p>24 I think some others may and I'll reserve the right to</p> <p>25 follow-up if they do. If I don't, thank you,</p>	<p style="text-align: right;">Page 185</p> <p>1 question.</p> <p>2 MS. BLAZICH: All right. Anyone else?</p> <p>3 MS. RIES-BUNTAIN: No questions.</p> <p>4 MS. HUETH: No questions.</p> <p>5 MS. BLAZICH: No questions from Chelsea.</p> <p>6 Jennifer, I'm sorry, I didn't hear you.</p> <p>7 MS. RIES-BUNTAIN: No questions.</p> <p>8 MR. BURTON: Are you going to ask</p> <p>9 questions, Shirley?</p> <p>10 MS. BLAZICH: Yes, just a couple.</p> <p>11 MR. BURTON: All right.</p> <p>12 EXAMINATION</p> <p>13 BY MS. BLAZICH:</p> <p>14 Q. Mr. Everlove, would you please give us a</p> <p>15 brief summary of your education and training.</p> <p>16 A. Yes.</p> <p>17 I am a paramedic. I have been a paramedic</p> <p>18 field training officer, paramedic educator, a paramedic</p> <p>19 supervisor and a clinical manager. Throughout the</p> <p>20 roles I've trained numerous people related to the</p> <p>21 standard of care for paramedics and prehospital</p> <p>22 providers and emergency services personnel.</p> <p>23 I have extensive experiences in the</p> <p>24 determination of root cause analysis or investigation</p> <p>25 of cases under the umbrella of unusual occurrences or</p>

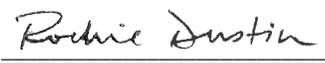
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1 sentinel events, in which there were negative patient
 2 outcomes related to some event or contributing factor
 3 to an event.
 4 And also, educating paramedics and
 5 different prehospital providers related to the
 6 interaction between medical caregivers and aspects of
 7 consent, just to say those related to this type of fact
 8 pattern.
 9 Q. Do you currently hold any professional
 10 licenses or certifications?
 11 A. Yes. I'm a nationally certified paramedic.
 12 I hold licenses in three different states, and follow
 13 the national scope of practice for all of my education.
 14 Q. Have any of your licenses ever been revoked
 15 or suspended?
 16 A. No, they have not.
 17 And if I can clarify also, I hold an
 18 advanced cardiac life support provider card, a
 19 pediatric events life support card, a basic cardiac
 20 life support card, and several other licenses related
 21 to, for instance, national education standards for the
 22 emergency medical services field.
 23 Q. How many years have you worked as a
 24 paramedic providing direct patient care?
 25 A. This is my 30th year.

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1 Q. Have all of your opinions today been to a
 2 reasonable degree of probability as required of
 3 emergency medical service personnel?
 4 A. Yes, it is.
 5 MS. BLAZICH: I don't have any other
 6 questions.
 7 MR. BURTON: Thanks, everybody.
 8 Rockie, we'll take our electronic.
 9 And then what I'll do, I think I only
 10 marked one exhibit, which was his CV. I'll send that
 11 to you, Rockie.
 12 THE COURT REPORTER: Great, sounds good.
 13 Is an electronic copy good for everyone?
 14 MS. HUETH: Yes, please. This is Chelsea.
 15 MS. RIES-BUNTAIN: Good for me, please.
 16 This is Jennifer.
 17 THE COURT REPORTER: Okay.
 18 MS. BLAZICH: Good for me as well. I would
 19 also like a condensed copy and a word index, please.
 20 MR. WEAVER: I'll have what Shirley is
 21 having. Thank you.
 22 (Concluded at 6:33 p.m.)
 23 (Exhibit 1 marked.)
 24
 25

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1 STATE OF UTAH)
) ss.
 2 COUNTY OF SALT LAKE)
 3 I, ROCKIE E. DUSTIN, Certified
 4 Shorthand Reporter for the State of Utah, certify:
 5 That the foregoing deposition of JOHN
 6 EVERLOVE was taken before me pursuant to Notice at the
 7 time and place therein set forth, at which time the
 8 witness was put under oath by me;
 9 That the testimony of the witness and
 10 all objections made at the time of the examination were
 11 recorded stenographically by me and were thereafter
 12 transcribed under my direction;
 13 I FURTHER CERTIFY that I am neither
 14 counsel for nor related to any party to said action nor
 15 in anywise interested in the outcome thereof.
 16 Certified and dated this 23rd day of
 17 February, 2021.
 18
 19 
 20 ROCKIE E. DUSTIN, CCR, RPR
 21 Certified Court Reporter
 22 for the State of Utah
 23
 24
 25

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1 Case: Schwartz v. Garvey
 Reporter: Rockie E. Dustin, CSR, RPR
 2
 3 WITNESS CERTIFICATE
 4 STATE OF _____)
) ss.
 5 COUNTY OF _____)
 6 I, JOHN EVERLOVE, Hereby declare: That I am
 7 the witness referred to in the foregoing testimony
 8 taken on February 19, 2021; that I have read the
 9 transcript and know the contents thereof; that with
 10 these corrections I have noted this transcript truly
 11 and accurately reflects my testimony.
 12
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PAGE	LINE	CORRECTION	REASON
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18 No corrections were made.
 19
 20 _____
 21 JOHN EVERLOVE
 22 SUBSCRIBED and SWORN to before me this
 23 ____ day of _____, 2021.
 24 _____
 25 Notary Public

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