IN THE SUPREME COURT OF THE STATE OF NEVADA

PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL

Petitioners

v.

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

Respondents,

and

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

Real Party in Interest.

Supreme Court No.

District Court No. CV-C-17-439

PETITIONER'S APPENDIX TO THE PETITION WRIT OF MANDAMUS
Vol. 1 of 6

TYSON J. DOBBS, ESQ.
Nevada Bar No. 11953
JENNIFER RIES-BUNTAIN, ESQ.
Admitted Pro Hac Vice
RICHARD D. DE JONG, ESQ.
Nevada Bar No. 15207
HALL PRANGLE & SCHOONVELD, LLC
1140 N. Town Center Dr., Ste. 350
Las Vegas, NV 89144
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Fax: (702) 384-6025
Attorneys for Petitioner PHC-ELKO, Inc. d/b/a Northeastern Nevada Regional Hospital

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ALPHABETICAL INDEX TO PETITIONER'S APPENDIX

Notice of Entry of Order Regarding Defendant NNRH's Motions in Limine (filed on August 1, 2022)	Vol. 6/PA. 1146-1167
Order Addressing All Parties' Motions For Summary Judgment (entered on July 12, 2022)	Vol. 5/PA. 1129-1145
Order Denying Defendants' Motions (entered on June 2, 2021)	Vol. 2/PA. 441-445
Plaintiff's Opposition to PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital's Motion for Partial Summary Judgment (filed on September 29, 2021)	Vol. 4/PA. 661- 898 Vol. 5/PA. 899-1080
Plaintiff's Third Amended Complaint (filed on June 28, 2021)	Vol. 3/PA. 446 - 529

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FACSIMILE: 702-384-6025

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.
CLAGGETT & SYKES LAW FIRM
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Las Vegas, NV 89107
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MCBRIDE HALL
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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

Tel: 702.792.5855 Fax: 775.753.4611
Fax: 702.796.5855
Email: rmcbride@mcbridehall.com
Email: crhueth@mcbridehall.com
Attorneys for Defendant Ruby Crest

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LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400
FACSIMILE: 702-384-6025

EXHIBIT 14

ProDox
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

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.

MICHELE A. PETTY
Notary Public, State of Nevada
Appointment No. 98-3757-6
My Appt. Expires 8-11-18

NOTARY PUBLIC

My commission expires: 8-11-18

Incident Number: EA16-2256
Patient Name: Schwartz , Douglas
EMS Unit Call Sign: 939
Patient Care Report Number: 68ffb27070654b639ee678a

Elko
729 13th Street
Elko, NV 89801
Work: 886-738-7406

Prehospital Care Report

Patient Information

Name: Schwartz , Douglas
Age: 58 Years
D.O.B.: 6/2/1958
Address: 736 Westcott dr Spring Creek Census Designated Place NV 89815
Gender: Male

Reason SSN was unable to be obtained (If applicable): Patient did not know it

Were any of the following medications administered prior to this EMS units arrival?:

Provider Impression

Primary Impression: Acute pain due to trauma

Narrative

Incident Number: EA16-2256 **Patient Name:** Schwartz , Douglas

EMS Unit Call Sign: 939 **Patient Care Report Number:** 68ffb27070654b639ee678a

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 inleft 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 Number: EA16-2256 **Patient Name:** Schwartz , Douglas
EMS Unit Call Sign: 939
Patient Care Report Number: 68ffb27070654b639ee678a

Provider's Primary Impression: Acute pain due to trauma
Initial Patient Acuity: Emergent (Yellow)

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 Number: EA16-2256 **Patient Name:** Schwartz , Douglas
EMS Unit Call Sign: 939 **Patient Care Report Number:** 68ffb27070654b639ee678a

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
Dest. Determ.: Closest Facility
Location: Street and highway
Response Delay: None/No Delay
Incident Address: 450 Commercial St City of Elko , NV 89801

Patient Transport/Positioning

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

Response Times and Mileage

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

Incident Number:	EA16-2256	**Patient Name:** Schwartz , Douglas	
EMS Unit Call Sign:	939	**Patient Care Report Number:**	68ffb27070654b639ee678a
Depart:	06/22/2016 20:41:58		
Arrive Dest.:	06/22/2016 20:48:38		
In Service:	06/22/2016 21:21:04		

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 Number: EA16-2256 **Patient Name:** Schwartz , Douglas

EMS Unit Call Sign: 939

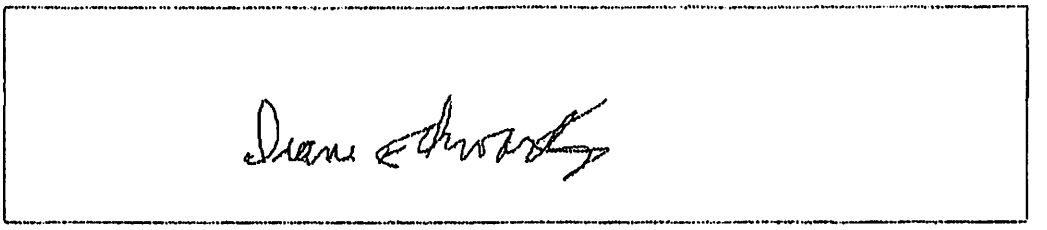
Patient Care Report Number: 68ffb27070654b639ee678a

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 Number:	EA16-2256	**Patient Name:** Schwartz , Douglas	
EMS Unit Call Sign:	939	**Patient Care Report Number:**	68ffb27070654b639ee678a
Incident #:	EA16-2256	**Patient Name:** Schwartz , Douglas	**Date Printed:** 06/29/2018 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) For Transport: R41.82, R52, V03.10XA

DESCRIPTION OF CHARGES	HCPC	QUANTITY	UNIT PRICE	AMOUNT
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**

DESCRIPTION OF PAYMENT	RECEIPT	PAYMENT DATE	AMOUNT
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^

Amount Due: $0.00

Patient Name: SCHWARTZ, DOUGLAS
Patient Number: EA16-2256
Call Number: EA16-2256
Current Date: 07/02/2018
Amount Enclosed $ _____

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

ECA 0010

NEEN000018

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) For Transport: R41.82, R52, V03.10XA

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		Total Charges	1346.68

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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^

Amount Due: $0.00

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

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

Amount Enclosed $ _____

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

Invoice 3

Anthem. BlueCross BlueShield

ELKO COUNTY AMBULANCE
PROVIDER ID NO: 886401139 12/05/16
CHECK NUMBER: 0186562997

PLEASE GO TO WWW.CAQH.ORG/SOLUTIONS/ENROLLHUB FOR ENROLLING INTO ELECTRONIC FUND TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (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 IN ANY ANTHEM ONLINE TOOL, OR SENT IN ANY OTHER MEDIUM INCLUDING MAIL, EMAIL, FAX, OR OTHER ELECTRONIC TRANSMISSION.

CO LUMENOS HSA PPO

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPLANS CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLANS CODE(S)	WHAT WE WILL PAY
[redacted]													FOR INQUIRIES CALL (877) 615-1021
05/16/2016 05/16/2016	A0427	41	1,186.00	1,186.00	0.00	0.00	0.00	0.00	0.00		0.00		1,186.00
05/16/2016 05/16/2016	A0425	41	205.00	205.00	0.00	0.00	0.00	0.00	0.00		0.00		205.00
	TOTAL:		1,391.00	1,391.00	0.00	0.00	0.00	0.00	0.00		0.00		1,391.00
INTEREST PAID													1.00
	TOTAL NET PAID												1,392.00

TOTAL APPROVED AMOUNT 1,391.00
TOTAL INTEREST 1.00
TOTAL NET AMOUNT DUE: CO LUMENOS HSA PPO 1,391.00

PPO

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP AMOUNT	EXPLANS CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLANS CODE(S)	WHAT WE WILL PAY
INSURED'S NAME SCHWARTZ, DOUGLAS R; PATIENT ACCOUNT# 5316-7256A; SERVICE PROVIDER NAME ELKO COUNTY AMBULANCE; NETWORK EX NETWORK				INSURED'S ID 441951956; CLAIM NUMBER 2016315CX1263; SERVICE PROVIDER ID XXXXX1839; RELATIONSHIP TO INSURED MALE SUBSCRIBER					PATIENT NAME SCHWARTZ, DOUGLAS R; RECEIVED DATE 10/31/2016; EXPL CD				FOR INQUIRIES CALL (855) 854-1438
06/22/2016 06/22/2016	A0427	41	1,238.00	1,238.00	0.00	0.00	247.60	0.00	0.00		247.60	167 2	990.40
06/22/2016 06/22/2016	A0425	41	102.00	102.00	0.00	0.00	20.40	0.00	0.00		20.40	167 2	81.60
	TOTAL:		1,340.00	1,340.00	0.00	0.00	268.00	0.00	0.00		268.00		1,072.00
INTEREST PAID													6.68
	TOTAL NET PAID												1,078.68

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: 8045040584
Sequence Number: 4

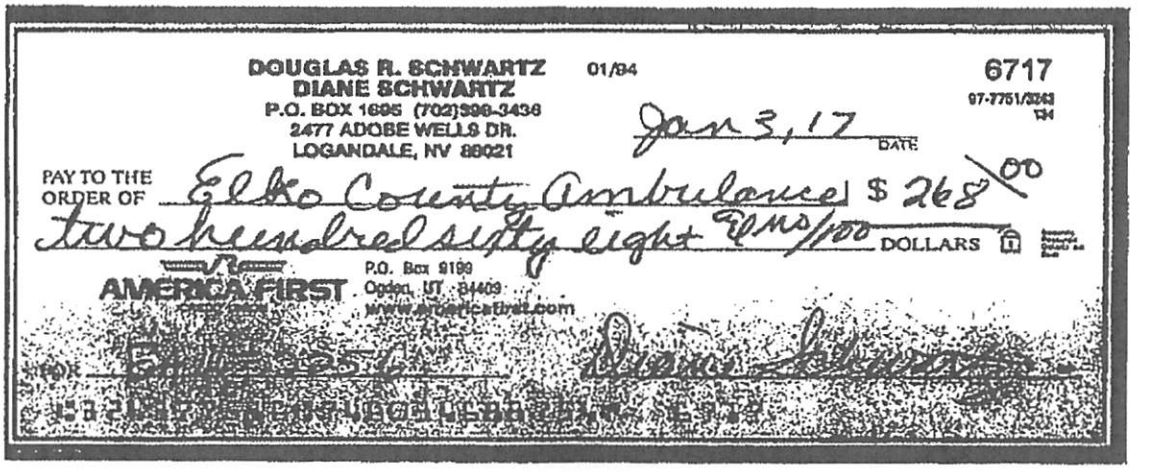
Check(s)

Deposit Date: 01/09/2017
Check Number: 6717
Check RTN: 324377516

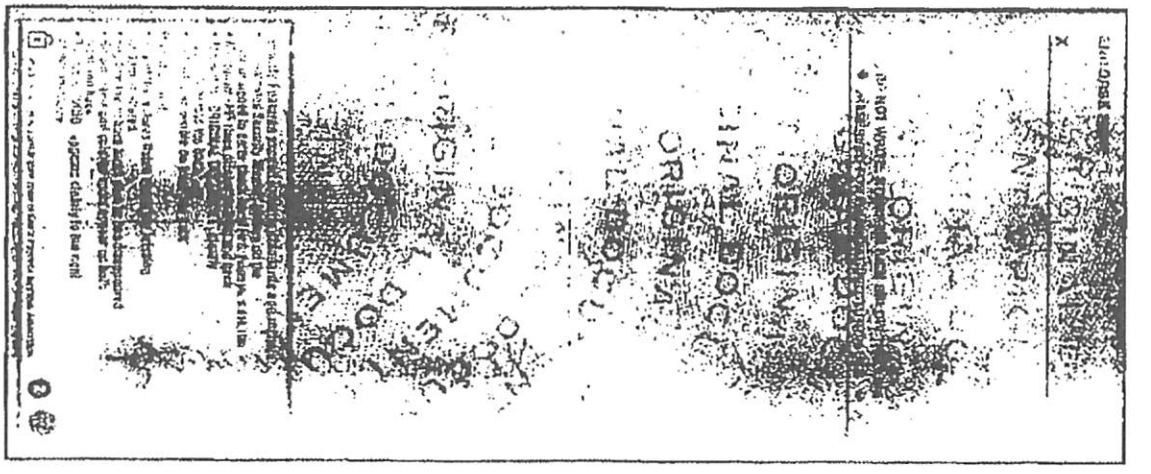
Check Amount: $268.00
Check Account Number: 7

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

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

Case No. CV-C-17-439
Dept. No. 1

DAVID GARVEY, M.D., an individual; BARRY BARTLETT, an individual (Formerly Identified as BARRY RN); CRUM, STEFANKO & JONES LTD., dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

DEPOSITION OF DAVID JAMES GARVEY, M.D.
Taken on Tuesday, June 25, 2019
At 10:17 a.m.
At 6385 South Rainbow Boulevard, Suite 600
Las Vegas, Nevada

Reported By:
Vicki Chelst Turner, CCR 375, RMR, CRR, CRC

APPEARANCES:

For the Plaintiff: JENNIFER MORALES, ESQ.
CLAGGETT & SYKES LAW FIRM
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For Defendant David Garvey, M.D.: KEITH A. WEAVER, ESQ.
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For Defendant PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital: JENNIFER RIES-BUNTAIN, ESQ.
HALL PRANGLE & SCHOOVELD, LLC
(telephonically)
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For Defendant Crum, Stefanko, & Jones, LTD, dba Ruby Crest Emergency Medicine: JORDAN W. MONTET, ESQ.
CARROLL KELLY TROTTER FRANZEN McBRIDE & PEABODY
8329 West Sunset Road
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Las Vegas, Nevada 89113

For Defendant REACH Air Medical Services, LLC, and for its individually named employees: JAMES T. BURTON, ESQ.
KIRTON McCONKIE
36 South State Street
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Salt Lake City, Utah 84111

Also Present: ELLEN HARMON, ESQ.
JAMES WATT, ESQ.
LEXI EPLEY, Law Clerk
DANIEL BRADY, Law Clerk
CASEY XAVIER, Law Clerk
ANDREW JONES, Videographer

EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This begins the videotaped deposition of David Garvey, M.D. Today's date is June 25, 2019. The time is 10:17 a.m. We are at 6385 South Rainbow Boulevard in Las Vegas, Nevada 89118, for the matter entitled Diane Schwartz, et al., versus David Garvey, M.D., et al., Case No. CV-C-17-439, being heard in the Fourth Judicial District Court of the State of Nevada in and for the County of Elko.

I'm the videographer, Andrew Jones. The court reporter is Vicki Turner with Turner Reporting Services.

Will counsel please identify yourselves and affiliations, and then the reporter will administer the oath.

MS. MORALES: Jennifer Morales on behalf of the plaintiff, Diane Schwartz and the estate.

MS. MONTET: Jordan Montet on behalf of Ruby Crest Emergency Medicine.

MR. BURTON: James Burton on behalf of REACH Air Medical. I also have with me in-house counsel Ellen Harmon and J.C. Watt.

MR. WEAVER: Go ahead, Jenn.

MS. RIES-BUNTAIN: Jennifer Ries-Buntain on behalf of Northeastern Nevada Regional Hospital.

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MR. WEAVER: And Keith Weaver for Dr. Garvey.
Thereupon--
DAVID JAMES GARVEY, M.D.,
was called as a witness by the Plaintiff and, having been first duly sworn, testified as follows:
EXAMINATION
BY MS. MORALES:
Q Can you please state your full name for the record.
A David James Garvey.
Q Dr. Garvey, how many times have you had your deposition taken prior to today?
A For any case?
Q Yes.
A Probably eight to ten.
Q Okay. And when is the last time that you had your deposition taken?
A Ten -- eight to ten years ago. Ten years ago probably.
Q Okay. I'm going to go over -- I'm sure your counsel went over with you, but I'm going to go over a few admonitions and procedure of having your deposition taken.
If you have any -- if you have any questions, please feel free to ask. Okay?

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A Uh-huh.
Q You understand that today the court reporter is taking down everything that is said in a question-answer format.
A Yes.
Q Okay. And because she is doing that, it's important to make sure we have a clear transcript. So I'm going to ask that you answer "yes" or "no" instead of "uh-huh" or "hu-uh."
Do you understand that?
A Yes.
Q Okay. Along the same lines, sometimes as a deposition goes forward, you get a little bit more relaxed, and people tend to nod their head. I'll ask that you make -- make sure that you make verbal responses in addition to just nodding your head. Okay?
A Yes.
Q As you can see, we have a room full of people, attorneys, and they have the opportunity to make objections. However, unless your attorney instructs you not to answer, I'm going to ask that you answer the question. Okay?
A Yes.
Q After your deposition is taken, you have an

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opportunity to review your deposition transcript and make any changes. However, any substantive changes -- for example, a yes to a no answer -- can be brought up at the time of trial, which could affect your credibility.
Do you understand that?
A Yes.
Q We never want you to guess, but we are entitled to your best estimate.
Do you understand the difference between an estimate and a guess?
A Yes.
Q Okay. Today if you need for any reason to take a break, just let us know, and we'll do that. However, if there is a question pending, I will ask that you answer the question before you take a break. Okay?
A Okay.
Q And I may have forgot something. I'm sure I did. But if I -- I did, I'll caution you as we move along. Okay?
A Okay.
Q You just testified that you've had your deposition taken eight to ten times.
Have any of those times that you had your

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deposition taken were in regard to where you have been named as a defendant?
A No.
Q Have you ever been -- besides this case, have you ever been a defendant in a medical malpractice suit?
A No.
Q Can you give me a brief synopsis of your educational history.
A Bachelor's degree, Miami University, Oxford, Ohio. Master's degree, University of Buffalo, New York. And Ph.D., anatomy, University of California, Berkeley. And M.D. degree, Wright State University, Dayton, Ohio.
Q Okay. And when did you earn your M.D.?
A Graduated in 1984.
Q And are you board certified?
A I was board certified for the last 30 years, but recently did not recertify. Within the past six months, I was supposed to recertify.
Q Okay. And why didn't you recertify?
A Because I'm preparing to retire.
Q Okay. And when are you planning to retire?
A Maybe August.
Q Congratulations.

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

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administrative position?
A A little over ten years.
Q And how much -- how much time did you put into the administrative position there?
A Most of my time. Probably 75 percent of my time was administrative.
Q Did you have any other employments during this five-year period of time?
A No employments. I think everything else was independent contractor.
Q Okay. And tell me, working at the Northeastern Nevada Regional Hospital, were you employed by anyone there?
A No.
Q Okay. What was your position -- sorry.
MR. WEAVER: I was just going to object it calls for a legal conclusion. I think he's interpreting to mean employee versus independent contractor.
Go ahead.
Q (BY MS. MORALES) What was your position there?
A An emergency physician.
Q Were you associated or employed by any groups?
A Not employed, no.

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

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

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

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

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

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MR. WEAVER: I think you said --
THE WITNESS: Year and a half to two years.
MR. WEAVER: Sorry. I think you said North Carolina. It's South Carolina.
MS. MORALES: South Carolina. I just went to North Carolina.
Q Okay. So -- so the last year and a half you've worked -- or you've lived in South Carolina?
A Yes.
Q And prior to that last year and a half, where did you reside?
A Huntsville, Alabama.
Q So in June of 2016, were you living in Huntsville, Alabama?
A Yes.
Q And in June of 2016, how much of your time was dedicated to working at Huntsville Hospital?
A Zero.
Q You had already stopped working there?
A Yes.
Q Okay. What other positions, if any, did you hold in June of 2016?
A Sort of a part-time consulting position.
Q And when you say "part-time consulting position," who was that for?

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

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

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MR. WEAVER: She just asked you how often you talk to him per month.
Q (BY MS. MORALES) December or January of this last year?
A Yes.
Q And who went on that vacation?
A His wife, my wife, and us. The two of us.
Q And where did you guys vacation?
A Death Valley.
Q And how long was that vacation?
A Five to seven days maybe.
Q Is that the only vacation that you've gone on with that couple?
A Yes.
Q Do you guys double date frequently?
A No. Never.
Q What about Dr. Crum? You share or rent an apartment. How often do you talk to Dr. Crum each month?
A Only when our shifts overlap. And that's rare. I may see him once or twice a month.
Q Do you socialize with him outside of work?
A No.
Q What about Stef- -- Stefanko?
A Stefanko.

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

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at Northeastern Nevada Regional Hospital?
A No.
Q Do you know who the COO was of Northeastern Nevada Regional Hospital in June of 2016?
A No.
Q What about the CEO?
A I -- I don't remember right now.
Q When you go in to work your five days a month at Northeastern, is it five consecutive days?
A Yes.
Q And what hours were you working in June of 2016?
A I usually worked the night shift. It's 6:00 p.m. to 7:00 a.m.
Q When you worked at Ruby Crest in June of 2016, how many -- how many beds were available in the ER during that period of time?
A Sixteen.
Q And was there only one emergency room physician on at a time?
A Yes.
Q Was there a certain number of nurses that would work in the emergency room in June of 2016 when you worked --
MS. RIES-BUNTAIN: Object to foundation. Sorry,

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

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

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

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things like that.
Q Since you've worked at the hospital for the last eight years, have you been asked to attend any type of educational meetings pertaining to clinical pathways, policies and procedures pertaining to medical care?
A By the hospital?
Q By the hospital.
A By the hospital, no.
Q Have you ever had your privileges -- have you ever had your privileges suspended?
A No.
Q Or terminated at any facility?
A No.
Q What about your medical license? Have you ever had any reprimands?
A No.
Q When you work in the emergency room at Northeastern Nevada Regional Hospital, do you wear a white coat?
A No.
Q What do you wear?
A Scrubs.
Q And does the scrubs have any identifying information on it?

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A It has my name and "Emergency Medicine," I think, on it.
Q Does your -- it just says "Emergency Medicine"?
A Yes.
Q Is there any identifying -- identification of Ruby Crest or the hospital?
A No.
Q And when you introduce yourself to patients, do you say -- well, what do you say when you're introducing yourself to somebody?
A Usually give them my name. "I'm Dr. Garvey."
Q Okay. So you don't say, "I'm Dr. Garvey, and I work with Ruby Crest" or --
A No.
Q Just "Dr. Garvey."
A Yes.
Q Have -- have you had any meetings with anyone at the hospital following the incident with Dr. Schwartz -- I mean Mr. Schwartz?
A No.
Q When you work in the emergency room -- and I believe you said your hours -- do the nurses also work the 6:00 p.m. to 7:00 a.m.?

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A No. Slightly different shift.
Q Is it 7:00 to 7:00?
A They -- usually 7:00 to 7:00, and then there are overlapping shifts, like a 1:00 to 1:00, and I'm -- I'm not exactly sure what their schedule is, but they -- they -- their shifts are sort of based on the patient volume.
Q In preparation for your deposition today, did you review any documents?
A Yes.
Q What did you review?
A The hospital chart, the medical record from my -- mine. The physician and the nurses. EMS records, REACH and Elko County.
Q So the hospital chart from Northeastern Nevada Regional Hospital.
A Yes.
Q Correct?
The EMS records from Elko Ambulance -- I don't know what it's called.
A Elko County --
Q Elko County.
A -- EMS.
Q Okay. REACH Air? Did you say REACH Air?
A REACH Air.

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Q Anything else?
A The hospital record. The medical record, yes.
Q Did you review any deposition transcripts?
A No. Not in preparation.
Q Did you review any discovery responses?
A No.
Q Did you meet with your attorney prior to your deposition today?
A Yes, I have.
Q Approximately how long did you meet with him?
A A couple times. Couple -- few hours each time.
Q Besides your attorney, have you talked with anyone else regarding having your deposition taken today?
A No.
Q Did anyone from the hospital reach out to you prior to having your deposition taken?
A No.
Q Without review of the medical records, did you have an independent recollection of this incident?
A Yes.
Q When you reviewed the medical records, do

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

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2016, had you worked with Barry Bartlett?
A Yes.
Q How many times do you estimate that you've worked with him?
A Again, several times.
Q And when you say several, is that more than five times? Less than five times?
A More than five times.
Q More than ten times?
A Probably.
Q Do you think it's more than 15?
A Oh, I don't know the exact number. But it -- I've worked with almost everyone at REACH Air for -- several times. A lot -- a lot of times. I don't know the individual, but, you know, the crews.
Q Did you know Mr. Bartlett personally?
A No.
When you say "personally," I'm taking it you mean socially?
Q Right. Outside of --
A No.
Q -- the work context.
Had you ever talked to him prior to June of 2016 about his education, training, and experience?
A Have I talked to him about it? No, I haven't talked to him about it.
Q Have you ever had any meetings or discussed this case with anyone from REACH Air?
A Possibly one quick telephone conversation when the case was filed, either making them aware of the case being filed or them making me aware of the case being filed. I don't remember which one it was.
Q And who did you speak with?
A I don't recall who I spoke with. Someone --
MR. BURTON: I'm going to object. To the extent any of those conversations happened with in-house counsel at REACH, I'm going to instruct you not to answer.
Otherwise, you can -- as far as the substance.
MS. MORALES: Based on what? That's -- that's not his attorney, so based on --
MR. BURTON: No. So -- so Dr. Garvey has a dual role, as has been disclosed in discovery. And to the extent he reached out to REACH Air in his role with REACH, it's governed by the attorney-client privilege, and I'm instructing him not to answer.
Q (BY MS. MORALES) Can you tell me what your dual role is with REACH Air?
A I was the medical director for REACH Air.

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Q And how long did you hold that position?
A Well, it started with Summit Air --
MR. WEAVER: She just asked how long.
THE WITNESS: With REACH Air, I can't -- can't remember when REACH Air started from Summit. But maybe with REACH Air, for two years.
Q (BY MS. MORALES) Okay. So let's -- let's -- from the time -- let's start with the eight-year time period when you're in Elko.
In that eight years, did you -- you mentioned Summit.
Was there any other companies that contracted for ambulance flight?
A Well, there were other companies, but --
Q That you worked with. I'm sorry.
A No.
Q It wasn't a good question.
A Started working with Summit Air a couple years after I started working at Elko. And then Summit became REACH. They merged or whatever they did do --
Q Okay.
A -- and --
Q So let's back up to Summit.
When would you estimate that you began

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working at -- with Summit?
A Probably four years prior to REACH.
Q So what year would you estimate?
A Maybe 2012 maybe. I'd have to look at my CV.
Q And who -- do you recall who -- well, strike that.
Did you see some kind of advertisement for a position, or did someone reach out to you and ask you to -- to fill a position that they had?
A They -- they approached me to be their medical director.
Q And -- and do you recall who approached you?
A What's his last name? Jeff. Whoever the manager of REACH -- or Summit Air was at the time. It was Jeff Antonichelly.
Q Was Summit already in existence at the time that they asked you to --
A Yes.
Q -- hold this position? Okay.
MR. WEAVER: Let her ask her whole question before you answer.
Q (BY MS. MORALES) Did they have someone step down from medical director or was it a new company?
A I don't recall the situation.

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Q Okay. What were you asked to do? What were your job duties? What were you asked to do as a medical director?
A Training and education and supervision.
Q And how -- how were you paid for that position?
A A monthly stipend.
Q Was it a set amount every month?
A Yes.
Q And that was with Summit; right?
A Both.
Q Okay. And I just want to make sure we're clear, so then I'll ask the next question when it was REACH Air.
But when it was Summit, what was your monthly stipend?
MR. WEAVER: Don't -- don't answer that question. It's an invasion of your privacy.
MS. MORALES: Well, I don't think it is.
MR. WEAVER: Well, I do, and I'm --
MS. MORALES: So --
MR. WEAVER: -- instructing him not to answer.
THE WITNESS: Well, I don't remember anyway.
MR. WEAVER: Don't -- don't -- be quiet. So if I instruct you not to answer, don't answer.

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MS. MORALES: Okay. And what's your objection based on?
MR. WEAVER: My objection is it's an invasion of his privacy to ask how much money he makes. It's no more relevant than how much you make.
MS. MORALES: Well, no, it's absolutely relevant when --
MR. WEAVER: How -- how is it relevant?
MS. MORALES: When he's holding two positions, one as an ER doctor and one as a medical director of the flight crew that -- or the flight company.
MR. WEAVER: How is the amount relevant?
MS. MORALES: It is the amount -- it is relevant as far as --
MR. WEAVER: How? How is the amount relevant?
MS. MORALES: It is.
MR. WEAVER: Well, you can say that it's relevant, but I'm asking you how is the amount -- how much he made relevant?
MS. MORALES: It's relevant to his position working as an ER doctor. I mean, I don't have to argue it out with you right now.
MR. WEAVER: Well --
MS. MORALES: But I --
MR. WEAVER: -- you have to --

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MS. MORALES: That's fine. I'll -- I'll reserve my right.
MR. WEAVER: Okay.
MS. MORALES: I'll reserve my right to take it in front of the judge.
MR. WEAVER: Okay. Just let me say what I was going to say, if you might.
Whether he had two positions might be relevant. I'm asking you if you can state how the amount he made is relevant.
MS. MORALES: Yeah, I think it is relevant, and especially if that amount fluctuates at all according to how many flights in or out.
MR. WEAVER: Well -- well, ask him that, then.
MS. MORALES: Okay. But I still think the amount is relevant.
MR. WEAVER: I'm instructing you not to answer.
MS. MORALES: And I'm going to reserve my right.
MR. BURTON: So the -- any amounts paid by REACH, I join the objection.
MR. WEAVER: You -- just so we're clear, you can -- you can ask him how he's paid or the -- the circumstances of him being paid. All I'm objecting to is you asking him the monetary amount he's paid.
MS. MORALES: Okay. Well, I still want to

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reserve my right.
MR. WEAVER: Fair enough.
Q (BY MS. MORALES) So you were paid every month by Summit?
A Yes.
Q Is that right?
And was that -- was that payment -- was that payment a set amount every month?
A Yes.
Q Okay. And did that vary at all as far as the number of transports out of the hospital?
A No.
Q How much time did you spend as -- well, from 2012 to -- how long did you work for Summit? Because I want to make sure that we're clear, Summit and then REACH Air.
A Roughly four years till REACH Air took it -- took it over. And I think it's probably two years prior to 2016.
Q So -- I thought you said 2012.
So is it 2012 to 2014?
A 2012 to 2014.
Q Okay.
A Four years. Or --
Q Two years.

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A 2014 -- okay. Yeah, maybe two years before REACH. The whole time is five -- maybe five years for both. And I don't know where the -- where it crosses over.
Q Okay. So from the time that you worked as a medical director for Summit, how much time did you spend in that position each month on average?
A For Summit, probably five to ten hours a month.
Q And what did you spend those five to ten hours a month doing?
A Meetings. Crew meetings once a month. And just reviewing cases and some education. A few lectures.
Q And when you say education, what type of education would you provide and to whom?
A Recurrent education for the flight crews, the nurses and the -- and the paramedics.
Q And where was that training held?
A Either in Elko or Reno.
Q Was it held at the hospital or was it -- did you ever hold that training at Northeastern Nevada Regional?
A No.
Q And did you -- for Summit, did you create

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

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

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you becoming medical director of REACH Air.
A Okay.
Q And I had asked if you knew who approached you for that, and you didn't recall.
Do you know who the owners were of REACH Air at the time that you were asked to be medical director?
A No, I do not.
Q At the time that you were asked to be a medical director for REACH Air, did you negotiate a different pay structure?
A No, I did not negotiate anything.
Q Were you offered a different pay structure?
A I received the same pay structure as -- the Summit structure continued.
Q And that -- that payment that you would get from -- well, that, I guess -- strike that.
When you started getting payment from REACH Air, it was the same amount that you used to get at Summit?
A Yes.
Q Did that ever increase?
A No.
Q Did you receive a payment like once a month? Twice a month?

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A Once a month.
Q Was it the same time or period of time every month?
A I think it was.
Q Do you know when you would receive payment every month?
A No. I don't remember.
Q And when REACH Air took over or you started working for REACH Air, did your duties change at all as a medical director?
A Slightly.
Q And how did they change?
A Had more responsibilities.
Q And when you say more responsibilities, what additional responsibilities did you have?
A More educational duties. More on-call duties.
Q More education -- more educational duties, what do you mean by that?
A They had a much more structured educational program for the crews. More robust than Summit.
Q When you -- when you say it was more robust and there was more education, how -- how much more education?
A Significant. They had biannual practical

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training sessions with all the crew members. They had monthly refresher educational requirements for each of the crew members.
Q And who -- who at REACH Air would you work with to set up the trainings?
A REACH Air has -- had -- has or had an educational person that would go base to base and help with the education. They usually use someone at the base who was also responsible for education.
Q Okay. And who was that person when you started working at REACH Air?
A Again, I -- I don't remember the names. I don't remember the name.
Q Was it just one person that you would work with?
A No. There were several. And sometimes based on their availability to be at our base.
Q Where -- where did REACH Air offer services?
A The -- the flight --
Q Yes.
A -- program?
Oh, several states in the west. Nevada, California, Oregon, Montana. Probably several other places that I...
Q As medical director, were you involved in

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

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

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Q When did that end?
A Oh, I don't remember exactly. Probably a year or so, a little over a year ago. Maybe a year and a half.
Q And why did you stop being the medical director for REACH Air?
A I think the main reason is they were consolidating programs, and there would be more -- they needed someone more local that -- I, you know, live in South Carolina and fly back and forth, and they needed someone for -- they were -- they were going to have multiple bases, and someone would have to be more local to be able to visit the bases more often.
Q Did Northeastern Nevada Regional Hospital purchase its own plane?
A I don't know what the business aspects of the -- helicopter, but not plane.
Q Okay. And do you know when they purchased that helicopter?
A No, I do not.
Q When you were a medical director in June of 2016, do you know if REACH Air transported patients from multiple facilities out of Reno?
A Out of Reno?

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Q Yeah.
A Usually the transports were into Reno, but -- so I -- I don't know if they were transporting from multiple facilities outside -- from Reno out. I -- I don't know.
Q Okay. So the knowledge that you had was that -- that there would be transporting from Elko to Reno; is that correct?
A Elko to Reno to Boise to Las Vegas to Salt Lake City, yes.
Q Okay. And when you say that when REACH Air took over, that your duties increased, how much time were you spending per month for your duties with REACH Air?
A Oh, 20 to 30 hours per month.
Q And were you required to keep any kind of time sheet to provide to REACH Air for the time that you were actually putting in?
A At some point in time, we were. I don't know if that -- how that -- if that continued. I don't know what the time frame of that was. We submitted our hours monthly, yes.
Q So that wasn't always the case when you started with REACH Air?
A I don't think it was always the case. I

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

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

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

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

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

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

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THE WITNESS: Yes.
MR. WEAVER: Go ahead.
THE WITNESS: Yes, there are.
Q (BY MS. MORALES) And as medical director for REACH Air, did those -- do you know if those things -- those materials existed in June of 2016?
A Yes, they did.
Q Did you have any duty to -- even if you didn't put them together, to review them for accuracy or amendments or revisions?
A Yes.
Q Was there any specific policies, procedures, and protocols pertaining to intubations?
A Yes.
Q And those intubation procedures existed in June of 2016?
A Yes.
MR. WEAVER: You mean policies and procedures?
MS. MORALES: Yes.
MR. BURTON: You're being specific as to REACH; correct?
MS. MORALES: Yes.
Q (BY MS. MORALES) Did the policies and procedures that REACH provided to its employees regarding intubation mandate how intubations are to be

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

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

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though?
MS. MORALES: Yes.
THE WITNESS: Yeah, that's not what I said.
Q (BY MS. MORALES) Okay. When are they to apply?
A Whenever they're indicated, and hopefully not during the flight.
Q Okay.
A If someone --
MR. WEAVER: You've answered. Let her ask her next question.
Q (BY MS. MORALES) What is the chain of command for the REACH Air crew?
MR. BURTON: Object to the form of the question. It's vague and ambiguous.
MR. WEAVER: Join.
Q (BY MS. MORALES) As medical director, you have an understanding of what the chain of command is for the flight crew; correct?
MR. BURTON: Objection. Lacks foundation.
THE WITNESS: Not -- not really. I don't know what the -- how -- what they actually have as chain of command, no.
Q (BY MS. MORALES) During -- during a flight to transport a patient, how many employees on average

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are on a plane?
A Usually a flight nurse, a flight paramedic, and the pilot.
Q You testified earlier that your job duties increased when you began working for REACH Air to 20 to 30 hours per week.
Besides -- can you explain to me what -- specifically what was different that was increasing the time that you were having to spend in that capacity?
MR. WEAVER: It's asked and answered, but go ahead.
MR. BURTON: I was going to assert the same objection, but go ahead.
THE WITNESS: I had on-call duties to -- if any of the flight crews pretty much for the entire organization had any questions inflight, had any concerns, et cetera, I was on call to answer those through their central EMS Flight Guard. And I had more educational duties. They had biannual practical sessions that I attended. They usually lasted three or four days. And then that -- that was pretty much it. And then some of the -- the crew meetings once a month.
Q (BY MS. MORALES) Did you have specific days

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that you were on call for REACH Air?
A Yes. Every four to six weeks for one week. Usually about every six weeks.
Q And would -- that one week that you would be on call for REACH Air, did you schedule that to be the same period of time that you were working for Ruby Crest in the ER?
A No. I tried to schedule separate from that.
Q And that on-call shift, was it 24 hours a day?
A Yes.
Q And on average, per week, what would you estimate how many calls you would get?
A Maybe three or four per week at the most.
Q And what kind of questions were you dealing with or handling while on call?
A It varied. Questions, concerns of the flight crew. Transporting a patient. Certain physicians that may or may not want something done prior to transport. Pretty much any kind of questions. Certain medication questions that they may not carry or -- or substitutions, anything like that.
Q And how long did your average telephone call last?
A A couple minutes.

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Q Of -- if you had to break it down, of the 20 to 30 hours that you would spend per month while working as medical director for REACH Air, how many of those hours per month were spent dealing with educational duties?
A On average, ten.
Q You mentioned the crew meetings.
How long that would occur -- I'm sorry. Did you say once a month?
A Once a month, and only when I was working usually. So I tried to -- initially tried to schedule the meetings while I was in Elko.
Q Okay. And how -- is that with all of the REACH crew that worked out of both bases?
A Yes. I only attended a couple of the Nevada -- or the Reno meetings, and that was usually during the time of the annual -- or biannual educational sessions. Or a special trip there.
Q So you didn't -- you didn't regularly attend these meetings every month?
A No, not regularly.
Q Why would you just do it biannually? Was there a reason?
A That's when REACH had their practical training sessions. They lasted for -- all the -- all

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the crew members were expected to attend. Oftentimes the Reno crew would come to Elko. Sometimes the Elko crew would go to Reno.

Q Okay. And we'll get back there, but I don't want to get off base there.

So ten hours per week doing education. The crew meetings were every month --

A Per month, not per week.

Q I'm sorry?

A You said ten hours per week.

Q Oh, per week in education?

A Ten hours per month.

Q Oh, per month. Sorry.

The crew meetings that you attended weren't every month, so where was the rest of your time spent that you worked for -- as medical director of REACH Air?

A I'm considering the on-call times, too, if you stretch them out.

Q And did you have some type of schedule of the time that you were provided for the times that you were going to be on call for REACH Air?

A Yes. We had an on-call schedule.

Q And was that provided to you like every month?

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A Pretty much. It just -- it rotated through all the medical -- regional medical directors.

Q Who was your direct supervisor?

A The medical director at -- at REACH in -- in Santa Rosa. I'm blanking on his name.

Q You can't remember his name?

A Right now, I cannot.

Q Okay. If during your deposition, because we'll be here a while, if it -- I'm bad with names too, but if it comes across your mind, please --

A I -- I know him, and I can't --

Q Yeah. Just answer the question that's posed to you, and then say, "By the way, that's the name of the medical director." Okay? Or supervisor.

How long -- so you said biannually you would go to these crew meetings that were the practicals.

How long -- how long was that training session, the practicals?

A All day.

Q And what did that consist of?

A Case scenarios. Different medical trauma. Mostly involving critical care procedures, intubations, lines. Anything that the crew had to do. It was a hands-on situation.

Q And after -- was there any type of written

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test that was administered to the -- the staff?

A They had a monthly, yeah, continuing education sort of refresher test that they -- I think all the bases did.

Q Besides yourself going out for these practicals, was there any other physicians or --

A No other physicians --

Q -- trainers --

MR. WEAVER: Just let her ask the whole question before you answer.

THE WITNESS: No other physicians.

Q (BY MS. MORALES) Who else would help train?

A Again, REACH had a education person that covered several bases, and then there -- each of the bases usually had someone designated as the education supervisor or whatever for the base.

Q Since you have been medical director for REACH Air, approximately how many transfers do you estimate that you've sent out to one of the neighboring states?

MR. BURTON: Object to the form.

THE WITNESS: Boy, sometimes three or four --

MR. WEAVER: Give her the answer. Don't think out loud. Just give her the answer.

THE WITNESS: Sometimes three to four a day.

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Q (BY MS. MORALES) And was that same average true in June of 2016?

A Yes. That wasn't an average, though. Sometimes three to four a day.

Q So if you had to estimate, would you think that you've sent out several hundred patients by transport since you've been medical director?

A Ten a week, hundreds, yes.

Q How do you make a determination when you're going to transfer a patient what facility you're going to transfer them to?

MR. BURTON: Objection. Asked and answered.

MS. MORALES: I don't think I have.

THE WITNESS: Usually the most appropriate. Sometime patient preference. You usually ask them their preference, Salt Lake City or Reno, and then find an appropriate facility at one of those two that will accept the transfer.

Q (BY MS. MORALES) Does the hospital have any protocols, policies, or procedures as to when it should be recommended to transfer a patient out?

MS. RIES-BUNTAIN: Objection. Foundation.

THE WITNESS: Not that I'm aware of, no.

Q (BY MS. MORALES) As medical director, did you attend any type of -- any type of meetings

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regarding this case?
A No.
Q As medical director for REACH Air, did you -- did you have any type of administrative meetings regularly at REACH Air?
A Yes.
Q And how often was that?
A It would be annually maybe.
Q And where were those held?
A Santa Rosa.
Q And who -- who was invited or who was normally in attendance at those meetings?
A Usually all the regional directors.
Q And do you know if there's any minutes that are kept during those meetings?
A I don't know if there are or not.
Q And if you were to estimate how many people attend those meetings, what would be your best estimate?
A Eight to ten.
Q And what's discussed at the annual meetings?
MR. BURTON: I'm going to object. To the extent any attorneys are present in those meetings and there's attorney-client privileged communications, don't disclose those. Otherwise you can answer.

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

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regional directors for REACH Air, are they -- do they also hold positions as emergency room physicians?
A To my knowledge, all of them do.
Q So, to your knowledge, you don't know of any other type of physician that's a regional director?
A No, I don't. I think they're all emergency physicians.
Q Are there any regional directors that work out of the University of Utah Hospital?
A No.
Q Did you -- when you became a -- a medical director for REACH Air, did you actually sign any type of contract?
A Yes, I think I did.
Q And do you know the period of time that contract was valid?
A No. I don't remember.
Q Do you know during your position as medical director if you signed more than one contract?
A I don't recall.
Q And you actually stepped down from the position as medical director?
MR. WEAVER: Asked and answered.
Go ahead.
MR. BURTON: Join.

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

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winter is not preferable. It's quicker to take a fixed wing and more comfortable for the patient and a little bit more room.

MS. MORALES: Okay. So I was given a little note that I have five minutes about three minutes ago, so I think it's probably a good place to take a lunch.

MR. WEAVER: Sure.

MS. MORALES: And then come back and we'll actually talk about the case.

MR. WEAVER: An hour?

THE VIDEOGRAPHER: We are off the record at 12:36 p.m.

(Whereupon, at 12:36 p.m. a lunch recess was taken, proceedings resuming at 2:00 p.m.)

THE VIDEOGRAPHER: We are back on the record, two o'clock p.m.

Q (BY MS. MORALES) You understand that you're still under oath; correct?

A Yes, I do.

Q Holding a position as a medical director at REACH Air and working out of the emergency room department, did you have to sign any kind of forms with the hospital acknowledging that you work for both?

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A Not that I remember.

Q Okay. Have you had any meetings with administration disclosing that you held both positions?

A No.

Q To your knowledge, were they aware?

A Yes.

Q Okay. So we're here to talk about Douglas Schwartz, the medical care and treatment received by Douglas Schwartz in June of 2016.

And I believe you testified earlier that you have an independent recollection of Mr. Schwartz; is that correct?

A Yes.

Q Okay. So as I go through the records -- luckily there's not a whole lot of them, but as I go through the records, I'm going to just ask you if you have independent recollections outside of that period of time that you were treating him. Okay?

A Okay.

Q All right. So Mr. Schwartz was transferred by ambulance on June 22, 2016, to Northeastern Nevada Regional Hospital.

Is that your understanding?

A Yes.

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Q Okay. And you have the records. I gave you the records, and we'll -- we'll mark that as the first exhibit, and then I'll just reference a page.

So the first exhibit will be the Northeastern Nevada Regional Hospital records.

(Plaintiff's Exhibit 1 marked for identification.)

Q (BY MS. MORALES) And now I'm looking -- because the first couple of pages were cover sheets, so I'm on page 3, Bates stamp 3.

MR. WEAVER: At the bottom.

THE WITNESS: Okay.

Q (BY MS. MORALES) Okay. So up on the left corner, it says 20:51.

And that is military time for 8:51 p.m.; is that correct?

A I can't --

MR. WEAVER: So Dr. Schwartz is having an eye issue, so he's having a --

THE WITNESS: Dr. Garvey.

MR. WEAVER: Dr. Garvey. Sorry.

He's having an eye issue, so he's having a little trouble reading, so...

THE WITNESS: I have to get close. I'm sorry. I'm having surgery next week.

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MS. MORALES: That's okay.

THE WITNESS: Yeah, 20:51. Okay.

Q (BY MS. MORALES) Okay. So that would have been the time that he arrived and was admitted to the emergency --

A Yes.

Q -- room; is that correct?

A Yes.

Q At the time that a patient such as Mr. Schwartz is presenting to the ER under the circumstances of -- of a car crash or being hit by a car, is it -- is it -- do you acquire information prior to their arrival to the hospital?

A I usually do, yes.

Q In this specific case, do you know if you got any information en route?

A I don't know if I did, but I almost always do.

Q Okay. Is that -- tell me what the -- how that information is conveyed.

A Usually by radio. EMS will call, giving us an ETA, an arrival time that they're bringing in, and tell us vital signs and sort of the general description of what -- what happened.

Q Okay. And is that -- while a patient is

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en route, is that -- do you document that anywhere within the medical chart as far as information that's received by EMS?

A No, not in the medical record. We will make -- sometimes make notes next to the radio, but that's about it.

Q Okay. And you don't have an independent recollection of exactly what was conveyed; correct?

A No.

Q Okay. So on this first page, page 3, at 21:15, there are some notations there. And I realize that you have -- you're having an eye issue, so --

A No, I can see them.

Q Okay. So it has "djg," and then, slash, "jkp."

Are these notes that you're writing, or is this a history that's obtained by somebody else?

A That's the history as obtained by me, but it is transcribed by the scribe.

Q Okay. And where do you get the information to include in what's listed under HPI?

A From the patient or from EMS.

Q Okay. And HPI means History of Present Illness.

A Yes.

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Q Is that fair?

So this -- this notation indicates that the patient was a pedestrian struck by a moving vehicle and thrown approximately ten feet. The onset, the symptoms/episode began/occurred just prior to arrival. His 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 ER the symptoms are unchanged. The patient has not experienced similar symptoms in the past and hasn't recently been seen by a physician.

Outside of that history, do you have any independent recollection of receiving any additional history from the patient?

A Most of that was probably from the patient and EMS. I don't know what portions were from either.

Q Okay. And then the historical aspect, those go through allergies.

What does PMHx stand for?

A Past -- PMH -- past medical history.

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Q Okay. And hypertension.

And then PSHx, what's that?

A Past surgical history.

Q Oh, past surgical. Okay.

And are you acquiring that information? Are you specifically asking that, or is that something the nurse asks?

A Usually the nurse will ask. I sometimes confirm it.

Q Okay. And do you have any recollection one way or the other in this case if you asked?

A No. But I usually do.

Q All right. And then the next notation is written at 21:18.

ROS, is that review of symptoms?

A Review of systems.

Q Systems? Okay.

And so constitutional, negative for body aches, chills, fatigue, and fever.

Eyes, negative for any visual disturbances, although it -- it talks about the right contact lens was lost; is that correct?

A Yes.

Q ENT, negative for drainage. Neck, negative for stiffness. Cardiovascular, positive for chest

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pain of the right lateral posterior chest. Negative for palpitations.

Is that correct?

A Yes.

Q Okay. And the respiratory, negative for hemo- -- what's that word?

A Hemoptysis. Spitting up blood.

Q Okay. And shortness of breath.

Does that mean that he was negative for shortness of breath at that point?

A Yes.

Q Okay. Abdomen, negative for nausea and vomiting.

Now, is it -- is it true that Mr. Schwartz was given Zofran in transport to --

A Yes.

Q -- the hospital?

A Yes.

Q Okay. And at that time that he got to the hospital, he wasn't experiencing -- at this time, at 21:18, it says he wasn't experiencing nausea; correct?

A This is the initial assessment, yes. Correct.

Q Okay. And back, positive for pain at rest of the left scapular area and left scapular -- well,

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it says the same thing, I guess. Oh, subscapular area. Positive for abrasions on the extremities. Neuro, negative. Skin, negative for pallor and -- what -- how do you say that? Di- --

A Diaphoresis.

Q Yeah.

Neuro, negative for dizziness, gait disturbance, or headache. And negative for anxiety and depression for psychiatry or psychological.

Is that consistent with your recollection of Mr. Schwartz when he presented?

A Review of systems are usually things that are happening prior to the incident.

Q Okay.

A This is like past history kind of stuff. But also it's computer generated, so the scribe doesn't put a lot of this in with her own words. So a lot of it is computer generated, so...

Q Okay. So this is information that upon presentation, that you're getting from -- is it from an evaluation that you're doing as well?

A Yes.

Q Okay.

A I asked most of those questions, if not all of those questions.

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Q Okay. And then it says "Exam." So that's ROS and then "Exam." And I don't want to have to go through each line again, but we can go through -- that's at 21:20. So that's only a couple minutes later.

And if you go to page 4 --

A Those times are when it was put in the computer, not the times that it was done.

MR. WEAVER: Let her ask you the question.

THE WITNESS: Okay.

Q (BY MS. MORALES) Okay. So this is -- this 21:20 was the time that it was entered?

A Yes.

Q Okay. How do we know the exact time that the -- like the examination, for instance, took place of Mr. Schwartz?

A You have to peruse the rest of the record. But the initial evaluation occurred on his arrival of just after 20:51. I think I was there at the time, and that's when all that initially occurred.

Q Okay. So at the beginning of your deposition when I asked you if there were any changes or any inaccuracies in the records, you had indicated the timing on some of these.

A Oh, that's -- that --

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Q Is that what you're talking about?

A Those are some of the things I'm talking about. The times were the times they were inputted in the computer, not the times they were done.

Q Okay. So to the best of your recollection, you would believe that the exam would have been done at or around 20:51?

A It was done at or about 20:51.

Q Okay. When you go into the computer system -- you said you have a scribe.

So does the scribe actually enter it for you? Like, you write it on -- on something, and then it's entered by someone else?

A No. The scribe watches the interaction, listens to the answers to the questions, and -- or puts down what I tell them I found on the exam.

Q Okay. So they're actually sitting with you.

A They are there the whole time.

Q So at -- at least what's documented as 21:20, the respiratory -- well, it says cardiovascular rate normal, rhythm regular. Respiratory, the patient does not display signs of respiratory distress. Respirations are normal. Breathing sounds are normal and clear throughout.

Is that correct?

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A Yes.

Q The abdomen, your examination of the abdomen also resulted in normal findings; is that correct?

A Yes.

Q At this time?

A Yes.

Q And then neuro assessment was normal as well; is that correct?

A Except for loss of recent memory.

Q When you say "recent memory," what does that mean? Because here it says, "Immediate memory is intact. Remote memory is intact."

So what's the difference between recent and immediate?

A Recent being within the last hour or so. He didn't remember the accident.

Q Okay. But that would mean after the actual incident itself, that he was able to recall; correct?

A Yes.

Q And he was conscious and, actually, it says pleasant and cooperative.

A Yes.

Q Did you know Mr. Schwartz prior to --

A No, I did not.

Q -- treating him? Okay.

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

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

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

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

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

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

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

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

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kidney -- potential kidney or bladder issue, there was nothing else --
A Nothing else remarkable, no.
Q So after you got the lab work back, did you make any additional orders?
A Probably not, no.
Q Okay. And after you saw the lab work, did you make a determination whether or not you were going to transfer the patient --
A No.
Q -- to --
MR. WEAVER: Wait till she's finished the question before you answer.
Q (BY MS. MORALES) -- if you're going to transfer the patient out?
A No, I did not.
Q Okay. The radiology studies, in between getting the lab work and the radiology studies, did Mr. Schwartz physically remain stable for evaluation? Did you check on him in between that period of time?
A Between what time?
Q The time you got the lab results back and the time before you got the radiology results.
A Yes. Usually there's communication between the lab -- the radiology tech, the nurse, and myself.

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

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

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

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A No. The radiologist after -- when they read it would have called me and told me their opinion on any -- any of the readings of the film.

When I looked at it, I can determine the size. And -- and being a traumatic pneumothorax, that's -- that's significant, and I know -- knew the patient was going to be needing to be transferred to a trauma center.

Q Okay. And can you explain for the jury what a pneumothorax is.

A A collapsed lung.

Q And it means when there's -- does it mean when there's like a pocket of air around the lung?

A A traumatic pneumothorax usually means that something penetrated the lung and caused it to collapse.

Q And is there a difference as far as the sizes -- the size of the pneumothorax as -- as far as urgency is concerned?

A Not necessarily.

Q Can a pneumothorax of ten percent or less resolve on its own?

A Usually not a traumatic pneumothorax. A spontaneous, yes, but not a traumatic. Almost always requires a chest tube.

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Q Is there -- when you say "almost always requires a chest tube," is there any other form of treatment for pneumothoraxes that are less than ten percent? Ten percent or less?

A Significantly less than ten percent. If -- if you have an occult pneumothorax that's shown up on CT scan, sometimes you can sit on them even if it's in the setting of trauma. But -- but once they get more than just a little sliver of an occult pneumothorax, I can't think of any cases in 35 years that the patient did not require a chest tube.

Q Okay. And is chest tube something that you commonly are familiar with doing in the emergency room?

A Yes.

Q And is there a way to determine -- besides just saying that a pneumothorax is ten percent or less, to determine if it's five percent, six percent? Is there such a rating or is it just that's how it's categorized?

A It's a guess -- guesstimate.

Q And did you agree with the radiologist that it was ten percent or less?

A I didn't pay too much attention to the size, but yes, I saw it was around ten percent. They might be able to determine it with the computer-generated images that they get. They might be able to be closer than my guesstimate, but that's probably about right.

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Q So if I understand you correctly, the fact that he had a traumatically-induced pneumothorax, regardless if it was five, six, seven, even 15 percent, you would have transferred him to a different facility?

A Yes.

Q And is that for observation purposes?

A No. It would be for continued treatment. He's going to have a chest tube in, and it will probably be three to five days before he gets that pulled out. So he will be under the care of a trauma surgeon and the trauma team until that -- if that is his only injury.

Q And are there any trauma surgeons available at -- in Elko, at the Elko hospital?

A No, there are not.

Q Can a regular -- like a pulmonologist or a regular general surgeon take care of pneumothoraxes?

A They can take care of pneumothoraxes --

Q Pneumothoraxes. Sorry.

A Pneumothoraxes. But I would not give them traumatic pneumothoraxes to take care of. That's why we have trauma centers.

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Q And do you have general surgeons and pulmonologists that contract out of Elko hospital?

A We have no pulmonologists, and we don't have any trauma surgeons that contract out of Elko.

Q In reviewing the film, I assume that you were looking at the CT of the chest; is that correct?

A Yes.

Q What other findings did you see on the CT of the chest?

A I'm not sure if I saw the rib fractures or not, but I think I sort of -- once I saw the pneumothorax, I started arranging for transfer.

MR. WEAVER: It's page 57.

Q (BY MS. MORALES) Okay. So as you sit here today, you don't recall whether or not you specifically were able to see the same fractures as identified by the radiologist?

A I don't remember whether I did or not.

Q And whether or not you saw the fractures yourself or read this report, did you have any concerns regarding the rib fractures?

A I'm -- I'm not quite sure of what your question is.

Q Did you have any additional concerns with

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the fractures of the ribs?
A After the radiologist told me about the fractures?
Q Yes.
A Yes. He went -- the patient went from serious to critical once I got the radiology report.
Q And why did he go from serious to critical?
A Because a flail chest is an immediate life threat. One of the deadly dozen.
Q And can you explain for the jury what a flail chest is.
A Multiple rib fractures, adjacent ribs fractured in multiple places. So you've got a segment that is independent of the rest of the chest.
Q And is it two ribs that are broken in two places or is it three ribs? How many ribs have to be broken to --
A Two or more.
MR. WEAVER: Just let her get her whole question out before you answer.
Q (BY MS. MORALES) So is it -- is it two ribs broken in the same area?
A Two or more ribs broken -- broke -- two or more adjacent ribs broken in multiple places, yes.
Q And what are the symptoms that are

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

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

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A No. Most of the other findings were subtle, and I did not get -- I mean, I was not alarmed until I got the CT report back.
Q And just to be clear, there were several CT reports, so CT of the chest.
A Several. CT of the chest.
MR. WEAVER: She's -- she's asking about the other films as well, whether there was anything concerning on the other CTs of the spine and --
THE WITNESS: Yes.
MR. WEAVER: -- head.
Would that -- that was your question?
MS. MORALES: Uh-huh.
THE WITNESS: Yeah. There -- there were findings concerning on every one of the CTs that were performed.
Q (BY MS. MORALES) Okay. Anything that made it emergent?
A Yes. All of them.
Q Okay. All of them on every finding made it emergent.
A Every CT scan that was done had an emergent finding that the patient would have been transferred to a trauma center.
Q Okay. And so let's go over what those

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emergent findings are.
A All right.
Q So CT of the C-spine, that --
A Except the C-spine.
Q Okay. So the C --
A Okay.
Q The CT of the C -- the C-spine, nothing on that; right?
A Nothing major on that. It was pretty unremarkable. But that is only -- that doesn't necessarily mean that there's no spinal injury. There could be a ligamentous injury. So we still keep the patient in -- in a collar even though that the CT was negative.
Q Okay. So Mr. Schwartz was in a -- had a C collar on at the time?
A Yes. The entire time.
Q Okay. The CT of the head without contrast, that's on NEN 62.
Anything emergent on that?
A Yes. He had what clinically -- 62? I'll get there.
Clinically it would be a possibility of a small subdural hematoma.
Q And did you look at that film yourself? Do

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

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

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

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film. Sometimes it takes a few minutes for the films to be processed enough that I can look at them. But I looked at them probably shortly after he arrived back to the emergency department.

Q Now, is there a note that you wrote within your medical records that would identify your review and diagnoses after you reviewed the films?

A I don't think there's a note. The only thing is that at that point in time, between the time that the patient returned from CT scan and the time the radiologist called the report, I called REACH. So I knew that the -- I knew that the patient needed to be transferred.

MR. WEAVER: The question was, was there a note.

THE WITNESS: No. I said no. Not that I recollect.

Q (BY MS. MORALES) Okay. And so what I'm showing is that, from the REACH Air documentation, they were contacted at 11:36 p.m.

A The patient returned from the CT scan --

MR. WEAVER: Dr. Garvey, let her ask you a question, and then answer the question she asks you.

THE WITNESS: All right.

Q (BY MS. MORALES) And -- and so that, you're saying, would have been at or around the time that

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these films -- that you had reviewed the films, talked to the radiologist.

A No.

Q Correct?

A No.

Q Or right after.

A No.

Q Okay. Go ahead.

A No.

Q When -- when was it?

A REACH was called after I reviewed the films personally --

Q Okay.

A -- and saw the pneumothorax.

At that time I knew the patient needed to be transferred. He was still in serious condition. He was not critical at that point in time.

Q And do you recall what you told the -- did you personally call REACH Air?

A No.

Q Okay.

A No.

Q Who do you have -- what's the custom and practice? Who do you have call REACH Air?

A Usually the clerk, if there was a clerk

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working. Otherwise a nurse would do it.

Q And do you tell the nurse or the clerk what to convey to REACH Air?

A In this case, probably told them to have -- "We don't have accepting yet, but Dr. Garvey wants you to come up to the emergency department."

Q So from the time that you reviewed the films, you had someone reach out to REACH Air, did you administer any additional treatment before -- before you get -- before trying -- attempting to intubate or put the chest tube in? Was there any --

A Well, the only treatment that we -- I remember coming back, we had to put the Venti mask on him because his oxygen saturation had gotten close to 90 percent -- 90, 91 percent while he was in CT scan.

And he returned back from CT scan still very nauseous, so I had to give him another dose of Zofran. So his airway was potentially unstable. So we -- you know, he's on a backboard and a collar and complaining of nausea, so he could have vomited at any time.

Q And so did you order more Zofran?

A Yes.

Q And do you know what dose you ordered?

A Usually four milligrams.

Q And did you have an understanding that

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Mr. Schwartz had a full meal just prior to getting hit by the car?

A Yes, I knew that.

Q And when you say he could have vomited at any time, what -- what was your fear with that?

A We would lose his airway. He would vomit and aspirate. He's on a backboard and a C collar.

Q And at what point did you call the University of Utah?

A Right after I got the CT readings.

Q And did you personally call?

A I didn't. The clerk usually calls. And as soon as they get on the line, the transfer center, I speak to whatever the accept -- whoever the receiving is. It's usually an emergency room physician.

Q And how did you make the determination to send him to the University of Utah as opposed to somewhere else?

A Probably his wife or -- he or his wife chose the University of Utah versus Renown or Saint Mary's. Those are the three typical trauma centers that we will transfer to.

MR. WEAVER: Can we take a break whenever you get through whatever line of questions?

MS. MORALES: Yeah. That's fine.

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

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

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

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A Dr. Ray, an emergency physician.
Q And have you worked with Dr. Ray before?
A No, I have not.
Q Okay. And so you never transferred a patient that you can recall to this specific physician?
A Not that I can recall. I possibly have.
Q And what information did you convey to him when you talked to him?
A I pretty much listed all the injuries that we know -- knew of at the time. Pneumothorax, flail chest, pulmonary contusion, hemoperitoneum.
Q So just so we're clear, you told him the flail chest, the --
A Pulmonary contusion.
Q -- pulmonary contusion, although you didn't know whether or not there actually was a contusion; correct?
A Clinically there was and radiographically concurred, so yes.
Q Okay. What else did you tell him?
A Hemoperitoneum. Blood in the belly.
Q Okay.
A That's probably -- I mean, I may have listed everything else, but those are indicators of major

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

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

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

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

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

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

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

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

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

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

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

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talking to Dr. Patent?
A During the care of Mr. Schwartz. Probably not after the results of the CT scans came back.
Q Okay. So you don't have a specific recollection of discussing or talking with Dr. Patent after -- after you got the radiology results.
A No. There was only a ten-minute period there, and I do not think I would have wasted time talking to Dr. Patent.
Q Do you have a recollection of Dr. Patent after Mr. Schwartz died asking you why you intubated Mr. Schwartz?
A I don't recall that, no.
Q Okay. And Dr. Patent testified that your response was that the receiving facility told you to intubate Mr. Schwartz.
Do you have that recollection?
A It's my --
MR. BURTON: Object. Lacks foundation. He's already testified he doesn't recall the conversation.
Go ahead and answer the question.
THE WITNESS: Yeah. No, I do not recall that. But --
MR. WEAVER: You've answered. Just answer the question.

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

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

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

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

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anesthetist?
A No, I did not.
Q Are there nurse anesthetists available at Northeastern Regional?
A There probably was one on call, yes.
Q And you would agree that nurse anesthetists are more experienced to deal with high-risk intubations; correct?
A Absolutely not.
Q Why? Why do you say that?
A I have no idea what the qualifications and the capabilities of the nurse anesthetists are. I know that they intubate in a controlled environment with fasted patients, but this is a completely different situation. This is a rapid-sequence intubation and not an operation-room intubation.
Q Would you agree that a nurse anesthetist would have more experience than an EMT?
MR. WEAVER: Object as to form.
THE WITNESS: No, I do not. I --
Q (BY MS. MORALES) And why is that?
A I know that -- I know that all of the REACH flight -- flight crew were very competent and qualified in airway management. That's the primary focus of their training. I do not know anything of

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the competency or the qualifications of the nurse anesthetists, and I don't know if they've ever -- a nurse anesthetist have -- has ever done a rapid-sequence intubation on a patient with a full stomach. But the paramedic does it quite frequently.
Q Was it an option to attempt to transfer Mr. Schwartz without intubation?
A No, it wasn't an option.
Q Why not?
MR. BURTON: I'm just going to object. It's been asked and answered several times.
MR. WEAVER: Join.
THE WITNESS: Because of the risk of aspiration en route, I would never be able to defend a bad outcome in a patient requiring intubation inflight or aspirating inflight and me having not intubated him. I can defend attempting to intubate, but I cannot defend not intubating.
Q (BY MS. MORALES) And it's the same risk that he had with trying to intubate on a full stomach at the hospital; correct?
A No. Completely different situation. You're in a cramped aircraft without the resources of the hospital. We had three suction units going, we had multiple hands involved, and we had plenty of room.

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And that -- that would have been disastrous for the patient and the crew if that happened inflight to -- to Salt Lake City.
Q Can you tell me where in the medical records it identifies that his oxygenation started to drop that identified -- or that necessitated the -- the mask.
A Like I said, he got back from CT scan around 11:15, somewhere around that. And that's when his oxygen saturations started hitting around 91 percent on the four-liter nasal cannula.
Q Right. And on page 4, it shows a nasal cannula all the way up until 23 -- well, actually until ten minutes after midnight --
A That's not --
Q -- on the 23rd --
A That's not true. There -- there's notes, there's documentation in the record when the Venti mask was started. I don't -- I -- I'd have to go through each of the pages of the record. But the Venti mask was started as soon as he got back from CT scan. Forty percent Venti mask.
I -- I don't know the time, but I know it's somewhere in the record. I saw it yesterday.
MR. WEAVER: It's on page 10.

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MS. MONTET: Page 10.
Q (BY MS. MORALES) Okay. Is the Venti mask different than the non-breather (sic) mask?
A Yes.
Q Okay. And what was the non-breather mask used for?
A That was to preoxygenate the patient prior to intubation. We not only put a non-rebreather mask on, we put a nasal cannula at 15 liters on, and we assist the patient in respirations until we can get the oxygen saturation up as high as we can before we intubate.
Q Okay. And that -- his oxygen dropped right after he was being moved back to the emergency room; correct?
A No. They actually dropped in the CT scanner.
Q I'm sorry?
A They dropped while he was in the CT scanner.
Q Where -- where are you seeing that?
A Just on the times. The 91 percent began before he got back.
They were 94 percent initially. That first gas, the 83 percent, is a room air gas. That's when the transition was made from four-liter nasal cannula

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

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

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

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

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

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

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

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

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it gets to that level, we abort the attempt and then try to reoxygenate the patient back up to a higher oxygen level before we do a second attempt.

And so I asked him -- he says he can't visualize. And I said, "The oxygen saturations are dropping. Why don't you go ahead and pull out. Let's get him oxygenated back up and then go ahead and reattempt."

And so when he inserted the blade for the second attempt, that's when the reflux and regurgitation started.

Q Okay. And if you can look at -- let's see. If you're able to tell on page 4, let me know, but I know there's handwritten notes I have to find as far as when after the first attempt and you had to pull out and reoxygenate, where that happened in the timeline there.

Here it is.

Okay. So going to page -- sorry, I asked you a question, to see if you can find it.

And you might -- I -- I don't know if it will help any more, but there is additional documentation on page 42 of intubation.

A Forty-two.

MR. WEAVER: What -- what was the question?

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MS. MORALES: Yeah, so --

MR. WEAVER: -- or were you just getting him --

Q (BY MS. MORALES) So at -- at what point -- you just mentioned that after the first, like, failed attempt, he pulled out and you told him to reoxygenate.

Can you show me where that occurred.

A Well, I don't --

MR. WEAVER: Just -- just let me object. I -- I don't think -- I think it misstates his testimony. I don't think he said it was a failed attempt.

But go ahead.

MR. BURTON: Join.

Q (BY MS. MORALES) Was it a failed attempt?

A There was no failure -- I mean, there was no tube that passed or anything. It was trying to visualize the cords. So at the first attempt to visualize the cords, that was unsuccessful, so we pulled out and tried to reoxygenate.

And let's see in my notes somewhere...

MR. WEAVER: Jenn, tell me the question one more time. I'm not saying you didn't say it. I just -- I just forgot what the question is.

MS. MORALES: So at the point that he pulled out to try again, he said he reoxygenated.

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MR. WEAVER: Oh.

MS. MORALES: So we're trying to find out where he reoxygenated --

MR. WEAVER: Right.

MS. MORALES: -- after pulling out.

THE WITNESS: Yeah, I'm not sure where -- you can read my -- my -- these are all, like I say, retrospective.

MR. WEAVER: The question is can you tell what time the reoxygenation occurred?

THE WITNESS: Right after he pulled out. I mean, that's what was -- he was told to pull out and reoxygenate.

Q (BY MS. MORALES) Okay. So if you look at page 4, it shows -- you would agree that it shows oxygenation level, correct, at different intervals of time?

A Yes.

Q And so just so we're clear -- and I only have a few minutes I was warned -- at ten minutes after on June 23, it shows 97 percent on 15 percent nonbreather mask.

Would -- that was preoxygenating the patient for the procedure to begin with; correct?

A Let's see. When was the first attempt at --

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Ketamine. Eighteen, 20. Okay. 20. Right there.

That may be the number that the patient dropped to before the patient was reoxygenated, yes.

Q Okay. But the procedure didn't start until -- it looks like at the beginning of this it has 0018. So this oxygenation was actually before the procedure started.

A No. No.

Q Okay.

A The procedure before the -- 99 percent on 15-liter mask. That would probably be the -- the oxygen level when the procedure was started, the 99 percent.

Q That wasn't preoxygenating the patient for --

A That --

Q -- the procedure?

A That was preoxygenating the patient for the procedure.

Q Okay. So that's why -- I just want you to follow along and make sure I'm right.

So that's preoxygenating the patient at 10 minutes after and 15 minutes; is that correct? During that period of time.

MR. WEAVER: I think where the confusion is, is

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

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

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

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

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suction as best we could with the suction we had available, but none of it was working very well. We suctioned it out as well as we could for my attempt at the intubation with the direct laryngoscope blade. And I thought I saw the tips of the cords. I thought I saw the tube pass.

I put the tube in. We inflated the balloon, and the tube filled with emesis.

We tried to clear it. We couldn't clear it adequately. We couldn't get a CO2 reading on it. Wasn't sure what the placement was. We kept that in for several minutes because I was almost positive that I had it in the proper position.

And eventually, since it was still filling with emesis, I said, "We got to pull it, and we got to try again." Pulled that, and we were never really able to clear the airway well enough to be able to ventilate the patient.

Q And are there any other options when that occurs as far as a patient then begins to regurgitate or aspirate? Is there -- are there any options to try to wake the patient?

A No. The -- the Rocuronium is going to last at least 10 to 20 minutes. That's the paralytic. And the Ketamine is going to last 10, 15 minutes at least.

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So no, there's no attempt -- no way that we're going to be able to wake the patient.

At that point in time, I decided that I was going to probably do the cricothyrotomy.

Q And that's when you --

A Yes.

MR. WEAVER: Wait.

Q (BY MS. MORALES) -- open up near the trach area?

A Yes.

Q And on this timeline, when did you decide to -- to do that?

A When I decided to do that was probably -- it was after those few intubations, right when the patient pretty much arrested. He went into cardiac arrest probably because of the low oxygen levels.

So I was going over to do the cricothyrotomy, and the -- one of the EMTs said, "I have a King airway. Do you want -- do you want us to insert that?"

Q Okay. And can you explain what a King airway is?

A A King airway is a rescue airway that has two balloons. One -- it's inserted into the esophagus. You blow up that esophageal balloon. At

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the same time you blow up a oral balloon, and then there's a opening right at the glottis that you can ventilate the patient with a bag. And some -- some EMS units use that as their primary rescue airway as opposed to doing intubations.

Q Okay. And was that -- do you use that on higher risk procedures if you know that the patient has a full stomach?

A No. We wouldn't -- you use that as an alternative to intubations, maybe for difficult intubation. It is considered a rescue airway. We don't have one in the emergency department. It just so happened that the EMS crew was there, and we used their King airway.

On my way over to the side of the bed to do the cricothyrotomy, he mentioned the King airway, and I said, you know, that's probably an excellent choice. We might be able to occlude the esophagus enough to get the oral airway suctioned.

Q And that was before you attempted to do the cricothyrotomy?

A That was before. Yes, that was right when the patient required CPR. We had CPR in progress during the placement of the King airway.

Q And how many suction machines did you have

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going?

A We had both of our wall suction machines and we had one of EMS's portable suction machines all going. Just with our suction machine, we got over a liter of emesis, and not telling how much the other ones got.

Q And so there were three people suctioning?

A Possibly three people. We had three suction units. I don't know if one had two in their hands or whatever, but we had three units going at once.

Q And did the King airway help?

A Yes, it did. I was pretty amazed. CPR was started. I think we gave a milligram of epinephrine. We were doing chest compressions. They placed the King airway, started bagging with the King airway. The oxygen saturations improved, and the patient regained a pulse.

Q And can you look at this timeline on page 4 and tell me when the King airway -- are you able to tell on here?

A Not on page 4. Page 4 is just sort of a computer-generated timeline, so I don't know what I'm looking at there.

But I would say the King airway was placed around 0335 -- 0035. That's when the patient

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arrested. King airway was placed, the oxygen saturations started improving with the King airway, and the pulse came back.

Q And then what happened?

A Then the patient started sort of deteriorating again. His pulse -- his oxygen saturation started dropping. And -- let's see. 035, King.

What I did -- since they started dropping, I thought maybe we could leave the King airway in place and deflate the balloons, suction the oral cavity, and see if I could pass the bougie into the cords while we still had the King airway in place occluding the esophagus.

I had digitally placed the bougie. I thought I felt the cords. I felt the bougie -- felt the bougie go through the cords. I put an ET tube in, blew up the balloon, pulled the King airway, and the ET tube filled up with emesis again.

Again, I, you know, in retrospect, feel that the tube -- both those tubes that I placed were in the proper positions, but the patient with his initial aspiration filled his trachea and had a massive aspiration from the -- from the initial attempts.

Q So he would have been -- strike that.

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So at what point -- I'm looking at 42.

So when you did -- did you actually wind up doing the cric procedure?

A Yes. We did the cric procedure after I pulled the King, after we pulled the tube that I thought I had in. I don't know if -- I can't remember if he arrested right prior to the cric procedure, but right around that time he went into arrest again. Did the cric. Put the cric tube in, and the cric tube filled with emesis.

Q Was Barry Bartlett still helping with this intubation after his initial failed attempts?

A It depends on what we were doing at the time. There -- both of us were -- after people thought they -- they suctioned enough, both of us attempted to visualize the cord and attempted intubations. But none were -- well, again, some were probably successful, but none were -- none secured the airway. Everything filled with -- with emesis.

Q And was a code called in this case?

A After the cric tube was switched out to another tube that was a little longer that I could float down an ET tube further down into the trachea, it also plugged up and -- which confirmed that it was a pretty massive aspiration. We pulled that tube.

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The patient stayed arrested, and a code was called.

Q So there was -- if I understand correctly, there was only the one time that he regained a pulse before he started crashing again?

A He went into the first arrest, King airway was placed, he regained vital signs, then went into a second arrest, and never regained it the second time.

Q So did you actually get the chest tube placed before this occurred?

A No.

Q How far along did you get in that process?

A All I did was prep the skin. Put the drapes on. I ended up putting needles in both chests just in case there was a tension pneumothorax that formed, but...

Q Since you're also medical director of REACH Air, did you ever have any ongoing or any communications with Mr. Bartlett after this incident occurred?

A No, I did not.

Q Did you work with him after this incident?

A I can't recall if I did or not. Again, I'm only there once a month, and it depends which crew is on. And I can't recall working with him since the -- after that incident. I have no recollection.

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Q Do you recall any of your discussions that you had with Diane Schwartz?

A When? After we --

Q After this occurred.

A Not -- I don't remember specifically. I just know it was very difficult to go and tell her that her husband passed away.

Q Okay. Do you have any recollection of explaining the intubation procedure or the need to intubate with Ms. Schwartz after he passed?

A No. I probably would not have gotten into that at all. Not the time.

Q And besides what we've talked about already with Dr. Patent, do you recall any other discussions with him or anyone else at the hospital?

A The only one I remember talking to was Dr. Patent. He's a podiatrist and a close friend. And -- and I may have even mentioned that he passed, that Mr. Schwartz passed before I spoke with Mrs. Schwartz, but I don't remember the specifics of the conversation.

Q Besides that day, the actual day that Mr. Schwartz passed, did you have any additional conversations with Dr. Patent regarding this case?

A I don't think I spoke to Dr. Patent at all

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

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

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

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A It depends -- you've got to weigh the risks and benefits. I -- patient safety is very important. But it depends on the situation and -- and, you know, in the context of what we're talking about, you know --
MR. WEAVER: If you can't give her a number, just tell her you can't give her a number.
THE WITNESS: I guess I can't give you a number.
Q (BY MS. MORALES) Okay. You agree that -- you agree that there are limitations on the way doctors practice medicine?
MR. WEAVER: Object as to form.
THE WITNESS: I don't understand the question.
Q (BY MS. MORALES) You've heard the term "clinical judgment"; correct?
A Oh, yes.
Q You've heard the word -- the term "best judgment."
A Yes.
Q Does that mean the same thing to you?
A It should.
Q And you understand that in using clinical judgment, that clinical judgment must be within the standard of care; true?
MR. WEAVER: Object as to form.

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

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

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

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

THE VIDEOGRAPHER: We are off the record at 4:48 p.m.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the record, 4:55 p.m.
MR. BURTON: I don't have any questions.
MR. WEAVER: We'll read and sign. Thank you. Good-bye.
THE VIDEOGRAPHER: We are off the record, 4:55 p.m.
(The deposition was concluded at 4:55 p.m.)

CERTIFICATE OF DEPONENT

PAGE LINE CHANGE

_____
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I, DAVID JAMES GARVEY, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript this _____ day of _____, 2019.

_____
DAVID JAMES GARVEY, M.D.
Deponent

REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Vicki Turner, a certified court reporter in Clark County, State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, DAVID JAMES GARVEY, M.D., commencing on June 25, 2019, at 10:17 a.m.

That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 16th day of July 2019.

Vicki Turner

G

NORTHEASTERN NEVADA REGIONAL HOSPITAL
PHYSICIAN ATTESTATION

Date: 6/24/16
Time: 12:43:52

PATIENT NAME: SCHWARTZ DOUGLAS R AGE: 58 SEX: MALE
PATIENT NO: 6139781 CHART NO: 000330967 HISTORY NO: 000330967
ADMISSION DATE: 6/22/16 DISCHARGE DATE: 6/23/16
FC: 94 LIABILITY (TPL) SRV:008 EMERGENCY DEPARTMENT
PHYSICIAN: 02818 DISCHARGE STATUS: 20 EXPIRED OR DID NOT RECOVE

FINAL DIAGNOSES		POA	ICD CODE
Coded by	CRO9538		
Finalized by	CRO9538		
PRINCIPAL DIAGNOSIS			
CARDIAC ARREST, CAUSE UNSPECIFIED			I469
SECONDARY DIAGNOSES			
TRAUMATIC PNEUMOTHORAX, INITIAL ENCOUNTE			S270XXA
FLAIL CHEST, INITIAL ENCOUNTER FOR CLOSE			S225XXA
FOOD IN RESP TRACT, PART UNSP CAUSING AS			T17920A
CONTUSION OF LUNG, UNSPECIFIED, INITIAL			S27329A
UNSP INJURY OF OTHER INTRA-ABDOMINAL ORG			S36899A
PED ON FOOT INJURED PICK-UP TRUCK, PK-UP			V0390XA
ACTIVITY, UNSPECIFIED			Y939
UNSP STREET AND HIGHWAY AS PLACE			Y92410
UNSPECIFIED EXTERNAL CAUSE STATUS			Y999
ESSENTIAL (PRIMARY) HYPERTENSION			I10

NORTHEASTERN NEVADA REGIONAL HOSPITAL

Facesheet

MEDICAL RECORD NUMBER	MRSA	VRE	PATIENT ACCOUNT NUMBER
000330967			6139781

PATIENT (Name, Address, Phone)

SCHWARTZ DOUGLAS R
736 WESTCOTT DR

SPRING CREEK NV 89815

COUNTY: ELKO
PHONE: (702)373-2436

BIRTH DATE	AGE	BIRTH PLACE	SOCIAL SECURITY NUMBER
06/02/1958	58		

SEX	RACE	M/S	ED CD	PREV ADM	REL	ADMITTED BY
M	W	M		07/22/14	R	LUE

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.)

ELKO FEDERAL CREDIT
MOUNTAIN CITY HWY
ELKO NV 898010000

PHONE: (775)738-4083
OCC: EXEC VICE PRES

EMERGENCY CONTACT (Name, Address, Phone, Rel.)

SCHWARTZ DIANE
736 WESTCOTT DR
SPRING CREEK NV 89815

PHONE: (702)277-6455
REL: Spouse

REFERRAL SOURCE / AGENCY / TEAM MEMBER

PHONE:
CONTACT NAME:

GUARANTOR (Name, Address, Phone)

SCHWARTZ DOUGLAS R
736 WESTCOTT DR

SPRING CREEK NV 89815

PHONE: (702)373-2436
REL: Patient is insured

GUARANTOR EMPLOYER (Name, Address, Phone)

ELKO FEDERAL CREDIT
MOUNTAIN CITY HWY
ELKO NV 898010000

PHONE: (775)738-4083

FINANCIAL CLASS

94 LIABILITY (TPL)

ATTENDING PHYSICIAN

GARVEY DAVID J MD 2818

ADMISSION STATUS	DISCHARGE STATUS
	20

PRIMARY 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

SECONDARY INSURANCE

BCBS PREFIX YF
PO BOX 5747

DENVER CO 802175747

PHONE: (877)833-5742

POLICY# YFO841M50938

GROUP #: A46847
GRP NAME:
AUTH#: NR/ER

SCHWARTZ DOUGLAS R
DOB: 06/02/1958 SEX: M
REL: Patient is insured

TERTIARY INSURANCE

PHONE:

POLICY#

GROUP #:
GRP NAME:
AUTH#:

DOB: SEX:
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 HI

T BY A CAR HIT AND RUN GAVE PT MRA PACKET NO PAYMENT OR DISCOUNT OFFERED

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
MRN: 330967
Account#: 6139781
Private MD:

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 djg/jkp

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.

Exam:

21:20 djg/jkp

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 accomodation.
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.

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

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 20:53 Body Mass Index 29.41 (92.99 kg, 177.80 cm) 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 20:52 MSE Initiated by Provider. 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

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 *Dispensable & Quantity*	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:

Name: Douglas Schwartz

MRN: 330967
Account#: 6139781

Print Time: 6/24/2016 12:08:23

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 separrate 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		jkp

Name: Douglas Schwartz
Age: 58 yrs **Sex:** Male **DOB:** 06/02/1958 **MRN:** 330967
Arrival Date: 06/22/2016 **Time:** 20:51 **Account#:** 6139781
Bed 16 **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 20:53 Presenting complaint: EMS states: right sided rib pain, right knee pain, right shoulder. Hit by car going 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:** 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. dk

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 00:35 **CPR assessment:** unresponsive, no respiratory effort, mechanical ventilation, Ambu ventilation, cyanotic, pulses absent w/ compressions. dk

00:35 Cardiac rhythm is asystole. dk

06/24 00:37 visited this patient and evaluated for pain, information needs and comfort. kp

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
06/22 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

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 20:53 Body Mass Index 29.41 (92.99 kg, 177.80 cm) 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 20:51 Patient arrived in ED. dk

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. Oxygen administration via nasal cannula @ 4L/min. dk

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

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 *Dispensable & Quantity*	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. Copius amounts of vomitus from posterier pharynx using 2 suctions simutaneously. 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. Copius amounts of vomitus from posterier pharynx using 2 suctions simutaneously. 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

Nurse's Notes Con't

Garvey, David, MD	MD	djg	Rangel, Hannah	hr
Abrams, Nancy, PCA	PCA	na	Olson, Sue	so
Kevitt, Donna		dk	Price, Julia	jkp
Payne, Kimber		kp		

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

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

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

Responsible Dept: Trauma

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

		arrest - Due to Asphyxiation	
06/23/16 03:06	**Bed Assignment**	**D1**	**Abrams, Nancy, PCA**
06/23/16 03:06	Patient Move	D1	Abrams, Nancy, PCA
06/23/16 03:06	Responsible Dept Assignment	Automatic : Unassigned	Abrams, Nancy, PCA
06/23/16 03:06	**Bed Assignment**	**16**	**Abrams, Nancy, PCA**
06/23/16 03:06	Patient Move	16	Abrams, Nancy, PCA
06/23/16 03:06	Responsible Dept Assignment	Automatic : Unassigned	Abrams, Nancy, PCA
06/23/16 03:18	Results Viewed	Ct Brain Head Wo	Garvey, David, MD
06/23/16 03:18	Results Viewed	CT T Spine W/O	Garvey, David, MD
06/23/16 03:18	Results Viewed	Ct Chest W	Garvey, David, MD
06/23/16 03:18	Results Viewed	Cbc W/ Auto Diff	Garvey, David, MD
06/23/16 03:18	Results Viewed	CMP	Garvey, David, MD
06/23/16 03:18	Results Viewed	Lipase	Garvey, David, MD
06/23/16 03:18	Results Viewed	Amylase	Garvey, David, MD
06/23/16 03:18	Results Viewed	Urinalysis	Garvey, David, MD
06/23/16 03:18	Results Viewed	CT C Spine Wo	Garvey, David, MD
06/23/16 03:18	Results Viewed	CT Abd/Pelvis IV Only	Garvey, David, MD
06/23/16 04:07	Vital Signs Modified		Kevitt, Donna
06/23/16 04:07	Vital Signs Modified		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 04:07	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 04:07	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 04:07	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	Kevitt, Donna

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

NORTHEASTERN NEVADA REGIONAL HOSPITAL

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.

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

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS / OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (P.A.'s), Nurse Practitioners (N.P.'s), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

    ☒ I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Northeastern Nevada Regional Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

12. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

13. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

14. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

15. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

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 Re> Diana Schwartz 6/22/16

Signature of Patient or Legal Representative for Health Care if Other Than Patient — Date / Time

Relationship of Representative

Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

<ESIG DESC=Witness> 6/22/16

Signature of Witness — Date / Time

CARDIAC ARREST RECORD

Northeastern Nevada Regional Hospital
2001 Errecart Blvd. • Elko, Nevada 89801

PATIENT NAME: Douglas R. Schwartz

PAGE _____ OF _____

DATE: 06-23-16 TIME OF ARREST: 0035 CPR INITIATED BY: _____ LOCATION OF ARREST: NNRH ER-Bed 12 DIAGNOSIS: Cardiac Arrest due to Asphyxiation

ED ARRIVAL TIME: 6-22-16 2353 ATTD PHYS NOTIFIED TIME _____ BY _____ FAMILY NOTIFIED TIME 0145 BY Dr. Garvey

WHITE - CHART COPY
YELLOW - CHARGE COPY
PINK - COURIER COPY

TEAM MEMBERS (Name and Title)

1) David Garvey, MD 2) Donna Kevitt, RN 3) Sue Olson, RN 4) Cyndy Fuss RN
5) Nancy Abrahms, Sitter 6) Bonnie, RN-REACH Air 8) Barry RN-REACH 9) Tom R.T. Paul EMS Ward

TYPE OF ARREST (CHECK ALL APPROPRIATE)

- ☐ RESPIRATORY
- ☐ CARDIAC
- ☐ WITNESSED
- ☐ UNWITNESSED
- ☐ ECG MONITORED
- ☐ V/TACH. _____
- ☐ V-FIB
- ☐ ASYSTOLE
- ☐ EMD
- ☐ OTHER

INITIAL ASSESSMENT

RESPIRATIONS ☐ PRESENT ☐ ABSENT ☐ AGONAL

CAROTID PULSE ☐ PRESENT ☐ ABSENT

INTUBATION

SIZE: _____ FIO_2 _____
TIME: _____
BY WHOM: _____
BILAT BS: ☐ PRESENT ☐ ABSENT

☒ IV PRESENT - Site 20g (R) hand
☑ IV STARTED - Site 20g (R) wrist
NEEDLE SIZE: _____
SOLUTION: NS
BY WHOM: EMS (1) / Paramedic student (1) (Kristina)

TIME	RESPIRATION S= Spontaneous A=Assisted	PULSE S= Spontaneous A=Assisted	RHYTHM	BP	JOULES	EXTERNAL PACING	SINGLE DOSES: EPI IV or ETT	SINGLE DOSES: ATROPINE IV or ETT	SINGLE DOSES: LIDOCAINE	SINGLE DOSES	SINGLE DOSES	DRIP MEDS: DOPAMINE (mg/min)	DRIP MEDS	DRIP MEDS	ABG: PH	ABG: PO_2	ABG: PCO_2	ABG	COMMENTS/LAB
0018	Ketamine 180 mg IVP, Rocuronium by Reach Air nurse Ronnie RN																		
0020	ET tube attempted / unsuccessful																		started bagging 7.5 tube by Barry RN
0033	〃		〃			〃									〃				7.5 tube / 9 tube by Barry RN
0035	CPR in progress			HR 36											O2 sat 37%				while bagging Brady.
0036	King airway placed 225/36														O2 sat to 79%				King placed by Barry RN
0040	HR 120			O2 sat 82%											249/40				
0044	ET tube attempted by Dr. Garvey / unsuccessful / started bagging																		
0047	〃		〃		〃				〃						〃		〃		/ started bagging
0050	O2 sat 65%			CPR continues													asystole		
0052	ET tube insertion attempted by Barry (Reach) unsuccessful 55-60% O2 sat / Bagging																		
0053	O2 sat 50% unsuccessful c ET tube insertion CPR continues																		
0054	HR 147			42% O2 while bagging											221/148				
0057	NPA placed by Dr. Garvey																		
0058	O2 sat 69% c NPA			CPR continues asystole															
0102	75% O2 sat HR 122																		
0104	65% O2 sat 203/43 121 HR																		
0108	Code attempted by Dr. Garvey.																		
0113	O2 sat 60% asystole continuing CPR																		

Cautioning throughout code

OUTCOME

☐ SUCCESSFUL DISPOSITION
☒ UNSUCCESSFUL Code Terminated At 0133 (time)
BY WHOM: Garvey MD

SIGNATURE OF RECORDER X Silvia Wines EMT
SIGNATURE OF MED NURSE X Donna Kevitt RN
SIGNATURE OF MD IN CHARGE X _____

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
ER #: 000330967 PT #: 6139781

PA. 113

SUMMARY OF CQI/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 _____

CARDIAC ARREST RECORD

PA. 115

Northeastern Nevada Regional Hospital
2001 Errecart Blvd. • Elko, Nevada 89801

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 _____ BY _____ FAMILY NOTIFIED TIME _____ BY _____

WHITE - CHART COPY
YELLOW - CHARGE COPY
PINK - CQI/RM COPY

TEAM MEMBERS (Name and Title)

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ &) _____ *) _____

TYPE OF ARREST (CHECK ALL APPROPRIATE)

- ☐ RESPIRATORY
- ☐ CARDIAC
- ☐ WITNESSED
- ☐ UNWITNESSED
- ☐ ECG MONITORED
- ☐ V/TACH. _____
- ☐ V-FIB
- ☐ ASYSTOLE
- ☐ EMD
- ☐ OTHER

INITIAL ASSESSMENT

RESPIRATIONS
☐ PRESENT ☐ ABSENT ☐ AGONAL

CAROTID PULSE
☐ PRESENT ☐ ABSENT

INTUBATION

SIZE: _____ FIO_2 _____
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: EPI IV or ETT	SINGLE DOSES: ATROPINE IV or ETT	SINGLE DOSES: LIDOCAINE	SINGLE DOSES	DRIP MEDS: DOPAMINE (mg/min)	DRIP MEDS	DRIP MEDS	ABG: PH	ABG: PO_2	ABG: POC_2	COMMENTS/LAB
0116																	O2 sat 37% HR 81 BP 126/95
0117																	CPR started. No pulse. O2 44% HR 33
0119																	O2 sat 36%
0120																	Asystole. No O2 cyanotic
0122																	52% O2 sat. CPR still in progress.
0124																	61% O2 sat. CPR still in progress. Gastric expansion.
0125																	49% O2 sat. CPR continues.
0128																	64% O2 sat. CPR continues.
0129																	Needle decompression - Right
0131																	Needle decompression - Left/Right chest
0133																	Stop compressions. Time of death 0133
																	During procedure - suctioning performed. Copious amounts of vomitus from posterior pharynx.

OUTCOME:

☐ SUCCESSFUL DISPOSITION

☒ UNSUCCESSFUL Code Terminated At 0133 (time)

BY WHOM: _____ MD

SIGNATURE OF RECORDER X Silvia Wines, EMT

SIGNATURE OF MED NURSE X _____

SIGNATURE OF MD IN CHARGE X _____

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

SUMMARY OF CQI/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:
ID: Patient 0206
Patient Mode: Adult
Start Time:
06/23/2016 12:06:14AM
Total Trend Events: 27
Dept:
Unit:
S/N: AI11K001505
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
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: AI11K001505
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
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
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

Organ and Tissue Notification:

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

Spoke with : Elizabeth Hill
Time: 0324 — 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 Coe Dept for investigation

The option of Organ and Tissue Donation has been presented:

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

____ **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

NORTHEASTERN NEVADA REGIONAL HOSPITAL

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.

n/a — Patient / Responsible Party's Signature
n/a — Relationship
Date

Summary of Risks and Benefits:

Risk of Transfer:

☒ Worsening of medical condition including risk to unborn/ newborn in the case of pregnancy. Disease specific risks: Death
☒ Transportation Risks plane crash
☐ Other:

Benefits of Transfer:

☒ Immediate access to specialized practitioner / equipment / monitoring, specifically: Trauma
☐ Bed capacity that is not currently available at this facility.
☒ Continuity of care
☐ Other:

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

X Diane Schwartz — Signature of Responsible Party — Spouse — Relationship — 6·22·16 — Date
[illegible], RN — Signature of Witness — Nurse — Relationship — 6·22·16 — Date

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 — Relationship — Date
Signature of Witness — Relationship — Date

SUMMIT AIR AMBULANCE

Flight # 16-14083 (16-14060)

Transport Info

Sending Facility _____

Unit _____ Bed _____

Physician _____

Receiving Facility _____

Bed _____

Physician _____

Patient _____

Weight 92 CODE STATUS _____

Chief complaint _____

Time	Drug / Fluids	Dose
	Dilaudid	

Time	Drug / Fluids	Dose

Called back with "GO" _____

Depart /arrive sending ~~1132~~ 1145 - 1155

Arrive bedside 1157

Called for ambulance _____

Ambulance arrives _____

Walk out of referring _____

Loaded and leaving referring _____

Arrive airport _____

Lift off from airport _____

Destination airport _____

Loaded and leaving dest. airport _____

Arrived receiving _____

Arrive bedside / handoff _____

Depart receiving _____

Past Medical History _____

Allergies: _____

Time	HR	B/P	Sat	Pain

10% pneumo 97%

REACH Flight Crew
Elko EMS
David Garvey, MD
Donna Kevitt, RN
Sue Olson, RN
Tom Evers, RT

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

deal 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.
'ent Check: Turn on > clear alarm > Select & scroll to "Vent Check" > select.
'ressure 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
nd peds. Adjust fIO2 and/or PC up or down PRN to increase sPO2 or change ETCO2.
'o increase sPO2 add more PC. To maniplute ETCO2 manipulate PC.
'IPAP 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.
larms: Set high 10 point above PIP and low 10 points below PIP.

Epi 1mg
Keta
ROC

Keta ROC
0018 0018

Tube 0020 - no
0023 unsuccessful
0033 unsuccessful 7.5
0033 unsuccessful 9.
0035 CPR
0036 king 1057 225/136 47 79 (Paul)
Resp O2
0040 1457 82 O2 Resp25 249/140
0044 unsuccessful
0047 unsuccessful
0050 O2 65%
0052 unsuccessful 2 55% , 60%
0053 50% O2 unsuccessful
0054 127 42 O2 221/148
NPA 0057 (69% 0058)

0102 177
75%
0104 suctions 65 O2 207/143 121
0108 Crik in prog.
0113 O2 60 (gun jump)

0116 37 O_2 81 126/95

0117 CPR started no pulse
44 O_2 33

0119 36 O_2

0120 asystoly - no O_2 cyanotic

0122 52 CPR still in progress

0124 61 O_2 CPR still gastric extention

0125 49 O_2 CPR

0128 64 O_2

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

SUMMIT AIR AMBULANCE

Flight # 16-14083 (16-14060)

Transport Info

Sending Facility _____

Unit _____ Bed _____

Physician _____

Receiving Facility _____

Bed _____

Physician _____

Patient _____

Weight 92 CODE STATUS _____

Chief complaint _____

Time	Drug / Fluids	Dose
	Dilaudid	

Time	Drug / Fluids	Dose

Called back with "GO" _____

Depart /arrive sending ~~#52~~ 1145-1155

Arrive bedside 1157

Called for ambulance _____

Ambulance arrives _____

Walk out of referring _____

Loaded and leaving referring _____

Arrive airport _____

Lift off from airport _____

Destination airport _____

Loaded and leaving dest. airport _____

Arrived receiving _____

Arrive bedside / handoff _____

Depart receiving _____

Past Medical History _____

Allergies: _____

Time	HR	B/P	Sat	Pain

10% Pneumo = 97%

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

deal 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
PC and PEEP together and that should ~ equate to PIP. This is a safe starting point for adults
nd peds. Adjust fIO2 and/or PC up or down PRN to increase sPO2 or change ETCO2.
o increase sPO2 add more PC. To maniplute ETCO2 manipulate PC.
BIPAP 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

Keta 180mg Roc

0018 0018

Tube 0020 - no

0023 unsuccessful

0033 unsuccessful 7.5

0033 unsuccessful 9.

0035 CPR

0036 king 1057 225/136 47 79 (Paul)
Resp O2

0040 1207 82 O2 Resp25 249/140

0044 unsuccessful

0047 unsuccessful

0050 O2 65%

0052 unsuccessful 2 55% , 60%

0053 50% O2 unsuccessful

0054 127 42 O2 221/148

NPA 0057 (69% 0058)

0102 177
75%

0104 suctions 65 O2 207/143 121

0108 Crik in prog.

0113 O2 60 (groin up)

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 payers.)

Patient Data | **Please Complete Each Sec**

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

Call # _____ Patient Name _____

Date of Service _____ Date of Birth _____

Diagnosis or Potential Diagnosis of Patient _____

Requesting Source

Requested By (full name and title) DR David Garvey

Requesting Entity (name and contact) NNRtt

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)

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

Specialty Care Required

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

- ☐ Cardiologist
- ☐ Cardiothoracic Surgeon
- ☐ Vascular Surgeon
- ☐ Neurologist
- ☐ Neurosurgeon
- ☐ Neuroradiologist
- ☐ Pulmonologist
- ☐ Gastroenterologist
- ☐ Neonatologist
- ☐ Pediatric Intensive Care Specialist
- ☐ Burn Specialist
- ☐ Trauma Surgeon
- ☐ ICU Not Available at referring
- ☐ Other (specify) _____

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 payor for any transportation cost. (Air ambulance supplier)

Signature/Date X [signature] RN Name (print) Donna Kevitt, RN

☐ EMT ☐ Paramedic ☐ Trained First Responder ☐ Physician ☐ Physician Assistant ☑ Nurse Practitioner ☐ R.N. 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

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 Nam **ervices Signature form**

Transport Date: _____ **Transport #:** _____

Privacy Practi signer acknowledges that **REACH Air Medical Services, LLC. (REACH)** provided
a copy of its Nc r party with instructions to provide the Notice to the patient. ***A copy of this form is**
valid as an ori

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

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 Diane 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

SECTION I – GENERAL INFORMATION

Patient's [illegible] Date of Birth: _____ Medicare #: _____

Transpo[illegible] nd trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: 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***:

[signature] 6.22.16

Signature of Physician* or Healthcare Professional — Date Signed

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

Donna Leavitt RN

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

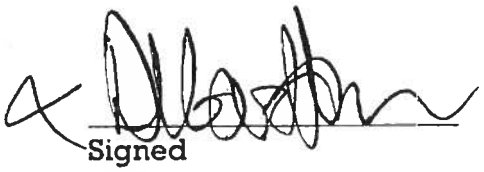
**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ 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 Kevitt

Printed Name

10-22-16

Date

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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)

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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)

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Northeastern Nevada Regional Hospital

Patient:	**SCHWARTZ, DOUGLAS (Male)**	DOB:	
MR #:	**330967**	Status:	ER
Date:	06/22/16 22:19	Slices:	0
History:	Study: CT ABD PELVIS IV ONLY		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT ABDOMEN & PELVIS With Contrast		
Contrast:			

Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000

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 hydroureteronephrosis. The small bowel loops are 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.

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 06/2 23:07 (-07:00)

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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	

statrad®
Leading Teleradiology

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

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

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

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

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

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

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********** **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

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

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

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

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

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.

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

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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.

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********** **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

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

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

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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

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

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

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********** **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

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

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 hydroureteronephrosis. The small bowel loops are

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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.

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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

Verify Receipt

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

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

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 hydroureteronephrosis. 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.

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

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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********** **ADDENDUM** **********

CR

Critical Value Communications

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

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

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

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

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed 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

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

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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REPORTING SOLUTIONS ADVANCED

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

-ooOoo-

DIANE SCHWARTZ, individually and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased,	:	Case No. CV-C-17-439
Plaintiff,	:	Dept. No. 1
v.	:	
DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., dba RUBY CREST EMERGENCY MEDICINE; et al.,	:	
Defendants.	:	

_____

VIDEO CONFERENCE DEPOSITION OF JOHN EVERLOVE

Taken on February 19, 2021

At 2:00 p.m.

Reported by: Rockie E. Dustin, RPR, CSR, CCR

(Nevada CCR# 968)

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A P P E A R A N C E S

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Page 3

Also Present: Aaron W. Byrd

-ooOoo-

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I N D E X

-ooOoo-

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February 19, 2021 2:44 p.m.

P R O C E E D I N G S

JOHN EVERLOVE,

called as a witness herein, having been first duly sworn by the Certified Court Reporter to tell the truth, was examined and testified as follows:

EXAMINATION

BY MR. BURTON:

Q. Mr. Everlove, can you tell me when you were retained in this matter?

A. Approximately one year ago, best of my recollection.

Q. Do you have a date on which you were retained?

A. Not that I recall. I recall it being approximately March of last year, or at least that's the first reference that I have, but I would be happy to look it up for you.

Q. Do you recall who retained you?

A. Yes. Ms. Blazich.

Q. Do you know how she found you?

A. I don't recall if we had that conversation.

Q. Do you know if she was one of your on-line advertising sites or not?

A. I don't recall exactly how she found me.

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Q. You do advertise your expert services; right?

A. Yes, I do.

Q. Where all do you advertise?

A. Seek Expert Directory, Juris Pro, and experts.com, I believe are the only three I've used.

Q. How long have you advertised your expert services?

A. Approximately four to five years.

Q. Mr. Everlove, what is your understanding of your -- of the role that you've been asked to fill in this case?

A. I was asked to review the materials related to the treating of Doug Schwartz in the hospital and in the care treatment and potential transportation provided by REACH Air Medical Services.

Q. Is there some way to turn up your volume? I know you're using your headset, but sometimes when you turn away from your -- the mic I think is on your headset. Sometimes when you turn away, it fades out.

A. Okay. I'll do a better job of trying to project. Hopefully that will help.

Q. The burdens of Zoom.

A. Yes.

Q. Can you identify every provider whose care you intend to offer an opinion on if this case goes to trial?

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A. I intend to offer an opinion on the REACH Air Medical Services care. I don't intend to offer an opinion on the care of Dr. Garvey, which are the two that I qualify as the providers of care. I know there are nursing staff that were involved. I don't intend to offer an opinion on the nursing staff from NNRH Hospital.

Q. On the REACH side, you indicated that you intend to offer an opinion on the REACH Air Medical Services care.

Do you intend to offer an opinion as to the care provided by both Barry Bartlett, the flight paramedic, and Ronnie Lyons, the flight nurse?

A. Specifically related to the care, I don't intend to offer an opinion related to Ronnie Lyons as a nurse. However, related to issues of consent and the transition or transport of care related to the transport company, offering interfacility transport, my opinions may apply.

Q. Well, today's the day for us to know if you intend to offer those opinions. So do you intend to offer an opinion regarding the care of Ronnie Lyons?

A. The care provided Mr. Schwartz by Ronnie

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Lyons, those -- any of that would have been outlined in my report. I don't believe I offered a specific opinion regarding care provided by Ronnie Lyons.

Q. And I'm not so much worried about what's in your report. I want to know, do you intend to offer an opinion regarding the care provided by Ronnie Lyons?

A. I believe I've given you my best answer. And as I sit here today, under oath, my report, I believe, touches on the areas that I intend to offer an opinion.

Q. I understand that. I'm not asking you to qualify it in terms of your report. What matters is your testimony. Your report is not what I'm worried about.

When we go to trial, do you intend to offer testimony regarding the care provided by Ronnie Lyons? Yes or no?

MS. BLAZICH: I'll object that it's asked and answered.

THE WITNESS: Giving you the qualification regarding care, that may touch on issues related to consent that involved Ronnie Lyons. So I believe I'm giving you the best answer and most truthful answer I can.

BY MR. BURTON:

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Q. All right.
Outside of the issue of consent, do you intend to offer any opinion regarding the care provided by Ronnie Lyons?
A. I would ask that care may also apply to the oversight of the care provided by Barry Bartlett as a field training officer or training superior, that Ronnie Lyons was overseeing Barry Bartlett, that may be an applicable opinion to care.
Q. And you keep qualifying as it "may be." Today is the only shot I get to know your opinions. And I'm -- I need a direct answer to this.
Do you intend to -- outside of the issue of informed consent, do you intend to offer opinions regarding the care provided by Ronnie Lyons to Mr. Schwartz?
MS. BLAZICH: Objection. It's been asked and answered.
MR. BURTON: It's not been answered.
BY MR. BURTON:
Q. Go ahead.
A. Yes, I think I would ask you, then, to clarify your use of the term "care," to make sure that I understand completely what you're asking.
Q. Well, you're the one holding yourself out

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as a medical expert; right?
A. Yes.
Q. And you don't understand the term "care," in the terms of a medical malpractice case?
A. I understand that the term care can apply to a lot of different interactions between a patient and a caregiver. Hence, the reason it's the depth of that understanding that I'm asking for either more clarification or my original answer still applies.
Q. All right.
Based on your understanding of the term medical care, do you intend to provide any criticism of the medical care provided by Ronnie Lyons, outside of the issue of consent, if this case goes to trial? Yes or no?
A. I believe I've given you my best answer.
Q. I want you to answer the question again.
MS. BLAZICH: Objection. It's asked and answered.
BY MR. BURTON:
Q. Go ahead.
A. Again, I believe I've given you my best answer, understanding my interpretation of the word care as it applies to all aspects of the patient caregiver relationship.

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Q. Remind me what your answer is. I don't think you actually gave one, but remind me what your answer is.
A. My answer is that as it applies to care, that would include the oversight of Barry Bartlett as a trainee for the REACH Medical team, and it would also apply to issues related to consent.
Q. You do understand Mr. Lyons is a nurse; correct?
A. Yes, I understand that.
Q. And you're not a nurse?
A. Yes, I understand that.
Q. And you're not a flight nurse; correct?
A. Yes. That is correct.
Q. Do you intend to offer an opinion as to the care that Ronnie Lyons, as a flight nurse, should have given in his role as a supervisor to Barry Bartlett, knowing that you lack the credentials to do that?
A. If we isolate care to the administration of medications, yes, I do not intend to offer an opinion related to Ronnie Lyons.
Q. I don't know why you would isolate it that way. That's not what my question was. My question was very specific.
Do you intend to offer an opinion as to the

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care that Ronnie Lyons, as a flight nurse, should have provided in his role of a supervisor of Barry Bartlett?
A. I believe I've given you my best answer.
Q. I want you to answer the question. Go ahead and answer it.
MS. BLAZICH: He's answered the question.
MR. BURTON: No, he hasn't.
BY MR. BURTON:
Q. Go ahead.
MS. BLAZICH: He's answered the question. He's delineated the testimony about a supervisor, that he does plan to give that.
MR. BURTON: Shirley, that's a speaking objection. Please don't do that.
BY MR. BURTON:
Q. Go ahead, Mr. Everlove, and give me your answer again.
A. My answer is that in the context of care that can apply to several different layers of patient caregiver interaction, that the administration of medications by Mr. Lyons would not be part of my opinions, but that the care may include issues related to consent and issues related to oversight by the private medical transportation team of a patient like Mr. Schwartz.

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Q. Is it fair to say that your report contains all of your opinions?
A. As I sit here today, yes.
Q. Do you intend to offer additional opinions at trial?
A. I intend to review further documentation subject to discovery that may either support, amend or create new opinions.
Q. But based on the records that exist today, does your report contain all of your opinions?
A. Yes, it does, with the caveat that there was discovery I received from other experts that I have not submitted a supplemental report for or been able to offer opinions, such as the reports of Dr. Jobin, the deposition transcript of Dr. Osborn, and the report by Mr. Byrd.
Q. Do you -- does your report contain all the factual support that underlies your opinions?
A. Yes, I believe it does.
Q. Did anybody help you review records for purposes of creating your report?
A. No, they did not.
Q. Did anybody help you draft your report?
A. No, they did not.
Q. Did anybody proofread or offer revisions to your report?
A. Yes. I did have somebody proofread for grammatical and sentence structure. Nothing of content.
Q. Nothing of substance?
A. Yes, that's correct, nothing of substance.
Q. Are you aware of any typos in your report?
A. As I sit here now before you, I'm not aware of them.
Q. What about any mistakes? Are you aware of any factual mistakes in your report?
A. Not to the best of my knowledge.
Q. Aside from Ms. Blazich, have you spoken with any of the other attorneys at Claggett & Sykes, if you can recall?
A. I recall a phone conversation with another representative. I don't recall her name. It would have been some time ago.
Q. Was it a female?
A. Yes, it was.
Q. How many hours do you think you've spent reviewing medical records in this case?
A. Isolating it just to medical record review, I don't recall exactly how many hours.
Q. Let's make it more broad.

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How many hours have you spent reviewing any records in this case, whether they be medical records or transcripts or policies, etcetera?
A. I would be able to give you an estimate of how much time I spent on the case, which would include a drafting of the report up to today, which would estimate approximately 32 to 33 hours.
Q. But you can't break it down by how much time you spent reviewing records?
A. As I sit here, I regret I don't have a recollection to the details of that.
Q. Are all of the materials that you've reviewed for purposes of forming your opinion contained in the -- in your report?
A. Yes. At the time of the report, yes, all of those documents were included.
Q. You didn't review any other documents -- again, I'm trying to characterize at the time of your report. You didn't review any other documents to come up with your opinions besides what was listed?
A. Yes, that's correct. If I reviewed a document that was relevant to my opinions, I included it in the report.
Q. But did you only include documents you thought were relevant or did you include all documents that you reviewed?
A. To the best of my knowledge, it was documents that I reviewed that were provided to me. And then others that were isolated -- I'm sorry, of that list, they were specifically denoted in the report.
Q. And it sounds like you've reviewed documents since submitting your report?
A. Yes, I have.
Q. Can you identify all of those for me? For purposes -- again, documents obviously that are relevant to your opinions.
A. Yes. Thank you for clarifying.
The documents I've reviewed were ones provided to me subject to submission. Again, I recall Dr. Jobin's report, Dr. Osborn's deposition transcript, Mr. Byrd's report. I also believe there was one other physician report that I have to pull up if you'd like.
Q. If you don't recall, I don't need you to pull it up.
Anything else you recall reviewing?
A. I believe there was also one other procedural filing, if I recall, but I -- nothing that I recall as being substantive to my opinions.
Q. Of the materials that you've reviewed since

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your deposition, do any of those materials change your opinions?
A. None of those change my initial opinions.
Q. When I -- I'm a lawyer so I focus on the words that you use. When you say "initial opinions," I'm talking about your opinions today. Because, again, this is my one time to talk to you.
The materials that you've reviewed since you issued your report on October 25th, do any of those subsequently reviewed materials change your opinions?
A. No.
Q. Have you talked with any member of the Schwartz family?
A. I have not.
Q. Have you communicated with any of the other experts in this matter regarding this case?
A. I have not.
Q. You've previously worked on cases with Dr. Womack; is that correct?
A. Yes, I have.
Q. And you and he have -- correct me if I say this wrong -- referred cases back and forth to each other?
A. Yes. My understanding of a referral is an attorney phone number or email address that may look

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for somebody with that area of expertise.
Q. And you and Dr. Womack have done that with each other in the past; correct?
A. Yes, we have.
Q. How many other cases have you worked on with Dr. Womack?
A. Only one -- well, first of all, I haven't worked on any cases with Dr. Womack. Dr. Womack's been retained as an expert for other cases I've been involved in as a retained expert. I recall only one other time.
Q. Where you and he were retained by the same party?
A. Yes. That's correct.
Q. What about the other experts in this case, have you ever been on a case where another expert in this case also provided an opinion?
A. Not to the best of my knowledge.
Q. What documents do you have in front of you? Obviously, if we were here in person I could see what you have. I assume you're at your home or your office.
What documents do you have in front of you?
A. I created a three-ring binder. I'll show it to you on camera, for purposes of you being able to see it.

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It is just a printout copy of the documents that are listed in my report. Currently, my -- it's open to my report, for the ease of reference and to expedite the process.
I also have with me several of the texts that I used within my report regarding my opinions related to the standard of care.
Q. Do you have any documents in front of you that have not been disclosed or itemized in your report?
A. Yes, with the clarification, those documents are the ones I just described to you, which would have been Mr. Byrd's report and -- I don't recall whether I printed up a copy of Dr. Osborn's deposition transcript. I don't think I did. Absent those documents we've already discussed, there is no other additional information in front of me.
Q. Do you have any devices in front of you that would allow you to communicate? Let me clarify that. I don't think that you will communicate, I'm just asking if you do.
A. I don't have any devices in front of me that I have access to communicate outside of what you are doing.
Q. You will agree not to communicate to anyone

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when we're on the record?
A. Yes, I understand that.
Q. Again, it's not that I think that you would, I just want to ask.
Have you ever had any action taken against any of your medical or paramedic licensure?
A. No.
Q. No discipline with respect to your medical licensure?
A. No.
Q. Have you ever been convicted of a crime?
A. No.
Q. Have you ever been sued for malpractice?
A. No.
Q. In your past expert experience, have you ever been excluded as an expert, whether -- let me say, whether partially or in full?
A. Not to the best of my knowledge, I've never been excluded.
Q. And you would know; right? If you had been told you can't participate at trial or can't offer an opinion, you would remember that, wouldn't you?
A. Yes. The reason I clarify or qualify my statement is I don't know what attorneys have experienced that maybe I didn't know at the time.

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However, the expectation is that if any of that took place, I would be told about it and know about it. And to the best of my knowledge, I've never had anything excluded.

Q. If a lawyer never tells you that you're not excluded, you better get after that lawyer. That's not a good thing.

A. I wouldn't disagree. And it's an expectation that we have communication about something that important.

Q. Have you ever had anybody attempt to exclude you as an expert, either in full or with respect to any of your opinions?

A. Yes, I did have one case.

Q. What case was that?

A. That was a case in Montana related to the services provided by a volunteer emergency medical services organization.

Q. Do you recall approximately what year that was?

A. It's listed on my transcript -- I'm sorry, my testimony log. It was a case in Montana. I believe it was approximately two or three years ago.

Q. So I've got your testimony log in front of me, and I appreciate you providing the states. I know

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that we asked for that. And I don't see, unless I'm misunderstanding, that MT is the acronym for Montana, I don't see Montana listed.

A. That was my error. I believe I listed MO, which is Missouri, and that would have been an oversight and I did it quickly. That's an error. That would have been the Montana case and I believe it was -- the name of the case was Williams versus Laurel EMS.

Q. Do you know if that was in Montana state court or federal court?

A. To the best of my knowledge, it was Montana state -- recollection is Montana state court.

Q. What was the -- as best you can recall, what was the basis upon which they moved to exclude you?

A. I don't recall the details, and I recall notification from the retaining attorney that it was not -- that it wasn't a successful or didn't receive a successful judgment in that time.

Q. Do you know if it was an attempt to exclude you in full or just portions of your opinions?

A. If I recall correctly, it was portions of my opinion.

Q. Okay.

A. I don't recall the details.

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Q. All right.

What percentage of your annual income is tied to doing expert work in legal cases?

A. Approximately 20, 25 percent.

Q. Are you aware of other cases where you said it's been as high as 40?

A. I don't recall saying as high as 40 for expert witness work. If I said 40, it may have included the education and consulting component, which would have been inclusive of all of my work with the claim consulting.

Q. And your work -- how would you say it's split between -- on your testimony log, it didn't identify whether you were working for the plaintiff or the defendant -- well, maybe it did.

So I've got this in front of me. It's got a P and a D. Is that the way that you allocate between plaintiff and defendant?

A. Yes, it is.

Q. And I'll let you go through the numbers, but what's the percentage plaintiff to defense work, if you know?

A. I estimate 60 to 40 percent plaintiff or defense.

Q. You've got an acting career as well I

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understand?

A. No. I had a previous -- I have previous experience doing that.

Q. And there aren't very many people that can say you play a paramedic by day and a paramedic on screen, but you've played a paramedic in different movies and TV shows?

A. Yes, I have.

Q. When was the last time that you acted?

A. Approximately three years ago, to the best of my knowledge.

Q. All right.

So let's talk about your CV.

The CV that I have, and I'll just note for the record and we can make it an exhibit, is Schwartz 549 to 552.

Do you have that in front of you? I don't know if you have Bates stamped copies of CVs.

A. Yes, I don't have the Bates stamped copy of the CV in front of me, but I am going to pull up my copy of it.

Q. Is this -- the copy that was attached to your report, is that the -- an updated copy of your CV?

A. As I don't have a copy that was Bates stamped and attached to my report, I'm unable to give

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you an affirmative answer as to whether that's the most updated copy. However, the most updated copy should have reference to my work as a -- at Moorpark College related to the health sciences department. Is that the copy that you have?

Q. Yes. That's the first entry under experience.

A. Okay. Yes, I'm going to agree that that is most likely the most updated.

Q. Did you work for the City of Fillmore?

A. Yes. I'm a paramedic firefighter with them.

Q. Is that listed on that version of your report -- of your CV, excuse me?

And I'll tell you, I'm not trying to trick you here.

A. I appreciate that.

Q. I don't see it listed here, but I understand that you do work for the City of Fillmore.

A. Yes. Thank you. That's correct, I do. The copy I have has it listed. And -- but yes, that's true.

Q. All right.

You're not a certified flight paramedic; correct?

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A. Yes. Correct. I'm not.

Q. And you've never been a certified flight paramedic; correct?

A. Yes. That's correct. I have not.

Q. And if I call that -- I'll probably call it certified flight paramedic but it's also known as an FP-C. Would you agree?

A. Yes, that's my understanding.

Q. And that's the licensure that Barry Bartlett had, was a certified flight paramedic. Would you agree?

A. I don't recall that he had the flight paramedic certification or if he had been granted authority by the state of Nevada to operate as an air ambulance paramedic.

Q. Sorry. This Zoom thing drives me crazy because I can't tell when you're done as well as I could if we were in person. Sorry to interrupt you.

Do you know if he had a certified flight paramedic license in the state of California?

A. Yes, I recall reading that.

Q. Based on your current licensure, would you have been qualified to work in the same role that Barry Bartlett did at REACH? Do you know?

A. According to the REACH policies, yes. I would have been able to work in that role while achieving my FP-C within, I believe, the first six months of my employment.

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Q. So you would have agreed to obtain that licensure to keep a job if you were hired?

A. I'm sorry, I couldn't hear you. Could you repeat?

Q. You would need to obtain the FP-C licensure to keep your job if you were hired by REACH? Would you agree?

A. I believe that was what their expectation was, yes.

Q. And you're also not a -- are you familiar with the term critical care paramedic certification?

A. Yes, I am.

Q. What is that -- what is your understanding as to what that certification is?

A. Much like the flight paramedic certification, they are reemphasized portions of the paramedic standard of care that we received in paramedic school, that apply to specific job functions.

Q. And you do not hold that certification; correct?

A. Yes, correct. I do not.

Q. You do not; right?

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A. Yes. Correct. I do not.

Q. Sorry, it cut out.

Do you still work for AMR?

A. I do not.

Q. Do you know if AMR owns REACH?

A. American Medical Response does not own REACH. My understanding is Global Medical Response, which is the parent company that oversees all of those assets, owns REACH.

Q. Does GMR own AMR?

A. Yes.

Q. When did you stop working for AMR?

A. I estimate 20 -- I believe it was the beginning of 2020. Yes, it would have been the beginning of 2020.

Q. So the copy of your CV that we have -- we'll mark -- we've marked as Exhibit 1, it says you worked there 2018 to the current. I know you had earlier jobs as a supervisor in 2007 to the current as a paramedic.

So that part is outdated as well?

A. Let me pull up a copy to verify. I think I'm getting my years confused.

Q. And I can -- I can screen share with you, too, so that you can see what I'm looking at.

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A. Thank you, yes. It would have been -- it would have been right after receiving my employment at Moorpark College. So I believe it's 2020, which is what I represented in my CV, beginning in 2020.
Q. So just so that you and I are talking apples to apples, I'm going to share my screen over here.
Are you able to see my mouse over here?
A. Now I can, yes.
Q. All right.
Do you see down here how it says that this is current -- this is current, that those are outdated; right?
A. Yes, that's correct.
Q. Currently, is the City of Fillmore -- is that the only place where you actually treat patients as a paramedic?
A. Yes.
Q. When you worked for AMR, what was the geographic area where you worked generally?
A. Ventura -- I'm sorry, I cut you off.
Q. No, sorry. I added that wording a little late.
A. I worked for AMR of Ventura County.
Q. And does AMR of Ventura County have

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aircraft as part of its options to transport patients?
A. Yes.
Q. How many aircraft do they have?
A. We have county providers of aircraft transportation and we have private providers of interfacility aircraft transportation available to us.
Q. Are those helicopters and fixed-wing aircraft?
A. We have both. So we also have a local airport that is routinely used for fixed-wing Air Medical transportation.
Q. And in Ventura County did AMR -- does it offer interfacility transfer services?
A. Yes.
Q. And is this different -- would you say that interfacility transfers, or IFTs, are different than on-scene transfers?
A. In what regard, please?
Q. Would you agree that an on-scene transfer is there's a car accident, a helicopter flies to it, picks up a patient and takes the patient to the hospital?
Can we agree that's an on-scene transfer?
A. The definition of those two would be a scene call versus an interfacility transfer, yes.

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Q. All right, scene call. That's a better way to say it. I'll use your terminology.
And an interfacility transfer, would you agree that's taking a patient from hospital A to hospital B?
A. That would represent one type of interfacility transfer, yes.
Q. What other types of interfacility transfers are there?
A. Transportation to other nonprimary care facilities, like residential care facilities, for instance. There's transportation to other locations that would be associated with an airport that would be part of the -- a certain type of interfacility transport, regarding the transportation of a patient in totality.
There may be different segments of that process, for instance, but an interfacility transfer is generally qualified as transportation from a primary caregiver, or definitive care facility, to an alternative location.
Q. And that alternative location does not have to be to another care provider?
A. I'm sorry. You were a little low volume.
Q. Is it always to another primary care

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provider, or is there always a primary care provider on the receiving end of an IFT?
A. There is not always a primary care provider on the receiving end of the same level of medical direction or qualification. In an interfacility transport that is between two hospital facilities, then there are two coordinating physicians or discharge staff members that are coordinating the interfacility transportation.
Q. Are you familiar with the phrase "convalescent transfer"?
A. Yes.
Q. Is that different from an interfacility transfer?
A. No.
Q. Would you use those -- would convalescent transfer, in your view, be under the umbrella of an interfacility transfer?
A. That would be inclusive, yes, based on the definitions within the standard of care.
Q. All right.
So with your -- with respect to your experience specifically, while working for AMR, did you participate in interfacility transfers using aircraft, not using ground transport?

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A. Yes.
Q. Did you do this in the context of critical care transports in the -- as an interfacility transport?
A. Yes.
Q. Approximately how many interfacility transports in the critical care realm do you think you did?
A. Critical care transports? I would estimate hundreds.
Q. Give me an example of what one would be.
A. An example would be picking up a patient from a local emergency department at a preceding hospital with a nurse, and coordinating the treatment and transportation of that patient to an alternative specialized facility, that might be a cardiac care facility, or a trauma facility, or some other definitive care facility.
Q. In that way, did you ever take a patient from a rural hospital to a higher level of care hospital?
A. The term "rural" might apply to some of our locations. Certainly, hospitals that had a lower level of service that they could provide for the patient at the time, that required the transport of the patient to

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a different definitive care facility.
Q. You would agree, wouldn't you, that in Ventura County there are hospitals that you would consider rural hospitals, would you?
A. The term "rural" as a specific definition? Yes, I would consider at least one of our hospitals to be a community hospital versus a larger definitive care facility.
Q. On the transfers that you did, were you the medic in charge or were you assisting the nurse on these critical care transports?
A. I believe the best way to answer that question is that we were part of a critical care team, working together to treat a patient and provide the transportation.
Q. Well, and that's not my question.
My question -- let me rephrase my question.
Was the nurse your supervisor or were you the nurse's supervisor, or neither?
A. In those situations, neither.
Q. Did the nurse have higher medical training than you?
A. Yes.
Q. Let me put it in the context of Barry Bartlett and Ronnie Lyons. Who was -- you would agree

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that Ronnie Lyons was in a more superior position of authority over Barry Bartlett on their team, would you not?
A. Superior position related to -- of authority related to medical education, or in what capacity?
Q. All right.
Let me phrase it this way: When you're working on a team -- let me step back. Not Ronnie Lyons, not Barry Bartlett.
In Ventura County, you're on an aircraft with a nurse. Does the nurse have higher decision authority than you or do you have equal decision authority with respect to patient care?
A. Medical authority for patient care comes from medical direction. And the person providing the care may be the nurse and the doctor.
And you clarified via aircraft. I want to make sure that we understand each other.
The critical care transports I'm talking about were by ground.
Q. I asked you earlier -- and I'm glad you clarified that. I thought I asked you earlier, if I didn't, I apologize.
Did you ever provide critical care

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transport using either a helicopter or a fixed-wing aircraft while working for AMR in Ventura County?
A. Not on the aircraft, no.
Q. So all of your transports were via ambulance or some type of -- I don't want to say car because I know an ambulance is not a car, but on the ground?
A. A transport vehicle on the ground, yes, that's right.
Q. Have you ever in your career provided a -- or assisted in a critical care interfacility transport using an aircraft?
A. My answer previously was yes, with clarification that we routinely transported patients from hospitals to the local airport with fixed-wing and rotor-wing transports.
Q. All right, but you said earlier -- I asked you, I said, "Did you ever provide critical care transport using either a helicopter or a fixed-wing aircraft while working for AMR?"
And you said, "No, not in the aircraft."
A. Yes. That's correct.
Q. So I guess I'm not understanding.
How did you provide critical care transport but not using -- it seems like you're giving two

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different answers and I'm sure I'm misunderstanding.
A. That's quite all right.
Because AMR doesn't have helicopters, there's the clarification, in Ventura County. So the transportation I provided is with the sheriff's department aviation unit. We had several patients which we transported, critical burn patients, for example, or diving accidents from one facility to another so that they could receive care.
So there was the experience I was referring to.
With regard to the fixed and rotor wing and the transportation of patients with a critical care team, there was that experience also. And then AMR has ground transportation resources in Ventura County, in which I've transported patients routinely in interfacility transports alongside aides.
Q. So let me be specific. How many times in your career have you gone to a facility, picked up a patient who is a critical care patient, and transported them via any type of aircraft to another facility for a higher level of care?
A. Approximately ten.
Q. When were those -- or let me make it easier. When was the last time you did that?

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A. Approximately 20 years ago.
Q. Was this part of your search and rescue days?
A. Yes.
Q. And that was in partnership with AMR and Ventura County; right?
A. When you say "a partnership," can you be more specific?
Q. You were basically borrowed -- that sounds bad, but you were loaned to Ventura County Search and Rescue as an AMR employee; correct?
A. For a period of time, yes. And then for a period of time, no. That program ended.
Q. And the aircraft you used, that was a Ventura County Search and Rescue aircraft; correct?
A. It was a Sheriff's Department aircraft. It wasn't designated only for search and rescue.
Q. Was it a helicopter or an airplane?
A. Helicopter.
Q. If you had to describe what critical care transport, how would you describe that? What's your definition?
A. My definition of critical care transport is the interfacility transport of patient from one definitive care facility to another, utilizing a

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critical care team.
Q. Do you understand the acronym BLS?
A. Yes.
Q. And do you also understand the acronym ACLS?
A. Yes.
Q. What level of care is used between those two on a critical care transport?
A. You may use all levels of care in a critical care transport.
Q. Fair enough.
On a critical care transport, you would agree that you use BLS; right?
A. Yes.
Q. And also ACLS?
A. I believe you're confusing the two terms.
ACLS is advanced cardiac life support with the American Heart Association program. And ALS is advanced life support, the umbrella by which all paramedics operate.
Q. Yes, and I've been asking for the base ALS. ALS is what I'm referring to.
A. Yes. Correct. ALS and BLS care, correct.
Q. Thank you. Too many health care cases, too many acronyms.

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The transport to Ventura County, were those under ALS protocol or BLS?
A. Both.
Q. You describe yourself as a flight paramedic with Ventura County in your CV. Do you agree?
A. Yes.
Q. Do you have any actual flight paramedic certification that would allow you to use that name, or is that just a name that you chose?
A. It was our title as paramedics on the flight crew. We were flight paramedics.
Q. Who gave you that title?
A. That was a title given to us I believe both by AMR and by the Sheriff's Department aviation unit.
Q. You would agree that search and rescue is different than interfacility transfer? Agree?
A. Yes.
Q. And even search and rescue, where you transport a patient that you actually rescued, that's different than interfacility transfer; right?
A. The nature of the call is different, yes.
Q. So if you hoist somebody off a mountainside or pluck them out of the ocean, I don't know what you do with search and rescue, that's not an interfacility transfer; right?

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A. Yes, that's correct, that is not.
Q. Were there flight paramedics with Ventura County who were not ALS trained?
A. No.
Q. Every flight paramedic was ALS trained?
A. Yes.
Q. Have you ever transferred a patient on a fixed-wing aircraft or airplane?
A. No.
Q. When you were with Ventura County -- let me back up.
You're familiar with the term RSI?
A. Yes.
Q. Rapid sequence induction?
A. Yes.
Q. When you were working with Ventura County search and rescue as a flight paramedic, did you ever perform an RSI?
A. I never performed the administration of the medications. That was outside of the policies and procedures of Ventura County.
Q. All right.
Did you ever actually perform the procedure of a rapid sequence induction while working as a flight paramedic for Ventura County?

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A. The rapid sequence induction portion is the administration of the medications. That's what I'm referring to. And no, I did not. That was not within the protocols.
Q. Are there other portions of the RSI besides the administration of the medications?
A. Yes, the actual passing of the tube and intubation of the patient.
Q. Did you ever perform that portion of an RSI while working as a flight paramedic for Ventura County?
A. Yes.
Q. Approximately how many times?
A. I would estimate less than ten.
Q. Give me one second. Let me ask the question this way.
At any point, while you were working as a paramedic for Ventura County, did you perform a rapid sequence intubation {sic}?
A. Ventura County AMR or Ventura County Aviation?
Q. No, not AMR, not Ventura County AMR, but Ventura County, the flight paramedic.
A. The administration of the drugs, no, I did not.
Q. Well, I'm asking you if you performed a

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rapid sequence intubation {sic}.
A. Rapid sequence induction, as we just agreed, is the RSI term.
Q. Sorry.
A. The process of administering medications, no. I would estimate that there were less than ten, approximately five times in my career, in which there was a flight nurse on the helicopter with us for the Sheriff's Department aviation unit that would have administered medications. And I would have passed the tube or performed the intubation.
Q. While working for AMR in Ventura County, did you ever perform a rapid sequence induction?
A. No.
Q. So in your life, in total, how many times would you say you've performed an RSI, in any context, in any situation? And let me back up.
Not including training, not on a mannequin, not on a cadaver, on an actual real live patient.
A. I would estimate ten times.
Q. Do you recall approximately the last time you did that? Was this 20 years ago?
A. Yes.
Q. Okay.
Have you ever done an RSI on an airplane?

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A. No.
Q. And you already testified you've never pushed the drugs for an RSI as a paramedic; correct?
A. That's correct.
Q. And you've never administered Rocuronium; correct?
A. That's correct.
Q. And you've never administered Ketamine; correct?
A. That's correct.
Q. Back when you were working for AMR, how much of your work was prehospital work? Let me back up.
When you say -- in your report oftentimes you talk about prehospital, or your resumé, your CV uses that phrase, "prehospital," what do you understand that phrase to mean?
A. Seeing calls for those patients that are not in a definitive care facility.
Q. All right. Under that definition, how much of your work was spent, when you were working for AMR, on prehospital patient care versus interfacility transfers or patients that had already been admitted somewhere?
A. I would estimate 60/40, approximately,

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scene calls versus interfacility transports.
Q. Of your interfacility transfers that you participated in while working for AMR, what percentage were ground transports and what percentage were air transports?
A. As I qualified earlier, all of them would have been ground transports for AMR, and moving of patients with an air crew or the movement of patients with a nurse or with another paramedic.
Q. And that's when you were working for AMR; correct?
A. Yes, that's correct.
Q. When you're doing a ground interfacility transport, when do you consider you to have assumed control of the patient?
A. The transfer and care process involves control of the patient care. So at the moment that I introduce myself to a patient, retain the records for that patient, move the patient over to my gurney and receive an off-going report, those things in combination create a transfer of care.
Q. Going back to -- I want to get back to the patient control issue.
When you were doing interfacility transports, what percentage of your transports were

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critical care versus convalescent transport?
A. I would estimate about 40 percent of our transports that I participated in were critical care. Approximately 60 percent would have been convalescent care facilities.
Q. Going back to the patient control issue, you would agree that a patient being treated in the hospital, the emergency department, is the patient of multiple providers, would you not?
A. Could you ask me that question again, please.
Q. Sure, and I'll be more specific.
A patient in the ED is the patient of the attending physician, or the physician that's attending to the patient; correct?
A. They are part of the attending personnel, if that's what you're referring to.
Q. No. I'm asking specifically, if I'm in the emergency department being treated by a physician, I'm that physician's patient; correct?
A. Yes.
Q. And if that physician has a nurse assisting him or her, I'm also the patient of that nurse; correct?
A. Yes.

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Q. And if phlebotomy needs to come to draw my blood, I'm also the patient of a phlebotomist; correct?
A. Yes.
Q. And if I need to run down to radiology to get my x-ray on my broken arm, I'm a patient of the radiology tech doing the x-ray as well; correct?
A. Yes.
Q. And if I need to be transported to a higher level facility, I also become the patient of the flight crew that's transporting me; correct?
A. Yes.
Q. And so what I want to -- and those relationships can exist at the same time; correct?
A. Those being all of the ones you just listed or specific ones?
Q. I'll be more specific.
The patient relationship can exist amongst the doctor, the nurse and the flight crew at the same time in certain circumstances; correct?
A. The patient relationship? Is that what you asked me?
Q. Yes.
A. A patient caregiver relationship can be amongst multiple caregivers.
Q. All right.

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So let's be specific. Let me give you a hypothetical, which obviously you're an expert, I'm allowed to do that.
If I'm in the emergency department and I need to be transported to a high level of care, when the flight crew arrives, prior to the introduction of the flight crew to the patient, you would agree I'm the patient of the attending physician and the nurse; correct?
A. Correct.
Q. The flight crew comes in and says, "Hey, my name is John." I then start to establish a patient relationship with that flight crew; correct?
A. Yes. Correct.
Q. But I haven't yet given up my patient relationship with the physician; correct?
A. Based on the introduction hypothetically, that -- in giving up -- I think that's the hard part for me, is the "giving up" term.
Q. All right.
The physician is still my doctor; correct?
A. Yes.
Q. And the nurse is still my nurse; correct?
A. Yes.
Q. So my question for you is: When is the

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point in time where the flight crew assumes sole patient care of the patient, when they arrive at an emergency department to transport a patient for an IFT?
A. I think there are several steps to that process.
Q. Explain each of them to me, please.
A. First would be, as I outlined, the introduction.
Q. And let me back up.
I just want to know -- I don't want to know when it starts a transition. I want to know what is the point in time where that relationship is now solely with the flight crew?
A. I think my best answer in this case is related to when the flight crew believed it was their patient.
Q. I'm not asking -- I'm not making it specific to the Schwartz case. I'm saying in general.
Is it when they arrive at the hospital at the introduction, when they push the patient down the hall, when they exit the hospital doors, when they actually get on the rig and start driving away? At what point is it?
A. At the point in time in which there is the introduction, the transfer of documentation, the

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off-going report by the treating or attending staff, and the patient is moved over to your transportation equipment. That is the transfer of care.
Q. What is the off-going report?
A. An off-going report would be the nature of the illness or the mechanism of injury, and nature of the treatment provided to the patient prior to the arrival of the transport crew. And the ongoing care that's anticipated to be provided to the patient in the medical documentation.
Q. Sorry. I didn't mean to interrupt you.
As part of the off-going report, is there an approval from the attending physician that the patient is ready for transport?
A. Yes.
Q. And so if the physician never approves transport of the patient, I mean he is ready to go, you can go out the door, the flight crew hasn't assumed control of the patient yet; correct?
A. That may not be the case as outlined in this case.
Q. Again, I'm speaking generally.
You're familiar with discharge orders?
A. Yes.
Q. What's your understanding of what a

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discharge order is?
A. It's a consent for transportation. It's an outline of documentation to be provided to the transport crew, a destination location and the statement of a receiving physician at the receiving facility.
Q. So I want to ask you a -- present a hypothetical.
Let's assume you've done -- let's see, what did you call it? You called it the "off-going report." Let's assume you've done the off-going report, or received it, sorry. Got the approval from the attending and the patient is good to go. You're walking down the hall towards the door, pushing the patient on the stretcher, and the patient arrests.
Do you continue on to the receiving facility or turn right back around and go to the ED?
A. The patient would no longer be eligible for air transportation or ground transportation. They would stay within the emergency department and be treated by the staff.
Q. What if you were in the parking lot, between the door of the hospital and the door of the ambulance, and the patient arrests, would you turn back around and go into the emergency department?

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A. Yes. I believe you're asking my questions related to EMTALA. I believe there's an expert that's going to offer an opinion related to EMTALA. So without offering opinions that are contrary or lack sufficient facts and information, my understanding of EMTALA is that that patient would still belong to the hospital, but they would need to then reenter that patient into their system as the patient would already have been discharged.
Q. All right.
Let's talk about your testimony log.
I only see one case where there's a Nevada case, and I think the firm's name is listed wrong.
It says Kemp Thord & Coulthard. Is that supposed to be Kemp Jones & Coulthard?
A. It may be.
Q. Do you know which attorneys you worked with at that firm?
A. I don't recall.
Q. In that case, it looks like you only did a deposition.
A. If that's what it's listing; correct. I don't recall testifying in court on the case.
Q. And I'll represent to you it says "depo."
Are you aware of any other cases, and I

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realize this only goes back four years, any other cases where you provided expert opinions in Nevada -- or sorry, expert testimony in Nevada?

A. No, there are no other cases I provided expert testimony in Nevada.

Q. This case and one other case?

A. Yes. That's correct.

Q. All right.

Let's -- I don't know exactly how long we've been going but it seems like it's more than an hour. Do you want to keep going or do you want to --

MR. BURTON: Or does anyone else need a break?

MS. BLAZICH: I never turn down a break.

MR. BURTON: Let's take a five-minute break just to stretch our legs.

(Recess taken from 3:40 p.m. to 3:51 p.m.)

BY MR. BURTON:

Q. Mr. Everlove, are you ready?

A. Yes, I am.

Q. Mr. Everlove, would you agree that being hit by a car going 35 miles an hour is an emergency?

MS. BLAZICH: Objection. Calls for speculation.

BY MR. BURTON:

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Q. Go ahead.

A. In this situation, regarding Mr. Schwartz; is that correct?

Q. No, just generally.

Would you agree that if a pedestrian gets hit by a car and the car is traveling 35 miles an hour, that that's an emergency situation?

MS. BLAZICH: Objection to the form of the question. Calls for speculation.

THE WITNESS: We use the term "a significant mechanism of injury." And yes, it's a significant mechanism of injury.

BY MR. BURTON:

Q. What is your understanding, now specific to this case, as to the injuries that Mr. Schwartz received from being hit by a car going 35 miles an hour, approximately 35 miles an hour?

A. My understanding of the injuries as determined by the hospital or injuries that were initially determined on scene of the incident?

Q. You can give me both.

A. Initial impact location, when the ground paramedics arrived on scene, they found Mr. Schwartz with musculoskeletal complaints of pain and initially described difficulty breathing due to the pain from his

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chest. They placed him in spinal immobilization as a precaution and then transported him to the hospital.

Q. Are you aware of any specific injury that Mr. Schwartz received because of being hit by the car?

A. In the hospital it was determined that he had rib fractures and a pneumothorax of a small percentage.

Q. Do you know how many rib fractures he had?

A. My initial recollection was three rib fractures. I don't recall the exact number.

Q. Are you familiar with the term "flail segment"?

A. Yes, I am.

Q. What is your understanding of what a flail segment is?

A. It's two or more ribs fractured in two or more places that creates an isolated moving portion of the ribcage, independent of the other portion of the ribcage.

Q. In your opinion, is a rib fracture with a flail segment -- is that a traumatic injury?

A. Yes, it is.

Q. In your opinion, having three fractures, is that a traumatic injury after being hit by a car?

A. Yes. It's an injury that is secondary to

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trauma.

Q. But it's -- okay. Sorry.

What about a pneumothorax? Is a pneumothorax that comes about as the result of a motor vehicle/pedestrian accident, is that a traumatic injury?

A. And I'm using the term secondary to trauma. In this case, yes, it was secondary to the traumatic injury.

Q. What do you mean by the term, and I appreciate that clarification, secondary to trauma?

A. It means that the causation of the injury was a traumatic injury, or a traumatic event rather.

Q. So in this incident, to be more specific, the traumatic event was the car hitting Mr. Schwartz?

A. Or Mr. Schwartz hitting the ground secondary to being struck by the vehicle. I don't recall a specific denotation between the two.

Q. Fair enough.

And the injuries were secondary to those events?

A. That is my understanding, yes.

Q. Okay.

Do you drew a distinction between what you consider a traumatic injury and a critical injury?

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A. I believe the terms you're using are related to Mr. Schwartz, that he suffered a traumatic injury. And the distinction is whether it was a mild, moderate or severe injury or, in this case, a critical injury that required critical intervention. I believe that's what you're asking me.
Q. Yes. My question, though, is with those -- I mean in your report, you use the phrase "traumatic injury." You also use the phrase "critical injury." Are those different?
A. Yes. Any injury can be a traumatic injury. In this case, this was an injury secondary to traumatic event. And in this case, the denotation between what was critical and not critical, as far as Mr. Schwartz's presentation, secondary to the trauma event.
Q. So you would agree that Mr. Schwartz's injuries were secondary to trauma?
A. Yes.
Q. But your report says they were not critical, is that right, not critical injuries?
A. Yes.
Q. Why were Mr. Schwartz's injuries not critical?
A. Based on his presentation, he was in stable condition, not in a critical condition that required

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immediate intervention by the paramedics that transported Mr. Schwartz to the hospital. And his condition did not change while he was at the hospital. Even with the benefit of definitive diagnostic testing, there were no critical injuries noted.
Q. Do you have an opinion as to whether or not Mr. Schwartz should have been transferred to the University of Utah as a result of his traumatic injuries?
A. I believe those opinions were -- would be based upon Dr. Garvey's decision and the standard of care for an emergency department physician. And as I've already stated, I don't intend to offer those opinions.
Q. Do you believe that the transfer, the requested transfer of Mr. Schwartz, is appropriate or not?
A. I believe I just answered the question to the best of my ability.
Q. So is the answer no, or yes?
A. My answer is --
MS. BLAZICH: Objection. Misstates the testimony.
BY MR. BURTON:
Q. I'm trying to figure out what your

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testimony is, Mr. Everlove. Let me be more specific.
If this case goes to trial, do you intend to offer any opinion regarding whether or not Mr. Schwartz should have been transferred to Salt Lake City?
A. I intend to offer the opinion that I just gave you regarding whether he was critical or not, based on the injuries that he sustained.
Q. And that's not my question. My question is very specific.
If this case goes to trial, do you intend to offer any opinion as to whether or not Mr. Schwartz should have been transferred to Salt Lake City from Northeastern Nevada Regional Hospital?
A. I believe I've given you my best answer.
Q. Go ahead and give me your answer to that question.
A. Which would be the same as the previous question that you asked, which is: That that may be based on the standard of care for Dr. Garvey and under the scope of practice for a physician, of which there are other opinions being offered. But that I would offer the opinion that Mr. Schwartz did not have critical injuries at the time of his -- secondary to the traumatic event.

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Q. And that's not an answer to my question. This is -- you don't intend to offer any opinions that Mr. Schwartz should or should not have been transferred; correct?
A. I believe I've given you my best answer.
Q. All right.
Let me ask that question again: You do not intend to offer any opinions that Mr. Schwartz should or should not have been transferred when this case goes to trial; correct?
MS. BLAZICH: Objection. Asked and answered.
BY MR. BURTON:
Q. Go ahead.
A. I believe I've given you my best answer.
Q. Okay.
That's not an answer to my question. This is a yes-or-no question. I'm entitled to know today what opinions you intend to offer at trial. You would agree with that; correct?
A. Yes.
Q. And so do you intend to offer an opinion at trial regarding the appropriateness of Mr. Schwartz being transferred or not?
MS. BLAZICH: Objection. Asked and

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answered.
THE WITNESS: I believe I've given you my best answer regarding the scope of my opinions.
BY MR. BURTON:
Q. Okay.
And is your opinion that you're going to offer an opinion regarding whether he should have been transferred or not? It's just a yes or no. Are you going to tell the jury he shouldn't have been transferred or are you going to tell the jury he should have been transferred? It's a simple question.
A. I plan to offer the opinion to the jury that Mr. Schwartz was not a critical patient.
Q. And, therefore, because he's not critical, should he have not been transferred?
A. My opinion will remain that he was not a critical patient. What decisions the jury draws from that testimony will be up to them.
Q. So if I asked you at trial, "Okay, you say he's not a critical patient. Should he have not been transferred," are you going to answer that question at trial?
A. I would offer you the same answer that I'm offering now and refer to the scope of the opinions for the physicians that made the decision related to

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Mr. Schwartz's transfer.
Q. Is it your opinion that Mr. Schwartz could have been adequately treated at Northeastern Nevada Regional Hospital?
A. I was not asked to offer that opinion. I believe that falls under the scope of the physicians that made the decision regarding the transfer of care and that would be outside of my scope of practice.
Q. So you do not intend to offer an opinion as to whether or not he could have adequately been treated and stayed at Northeastern Nevada Regional Hospital?
A. I believe I just gave you my best answer to that question.
Q. Just yes or no. Do you intend to offer an opinion as to whether or not Mr. Schwartz could have been treated adequately at Northeastern Nevada Regional Hospital and not been transferred?
MS. BLAZICH: Objection. Asked and answered.
THE WITNESS: I believe I've given you my best answer.
BY MR. BURTON:
Q. You can't give a yes-or-no answer to that?
A. I believe I've given you the best answer, and that answer is that that would fall outside of a

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scope of my opinions related to a physician treatment decision, but that Mr. Schwartz at the time of the transport request was not critical.
Q. Can you just say no, you don't intend to offer that opinion? Wouldn't that just make this a lot easier?
MS. BLAZICH: He's answered your question, James, so you're badgering the witness at this point.
MR. BURTON: I'm not badgering the witness.
BY MR. BURTON:
Q. Am I badgering you, Mr. Everlove?
A. I appreciate your consideration of me, and I would offer the same answer to the previous question. That is, in an effort to be very clear about what my opinions will be, that I plan to testify to the jury that at the time of the transfer request, Mr. Schwartz was not critical as evident by his condition on scene and at the hospital.
Q. In the hospital setting, whose determination is it as to whether or not the patient's injuries are critical?
A. The in-the-hospital scenario is the physician of record and the treatment physician, in combination with the other staff members, such as the nurses and primary care providers.

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Q. Meaning the physician gathers input from others, but ultimately, the physician determines if the patient is critical or not; correct?
A. Yes. That's my understanding.
Q. And obviously, on scene, the paramedics can make a determination if they think the patient is critical or not; correct?
A. They can give an opinion regarding patient severity, yes.
Q. But once we get into the hospital, the ultimate decision as to whether or not a patient is critical does not rest with the paramedics; correct?
A. The paramedics that transport the patient to the hospital or the paramedics and flight crew or staff members that are responsible for the transportation of the patient from the hospital?
Q. Fair question. I'll break it down.
Once the paramedics that transport to the hospital transport the patient, they no longer make the determination if he's critical because the attending would make that determination; correct?
A. Yes. That's correct.
Q. And the nurse doesn't make the determination if the patient is critical; correct?
They may give input, but they don't make the

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determination; correct?
A. I'm sorry, in beginning to answer your question I cut off. Could you please repeat?
Q. Yeah.
And I think we took turns cutting each other off so my apologies. I think I actually cut you off first.
The nurse may give input as to the status of the patient, whether he or she is critical, but ultimately, the determination if the patient is critical lies with the physician; correct?
A. Determination is a difficult word because there may be critical lab values, critical findings that are denoted by another physician, as you pointed out, a radiologist or someone else in the care of the patient that may find something critical that another physician does not. So that's why I clarified, the determination is a combination of opinions potentially, or one opinion from one of the treatment or care providers.
Q. Fair enough.
The decision as to whether or not a patient is critical, the ultimate decision, that lies with the physician; right?
A. I believe I've just given you the best

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answer to the same question.
Q. In your experience, do hospitals routinely transfer patients for whom they're able to adequately provide health care?
MS. BLAZICH: Objection. Calls for speculation.
THE WITNESS: The term "adequate" may be subject to interpretation, and there are numerous reasons why facilities transport patients from one facility to another.
BY MR. BURTON:
Q. All right. Let's be specific then.
In this setting, would you agree that Dr. Garvey made the determination that he needed to transfer Mr. Schwartz because they couldn't provide him adequate care at Northeastern Nevada Regional Hospital?
MS. BLAZICH: Objection. Assume facts not in evidence. Lacks foundation.
THE WITNESS: As this was not part of my opinion and evaluation, I'm reluctant to give you an off-the-cuff answer. I don't recall whether that was a sole decision, a collaborative decision between receiving facility, and how exactly that determination was made, or conversation with radiologists and other care providers.

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BY MR. BURTON:
Q. Well, you read Dr. Garvey's transcript, didn't you?
A. Yes, I did.
Q. And you know that he called the University of Utah after Mr. Schwartz came to the hospital; right?
A. Yes. I'm aware of that.
Q. And the receiving physician at the University of Utah said that he would accept transfer. Do you agree with that?
A. I recall that testimony, yes.
Q. And Dr. Garvey decided to proceed with the transfer, you would agree with that?
A. Yes.
Q. All right.
Let's talk about transfer. In your report you say that the -- that -- I don't want to put words in your mouth -- that the transport from the scene to the hospital was without lights and sirens.
Do you recall that?
A. Yes. I recall that statement.
Q. Are you using that statement as support for the fact that this was not a critical injury?
A. Not by itself. But yes, that was part of my evaluation.

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Q. Have you ever in your -- how many ambulance runs do you think you've done in your career?
A. I would estimate a few thousand.
Q. Have you ever transported a critical patient not using lights and sirens?
A. Not to the best of my recollection.
Q. I want you to think about it. Think back. I know you've got a long career. Can you think of any time where you had a critical patient and you didn't turn your lights on or your sirens?
A. Specifically, a critical patient like the scenario with Mr. Schwartz; correct.
Q. No. I'm saying critical based on your earlier definition of critical.
A. As I sit here, I don't recall any scenario like that.
Q. Do you know how far -- or how much time is saved on average using lights and sirens versus not using lights and sirens?
A. That's a broad hypothetical. It depends on the location and the availability of resources.
Q. Are you aware of any studies that analyze that question, whether lights and sirens actually save time when transporting a patient?
A. In regards to policies and procedures for

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Nevada or generalized studies?
Q. Generalized.
A. Generalized studies, I know that there have been studies. I don't recall related to the transport of patients to facilities. I do recall studies related to the initial response of resources, in a 911 environment, that there are certain circumstances where they do not increase survivability.
Q. Do you know how far it was from the scene to Northeastern Nevada Regional Hospital?
A. The records, I believe for Elko Ambulance, I would have to review them to verify the exact distance.
Q. As you sit here, and this isn't a test and I just want -- do you have any approximation of how far it is?
A. I don't recall the exact mileage, but I know it's listed in the patient care report for Elko Ambulance.
Q. Do you know if there were -- how many stoplights there were between the scene and the hospital?
A. I don't recall that, no.
Q. Have you ever looked on a map to see what's located between the restaurant where Mr. Schwartz was

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hit and the hospital?
A. I do recall looking at the map. I don't recall the distance.
Q. Have you ever been to Elko, Nevada?
A. I have not.
Q. You're going to get a chance it sounds like in this case.
Do you know if it's a busy metropolitan area?
A. To the best of my knowledge, it is not.
Q. Do you know if it has a lot of traffic at 8:30 at night?
A. I couldn't speak to that. I don't think it would be appropriate since I -- I'm not familiar with the traffic patterns at 8:30 at night in Elko.
Q. Do you have an opinion as to how much time would have been saved if lights and sirens would have been used versus not lights and sirens in transporting Mr. Schwartz?
A. I have an opinion that that's not part of the policy consideration as it relates to using emergency systems to rapidly transport patients that are critical or priority and unstable.
Q. But you don't have an opinion as to whether or not it would have saved any time if lights and

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sirens would have been used?
A. Saved any time? That's a broad reference. Certainly, lights and sirens would enable somebody to get to a location more quickly, even if they were able to come in contact with one vehicle that yielded to them. So any, yes. I would offer the opinion lights and sirens are there for a purpose, to save time in transportation of patients to the hospital.
Q. Have you reviewed the Elko County EMS protocols as to when they should or should not use lights and sirens?
A. I don't recall specifically Elko. I recall reviewing the Nevada protocols related to the priority transportation of patients. And as part of it --
Q. Sorry. Go ahead.
A. As part of the standard of care in all of the educational materials, that the utilization of lights and sirens is for transporting priority or critical patients.
Q. But you have not reviewed Elko's policies, correct, Elko EMS?
A. I don't recall.
Q. And you've not reviewed Elko's policies as to what constitutes a critical versus noncritical patient?

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A. Yes. That's correct.
Q. Let's talk about Dr. Garvey's role.
Is it your opinion that Dr. Garvey was functioning as the REACH medical director on call when Mr. Schwartz was brought to the emergency department in June of 2016?
A. I believe the testimony was that he was not functioning as an assistant medical director for REACH.
Q. And in fact, if there was a reportable incident, Dr. Garvey would not be who the REACH crew would have called then; correct?
A. Correct. Yes. They would have contacted the medical director or assistant medical director on call, and done that through their operation center. And I believe there was a notification made, but I don't recall seeing any report related to that notification.
Q. In your report you indicate that Dr. Garvey was the attending and the REACH medical director. Was there some reason why you listed him also as the REACH medical director?
A. Because he identified that in his testimony, as part of his roles and responsibilities. If I recall --
Q. Sorry, the pause, every time I think you're

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done. I'm not trying to interrupt you.
A. I appreciate that and I understand it is a challenge, so thank you. No problem.
It's my recollection of the testimony that Mr. Garvey -- I'm sorry, Dr. Garvey was the attending physician, and also listed as his employment the assistant medical director position. Therefore, I utilized it as a reference in my report, that he was aware of or at least familiar with the policies and procedures related to REACH.
Q. Other than his awareness of the REACH policies, procedures and protocols, is the fact that Dr. Garvey was a REACH medical director significant in any other way for purposes of your opinions?
A. If your questions related to the legal distinction as to who was in charge of the patient, then my listing wasn't referring to that portion. It was referring more to a -- an enhanced understanding of the nature of the roles and responsibilities for the REACH medical team, transportation providers and the responsibilities related to the policies and procedures.
Q. What is your understanding of Mr. Bartlett's -- prior to this event, his work experience as a flight paramedic?

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A. He had extensive work experience.
Q. Would you say he was qualified, had experience as a certified flight paramedic?
A. I don't know that that would be an opinion that I would offer. I recognize from his resumé that he had significant experience.
Q. Do you remember how many RSIs Mr. Bartlett had performed over the course of his career?
A. I don't recall his testimony specifically to RSIs, but I remember him stating something to the effect of thousands of intubations, if I recall correctly.
And to clarify the distinction between the two, again, as a paramedic, the placement of an endotracheal tube can be on those patients that are unconscious, unresponsive, not related to the medication administration. RSI is the administration of the medications by another provider. So from a paramedic's perspective, the procedure is unchanged.
Q. In your report you refer to Mr. Bartlett as a trainee. You're not saying that he was inexperienced, he just was in a training role at REACH, would you agree?
A. When you use the term "inexperienced," that could apply to a lot of different things. I think,

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based on the records that I've reviewed, my opinion is that he was under the evaluation of Ronnie Lyons. He was a trainee of Mr. Lyons. And he was being trained on REACH policies, procedures, protocols and the medical transportation tasks of REACH Air Medical.
Q. All right.
Would you agree that Mr. Bartlett has significantly more flight paramedic experience than you do?
A. Yes.
Q. Let's talk about airway assessments.
Do you train students? Like EMT, paramedic students; right?
A. Yes, I have.
Q. What type of visual assessment of a patient do you instruct your students to do when encountering a patient? Focusing on the phrase "visual assessment."
A. The standard of care calls for an assessment of the patient's airway prior to any advanced airway procedures. That assessment includes the visual inspection, a patient opening their mouth, being able to do a Mallampati visual assessment. There are also several assessments related to the mnemonics, that I used, Mr. Byrd used, related to LEMON and DOPE. And I believe all of those are consistent with a visual

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inspection.
Some involved the introduction of fingers into a patient's mouth to also measure distances, to determine whether a patient is a difficult airway or not.
Q. So I used to be an EMT and I remember in my training that they would tell us, "The moment you walk in, you start your visual observation of the patient. How they're interacting, how they're responding, how they're verbalizing, how they're moving."
Would you agree that that's part of the training?
A. Yes. That is part of the EMT training specifically related to scene size-up and most often applies to on-scene calls. It includes forming a general impression of the patient, which is that visual assessment of cues from the environment, and their presentation that helps determine initially what may be wrong with the patient.
Q. Let's talk specifically in a hospital setting.
If a crew comes in, a flight crew, it's a flight paramedic, and they know they're going to come in and intubate a patient prior to transport, would you agree that part of their assessment is a visual

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assessment of how is the patient talking, how does his anatomy work, does he have any injuries, things of that nature?

A. So I think I'd like to back up to your hypothetical.

If I understand you correctly, a flight crew comes in with a ground transport unit, is going to transport a patient by air and they intend to intubate the patient, that's a very difficult hypothetical.

I don't recall being in a situation where a patient required treatment and transportation, via air or ground, that the primary transport providers were the ones that were going to intubate the patient.

Q. So you would agree that's generally the fact scenario we have in this case? And I'm not trying to play word games or trick you. I'm trying to create a hypothetical that's similar to our case here.

A. Thank you. I appreciate that, nor am I trying to be evasive, but I don't recall that the REACH Air Medical team knew when they walked in that they were going to be intubating the patient.

Q. All right, but at some point they knew. I'm not saying that they knew on the drive over that dispatch says, "Hey, you're going to intubate the moment you get there." That's not what I'm saying.

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They become aware that they're going to intubate the patient. Would you agree, that in that scenario, part of the assessment includes a visual assessment of the patient, the anatomy, how's the patient talking, are there any deformities, anything that we need to be worried about, without physically touching the patient?

A. I appreciate your hypothetical, and I understand you're asking me specifics related to the intubation airway assessment within the standard of care, but the premise that they were going to be the ones intubating the patient is a significant hurdle I can't clear.

Q. Okay.

A. The fact that they were going to be the ones performing a surgical intervention on a patient, because that patient needed to be stabilized for transport, is a difficult part of this fact pattern for the hypothetical and I'm maybe complaining to.

Q. Let's talk about your experience.

In all of your experience, have you ever intubated a patient in the hospital setting?

A. Yes. In a training role, I have absolutely intubated patients in a hospital setting.

Q. What do you mean by "in a training role"?

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A. In a training role as a paramedic trainee, then yes, we routinely performed intubations in the hospital.

Q. Let's talk about in a critical care transport, where you were taking a patient from one hospital to another hospital. Have you ever intubated a patient prior to transport from the sending hospital?

A. Absolutely not.

Q. Okay.

In your report you use the phrase "comprehensive primary assessment" and "comprehensive secondary assessment."

What is the difference between the two?

A. The primary assessment involves the evaluation of immediate life threats, airway, breathing, circulation. Some of those may be obtained by the scene size-up as you described, when you first walk in, to visualizing a patient.

The secondary assessment is the more detailed assessment that would be applicable to a patient that's going to be under your care.

The primary and secondary assessment don't differentiate between a scene call or an interfacility transport. They're the responsibility for any medical provider that is going to assume care of a patient.

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Q. All right.

Let's talk about -- do you intend to offer any opinion at trial that Dr. Garvey did not obtain consent for the intubation of Mr. Schwartz?

Let me make it more specific. I think it will be easier for you to answer.

Do you intend to offer any opinion at trial that Dr. Garvey did not obtain consent for him to do an intubation of Mr. Schwartz?

A. I don't intend to offer an opinion regarding Dr. Garvey.

Q. In your report you talk extensively about the use of REACH equipment and the use of REACH medications. Is the use of REACH equipment or medications, is that a significant fact for purposes of your opinions?

A. It is part of the fact pattern that is significant. It includes the movement of the patient over to REACH's transportation gurney, or in this case, the transportation gurney that was going to be used to move Mr. Schwartz by ground to the aircraft.

And the utilization of their equipment, because Mr. Schwartz was hooked up to their equipment, at the time that they were asked to perform this procedure or intervention.

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Q. And how is that significant for purposes of your opinions?
A. It denotes a transfer of care.
Q. A total transfer, or the start of a transfer of care?
A. It denotes a transfer of care. The patient's been moved to a transportation gurney. And in this case, documentation was provided to them, an off-going report was provided to them, according to the nursing staff. And they had retained care of the patient and the transfer of care, again, to the best of my understanding of the document, had taken place.
Q. So when you say REACH retained care of the patient, had Dr. Garvey given up care of the patient at that point?
A. Based on my understanding of the records, yes.
Q. So at what point -- be very specific here. At what point did Dr. Garvey give up care of the patient in your opinion?
A. Based on my review of the transport consent form that was signed, the documentation that was furnished to Mr. Lyons, Mr. Lyons had received an off-going report from the nurse, primary caregiver, to Mr. Schwartz, and the patient was moved over to their

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gurney, REACH's gurney. That was the transfer of care. All of that took place in the context of the transfer of care.
Q. But you would agree that after this point in time that you talk about, care was still provided to Mr. Schwartz by the hospital staff; correct?
A. Yes. That's correct.
Q. And care was still provided to Mr. Schwartz after this point by Dr. Garvey; correct?
A. Yes. That's correct.
Q. So help me understand, then, what -- how could Dr. Garvey have given up care of the patient while still providing care?
A. That is a challenge to the fact pattern. There are really two scenarios.
One scenario is that transfer of care took place, Dr. Garvey came in with a new request and did not take back the care of Mr. Schwartz.
The second scenario is that the REACH medical crew was providing care without consent from Mr. Schwartz, and the care was provided by Dr. Garvey and both of those crew members.
And I'm unable to come up with a third scenario, but those appear to be the two scenarios in the fact pattern.

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Q. Are familiar with the phrase "procedural timeout"?
A. Yes.
Q. Have you participated ever in a procedural timeout in a hospital setting?
A. Yes, I have.
Q. How do those generally work in your experience?
A. In my experience, there is a discussion prior to the interventions about risks, complications, needs of the procedure, and assignment of roles and responsibilities, ensuring equipment is available, and ensuring that all of the parties involved in the care are familiar with their -- with the expectations. And also, an understanding of what is going to be a cutoff point and when decisions are going to be made to alter the course based on a change in patient condition.
Q. Based on your experience, you would agree that these procedural timeouts usually occur immediately prior to a procedure; correct?
A. "Usually" is a difficult term. I can't quantify usually, but the timeout is indicated within the standard of care prior to performing interventions.
Q. And you're not talking three hours prior to, but very soon before the invention is performed;

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correct?
A. It is in close context, yes.
Q. When a procedural timeout is called, people don't say, "Hey, hold on, I'm going to go eat lunch and I will be back and we'll do this procedure," in your experience; right?
A. I have not had that happen.
Q. Meaning we do the procedural timeout and proceed to the procedure. That's been your experience; correct?
A. Yes.
Q. Are you aware if a procedural timeout occurred in this case?
A. I understand there's conflicting testimony as to whether that occurred or not. According to Mr. Lyons, it did not, and it did not meet the procedural timeout as I described to you in the standard of care. I understand that term was used, though, by Dr. Garvey, and if I recall correctly, or another caregiver in the room.
Q. So it's your testimony, based on your understanding of the records, that Ronnie Lyons testified that a procedural timeout did not occur, is that what you're telling me?
A. My testimony is that a procedural timeout,

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as I just outlined to you, based on my experience and my familiarity with the standard of care, did not occur.
Q. And you reviewed Ronnie Lyons's deposition transcript; correct?
A. Yes.
Q. Do you recall if he was asked if a procedural timeout occurred?
A. I recall the testimony. I don't recall the specific questions.
Q. I want you to assume that a procedural timeout occurred.
Would you have any -- is there anything from the record that tells you that in a procedural timeout, Dr. Garvey, in this instance, didn't say, "I'm going to go do a chest tube and Barry Bartlett's going to do the intubation"? Anything in the record that supports that that discussion did not occur?
A. I believe the procedural timeout term is very specific in its definition in the standard of care. The statements that you just read to me are my recollection of what took place. I don't connect those two as being equal. One is not a procedural timeout. The other, as I described, with all the detail that I described, is a procedural timeout and the standard of

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care.
Q. Do you recall if Ronnie Lyons was asked if a procedural timeout was an opportunity to voice any concerns regarding the proposed procedure?
A. I don't recall that exact question, but I'm going to believe that you're looking at the transcript right now and asking me a question based on the information you already have. Therefore, I --
Q. I'm asking for your recollection.
A. Yes.
I recall that there was a conversation regarding a role for the REACH crew and Dr. Garvey's role related to placement of a chest tube and intubation.
Q. My question was more specific.
Do you recall if Ronnie Lyons was asked if a procedural -- sorry.
Do you recall if Ronnie Lyons was asked -- let me totally start over.
Do you recall if Ronnie Lyons was asked if a procedural timeout was the opportunity to voice any concerns regarding the specific procedures?
A. I don't recall the exact question but I recall testimony along those lines.
Q. Do you recall if Ronnie Lyons was asked if

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anybody voiced concerns during the procedural timeout regarding the proposed procedure?
A. I recall that line of questioning or that testimony. I don't recall the specifics of it.
Q. So if a procedural timeout occurred, how do you square that?
I want you to assume that one occurred. If a procedural timeout occurred and nobody voiced objections, how does that square with your testimony that Dr. Garvey never instructed the REACH crew what they were doing?
A. I believe my answer earlier regarding what a procedural timeout is is different, significantly different, and within the standard of care, versus Dr. Garvey looking at the REACH crew and saying, You intubate and I'll place a chest tube. I'm paraphrasing, but something along those lines.
Q. Do you recall if Ronnie Lyons was asked to give a definition of what a procedural timeout was?
A. I recall the questions. I don't recall the -- something along those lines. I don't recall his testimony.
Q. Would it surprise you that his answer was, "A procedural timeout is where everybody comes to a stop. They focus on the person in charge. He then

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tells you who the patient is, what the planned procedures will be and everyone has to be in agreement. Everyone has to have their equipment ready to proceed before the next step is taken."
Does that sound like a definition of a procedural timeout?
A. My definition is based on the records and documents regarding the standard of care. And the educational materials include several pieces that are missing in that statement. Specifically --
Q. Sorry. Go ahead.
A. Specifically related to risks, complications, and also, what do you do when something is not going as initially intended regarding a medical procedure.
It also squares away, as you had stated, the specific roles and responsibilities for medical health caregivers in an environment that are all within the context of consent. I believe that in this case, the procedural timeout was also related to a transport crew being involved in surgical interventions on a patient that they didn't have a consent to treat.
Q. Is it your testimony that an intubation is a surgical intervention?
A. It is an advanced intervention.

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Q. I'm being specific as to surgical. You used the phrase "surgical."
Is the intubation -- is that a surgical intervention? Yes or no?
A. It could specifically be a surgical intervention, yes, when it relates to a failed airway that requires a cricothyrotomy. That's a surgical intervention.
So when you're talking about the context of intubation, and you lay out risks and complications, that is a potential end point that you would get to and it's a surgical procedure, as evidenced by the standard of care that paramedics, physicians, nurse anesthetists are isolated in the procedure of advanced airway placement using intubation.
Q. But you would also agree that the intubation is successful on the first attempt, when it goes in, tube goes in, patient is intubated, that's not a surgical intervention; correct?
A. As it stands alone, I don't recall whether that was termed surgical. It is advanced airway placement that involves surgical procedures.
Q. Do you know when in time the procedural timeout described by Ronnie Lyons occurred with respect to when did it occur in relation to the first

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intubation attempt?
A. My --
Q. Sorry. I interrupted you there.
A. That's okay. I do take a minute to pause and think about my answer to make sure that I'm answering it to the best of my ability and that pause throws people off. So I apologize.
The recollection I have is that it was a procedural timeout using his definition or what he believed to be a procedural timeout at the time prior to the intubation attempt.
Q. Can you put any time to it? Was it seconds? Minutes? Hours?
A. I don't recall a specific time.
Q. Do you recall if Dr. -- from your review of the records -- I realize you weren't there.
From your review of the records, was Dr. Garvey prepared to proceed with the chest tube when he called the procedural timeout?
A. Prepared? I recall there was a sequential order to it and there was intubation and prepping Mr. Schwartz for chest tube placement. So prepared versus prepping, I don't recall specifically.
Q. A chest tube is not within your scope of practice; correct?

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A. Yes, that's correct, it is not.
Q. But you -- have you ever seen a chest tube inserted?
A. Yes.
Q. Have you ever seen it done in a hospital setting?
A. Yes.
Q. Have you ever seen it done in a nonsterile environment, as far as the one performing the chest tube is not sterilized and the area is not sterilized?
A. When you say "not sterilized," so an OR -- I'll give you my definition of what sterilized is.
An OR surgical suite or surgical operating room would be sterile with certain procedural contexts for that.
A surgical procedure, like the insertion of a chest tube, requires sterile -- local sterilization of the -- of the patient prior to insertion. So I guess -- and it requires that the physician use sterile gloves versus traditional exam gloves, and other types of sterile instruments and surgical instruments that have to be sterilized. So I --
Q. Let me see if I can be more specific. I was watching an episode of Chicago Med the other day. A patient comes in, crashing, and boom, cut, the tube

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goes in.
That's not the scenario we have with Mr. Schwartz. He's relatively stable. Do you have any understanding, from your review of the record, that Dr. Garvey did not take appropriate steps to sterilize the area where the chest tube would be inserted and to appropriately put on protective gear for himself that would keep the area sterile?
A. Yeah, I agree that Mr. Schwartz was stable. I agree with the observation regarding that he was being prepped for a chest tube. Regarding the procedural aspect of that, I don't intend to offer an opinion regarding Dr. Garvey.
Q. I'm not asking you to offer an opinion. I mean you've reviewed the record. Based on your understanding, did Dr. Garvey take the steps to provide a sterilized or safe chest tube insertion?
A. I don't recall evaluating the records for that detail.
Q. Based on your review or your experience with procedural timeouts, do you have any reason to believe that Dr. Garvey, during the procedural timeout, didn't say, "I'm going to do the chest tube. I'm ready to go. Mr. Bartlett is going to do the intubation. Everybody's got their equipment. Let's proceed,"

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something along those lines? Not verbatim but that general idea.
A. If what you're representing to me is what happened, then that would be below the standard of care for procedural timeouts.
And, it also offers the opportunity for the REACH crew to say, "This is absolutely not something that we can do without consent, without further consideration of the risks, the consequences, the cutoff points," as we discussed. And if the patient is on their transport gurney, that is a surgical procedure being performed on their transport gurney. And then an intubation or advanced airway placement, which is a high-risk event and procedure on their transport gurney, clearly, there has been some discussion between them and Dr. Garvey. This would all have been within the context of a procedural timeout.
Q. Not my question. It's a long answer but I would move to strike if we were at trial. My question is very specific.
Is it really your opinion that the medical team treating Mr. Schwartz in the ED did not know that Barry Bartlett was the one who would attempt the intubation?
A. It is my opinion from the records that the

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REACH crew was asked to perform the intubation and a decision was made that Barry Bartlett would do it. If I remember the context of the testimony Ronnie Lyons offered, he had delegated that or the procedure had been delegated to Barry Bartlett.
Q. Who asked the REACH crew to do the intubation?
A. My recollection is it was Dr. Garvey.
Q. In your report you say, "According to Bartlett, he had no conversation with Dr. Garvey regarding who was going to perform the intubation."
So is that characterized strictly -- you're taking that from Mr. Bartlett's testimony or from the testimony of everyone at large?
A. I believe Mr. Bartlett testified to that. Mr. Lyons testified to the crew being asked to perform it. Hence, the reason I included it in my report.
Q. You earlier agreed that Dr. Garvey had consent. If he would have performed the intubation, he had consent to do that; correct?
MS. BLAZICH: Objection. Misstates the testimony.
BY MR. BURTON:
Q. I'm not trying to misstate your testimony. I asked you a question earlier.

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If Dr. Garvey had been the one to attempt the intubation, you don't disagree that he had consent to do that; correct?
A. If that was the exact question that you asked me, I agree that he had spoken to a family member regarding the procedure of intubation. Consent would be expressed and formed and require details to the conversation that are disputed based on the facts.
Q. But there are facts that demonstrate -- and I realize you can pick and choose which facts you want to believe, but there are facts that say that Dr. Garvey explained the process and got permission to do it.
You would agree with that; correct?
A. So I would not parse the facts. Explaining the process didn't give detail as to what that meant. Therefore, understanding that you had asked me earlier whether I intend to offer an opinion regarding Dr. Garvey, if I assume for a hypothetical that full, complete, expressed, informed consent was obtained for the procedure by Dr. Garvey, then that hypothetical would apply, yes, he received the consent.
Q. I'm not asking for a hypothetical. I'm asking specifically, based on your review of the records, did Dr. Garvey receive informed, expressed

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consent for intubation?
A. And I believe those are facts in dispute.
Q. So is that a no, he did not receive consent, or yes, he did?
A. I'm not a trier of fact. I'm offering the opinion that those facts are in dispute.
Q. So be more specific. When you say "those facts are in dispute," are you saying that there is not testimony where Dr. Garvey explained the process and got permission to do the process?
A. That wasn't my answer and that wasn't the question. The question was: Did he receive expressed, informed consent? And my answer was that there is testimony that he did and testimony that he didn't. It's a dispute of the facts.
Q. Okay. That's helpful.
Tell me what you mean by "expressed and informed consent."
A. Actually, to give it, I'd rather give you the definition within the documentation.
Q. I'm just asking for your understanding of what expressed and informed consent is.
A. It's based on my understanding of the standard of care related to consent. And it is defined very specifically, so I'd like to read it if I could.

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Q. What are you reading from? It looks like you have something other than your binder in front of you.
A. Yes, that's correct. This is one of the textbooks that I referenced in my report as being supporting documentation. It's a paramedic textbook. Specifically, it's the Mosby's textbook, 4th edition.
It's states, "Informed consent is patient consent that signifies the individual knows, understands and agrees to the care rendered. This consent is given based on full disclosure of the information. Verbal or written consent to the treatment is called expressed consent.
"Implied consent is different," and then it goes on to discuss it. So informed, expressed consent is, therefore, a full understanding of the risks, benefits and acknowledgment of those risks and benefits with authorization for anyone who treats the patient.
Q. All right.
I want you to assume that Dr. Garvey had express and informed consent. Are you with me?
A. Yes, I am.
Q. If Dr. Garvey had expressed and informed consent to perform the intubation -- if he had assigned that intubation to be done by a respiratory therapist,

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employed by the hospital, would the informed and express consent obtained by Dr. Garvey had applied -- would that apply to the RT as well?
A. It may or it may not, depending on the role of the RT within the hospital system, and whether the respiratory therapists were part of the employees of the hospital or, as by hospital policy, fall under the consent of the emergency department physician.
There are subcontracted roles and responsibilities that isolate specific issues related to consent. And for the support of that opinion, if you were to go to get an x-ray, for instance, as you discussed earlier, depending on the nature of that, that may require a separate consent for that procedure.
Q. I'm not -- I'm being very specific.
I want you to assume Dr. Garvey has expressed, informed consent and the RT is an employee of the hospital. Does that RT -- and that RT is asked, by Dr. Garvey, to do the intubation.
Does that RT need to say, "I can't do it until I re-explain to the patient the risks, the procedure, and I get their verbal approval based on a full understanding of the process"? Does the RT need to do that?
MS. RIES-BUNTAIN: Objection. Foundation

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as to what an RT would do.
BY MR. BURTON:
Q. You can go ahead and answer.
A. My best answer is it depends. It depends on the -- the scenario that you provided has a lot of issues related to the relationship between the staff and the RT or any of the caregivers in the hospital environment.
Q. Let me ask it this way: Is there a scenario where the express -- again, assume the informed consent of Dr. Garvey.
Is there a scenario where that consent, expressed and informed, would apply to a hospital employee, meaning the hospital employee would not need to get additional consent?
A. And my best answer is it depends. It certainly wouldn't apply to a medical transportation team.
Q. And that's not my question.
A. That's the part that I reviewed.
Q. That's not my question.
My question is: Give me a scenario where a doctor who has expressed, informed consent to perform an intubation can delegate that to a hospital employee, another hospital employee, and that hospital employee

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does not need to go get their own separate expressed and informed consent. Does that make sense to you?
A. I believe I understand the question that you're asking me. So in that case, yes, it makes sense. But regarding the hypothetical, there are so many different environments where there would need to be separate consents for a procedure or for a caregiver within that environment --
Q. That's not my question.
Sir, my question is this: Give me a scenario where that hospital employee would not need to go get their own separate consent. I understand there are lots where it would be problematic. I want you to give me an example where they wouldn't need to, if you can. And if you can't, that's fine. I'll move on.
MS. BLAZICH: I'm just going to object that this is outside the scope of his expert opinions.
MR. BURTON: It's not. It's squarely within the scope of his informed consent opinions.
BY MR. BURTON:
Q. Go ahead.
A. I wasn't finished with my earlier answer.
Q. Well, I want you to answer the question I'm actually asking.
A. I appreciate that.

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So in answer to your question, it depends.
Q. Can you give me a scenario where a hospital employee would not need to go get their own separate informed consent? Can you do that?
MS. RIES-BUNTAIN: Objection, foundation.
MS. BLAZICH: Join, and same objection as before.
THE WITNESS: It is a broad hypothetical that I can't give a blanket answer to.
BY MR. BURTON:
Q. Can you give any specific answer? I'm not asking for a blanket answer. I'm asking, can you give any example, based on your years of experience and your expertise, where a doctor's informed consent would apply to a separate hospital employee who would then not need to go get their own informed and expressed consent?
MS. BLAZICH: Same objection.
MS. RIES-BUNTAIN: Join.
THE WITNESS: Again, it depends. The hypothetical is too broad. I would need more specifics.
BY MR. BURTON:
Q. All right. What if it was an attending and a resident? The attending gets the expressed, informed

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consent to do the intubation and delegates it to resident. Does the resident need to go in and say, "I need to go get my own informed consent to do the procedure"?
MS. BLAZICH: Same objection.
THE WITNESS: In that scenario, there's a training relationship and the resident is a trainee as identified under the hospital policies and procedures, or for the institution with which they're being educated. That would require consent from the overseeing physician or primary care provider for the training physician, and the training physician would still need to reiterate the procedure to the patient and receive their own informed consent. Understanding that the issues to consent, as you describe, are not applicable in the same way to the medical transportation crew scenario that is related to the Schwartz case.
BY MR. BURTON:
Q. I'm not asking about that.
So is it your testimony -- and I'm not trying to misstate your testimony. I'm trying to understand.
Is it your testimony, in a resident hypothetical, that the attending would need to go back

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into the room and say, "You know what, I already got your approval. I'm actually going to have the resident do that, are you okay with it?"
A. That's a different hypothetical than you just asked me. My answer to the previous hypothetical was that the attending physician is responsible for the resident physician. And that if the attending physician and resident physician aren't there at the same time, to obtain informed, expressed consent in written or verbally expressed form, then both have an obligation to get that consent before the procedure.
And if I may, also, again, you're asking me questions regarding a resident in a training capacity related to a training hospital, which -- with which a patient would sign a consent at the moment they come into the hospital, acknowledging it's a training hospital and allowing them to be treated by students.
Q. If the resident was standing in the room when the attending received the informed, expressed consent, you wouldn't need to get a separate informed, expressed consent for the resident to do it; correct?
A. I believe I've given you my best answer, which includes that portion of the hypothetical.
Q. Would you need --
A. Generally speaking --

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Q. Would you or would you not need the additional consent?
A. I believe I gave you the best answer I just could give you. And generally speaking, when you're performing high-risk interventions, such as advanced airway management secondary to sedation and paralytics, you must obtain consent for that as you would other treatments.
Q. What if it was a nurse, experienced in intubation, and the physician had obtained consent and the nurse was in the room when the consent was obtained?
Would the physician need to specifically say, "I'm giving your consent for the nurse to do it," or is he just getting consent for the procedure?
A. Consent includes informed patient understanding of the procedure, which would include who is performing the procedure.
Q. And in every scenario it's your testimony that the patient -- that the patient is always informed who specifically will be performing the procedure; is that your testimony?
A. My testimony to your hypothetical was that, yes, if there's a procedure being performed on a patient, that requires expressed and informed consent.

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The informed consent would include the caregiver performing the procedure.
Q. Have you ever been in an emergency department and given a hand to the care that's being provided to some patient in the ED?
A. I don't understand what you mean by "giving a hand." Could you be more specific?
Q. You really -- you don't know what I mean when I say "giving a hand"?
A. Mr. Burton, I'm asking you to clarify what you mean by "giving a hand," because that could fall under many categories.
Q. All right, I'll be specific. I'm sorry you didn't understand what giving a hand means.
Have you ever assisted in patient care in the emergency department?
A. Yes.
Q. Have you ever assisted in patient care in the emergency department on a patient that you did not just transport into the hospital?
A. Yes.
Q. Have you ever assisted on patient care in the emergency department on a patient that you didn't just transfer in or that you don't intend to transfer out?

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A. Yes.
Q. So, for example, the hospital -- the ED is busy and someone says, "Hey, can you go start a line for me?"
A. Yes.
Q. And then I assume you've done that many times over the course of your career.
A. I wouldn't say many times, no.
Q. How many times do you think you've done that?
A. I don't think I could estimate, but I would say maybe 20 times in my career, that's happened.
Q. In the 20 times that you did that, did you always fill out a trip report with your EMS agency for that care that you assisted on in the emergency department, on the patient you hadn't just transported or you weren't intending to transport, because the ED was busy?
A. Well, the scenario wasn't necessarily that the ED was busy.
Q. All right, take out the busy part.
A. But yes, I did not always complete a patient care report for starting an IV on a patient in the hospital. I instead was --
Q. Well -- sorry.

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A. I instead was included in the patient care report for the hospital and I achieved informed, expressed consent for me to operate in that capacity, notified my employer that I was operating within the hospital to assist them in this particular instance I'm referring to, performing CPR and starting IV for triage patients related to a multi-casualty event.
Q. So in every scenario prior to providing care, you would call your dispatcher or your employer and say, "I've been asked to start a line. I've been asked to help with CPR, just FYI," and then go do the care?
A. Yes.
Q. Even in an emergent situation?
A. If I'm in the emergency department doing something specifically in partnership with the hospital that was care, yes, absolutely, I did that. And they were very rare related to, again, multi-casualty incidents.
And the other scenario I can recall is providing CPR. In fact --
Q. Sorry, I thought you were done.
A. In fact, just this weekend I responded on a call that required a patient to receive rapid sequence induction in the emergency department, a patient I

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treated and transported. And I absolutely did not provide any care in that scenario because I'm not a licensed caregiver in that capacity, except in disaster events.
Q. The times where you provided assistance in the ED, did you document your care in the hospital record?
A. Yes.
Q. Let's talk about informed -- staying on the issue of informed consent.
You're aware that nurses change shifts?
A. Yes.
Q. So oftentimes, it's 7:00 to 7:00 or -- you know, pick a timeframe. And a new -- old nurse goes off and a new nurse comes on. Would you agree?
A. Yes.
Q. Is it your opinion that in that situation, when an oncoming nurse assumes care of the patient, that she needs to -- he or she needs to get informed consent -- express and informed consent prior to providing any patient care?
MS. BLAZICH: Objection. It's outside the scope of his expert opinions.
BY MR. BURTON:
Q. Go ahead.

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A. Could you ask the question again, please.
Q. Yeah.
Oncoming nurse, prior to providing any care to a patient in an ED, does that nurse need to go in and get express and informed consent prior to providing any patient care?
MS. BLAZICH: Same objection.
THE WITNESS: I don't know that I feel comfortable offering an opinion in that hypothetical.
BY MR. BURTON:
Q. Do you have any opinion at all in that scenario, or regarding that scenario?
MS. BLAZICH: Same objection.
THE WITNESS: My answer is I don't know that I feel comfortable offering an opinion regarding that hypothetical.
BY MR. BURTON:
Q. I think I asked you earlier how many RSIs you've done during patient transport. I don't know if I asked that specifically. Let me ask it specifically.
Knowing that you've done -- I think you said, and don't let me put words in your mouth, but you've done 15 to 20 RSIs. I might be forgetting that. Is that accurate? Is that what you said?
A. Yes. In the hospital environment, in the

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context of the question you asked, I believe it was -- in my career, it was hospital environment, training environment, related to my paramedic work, yes.
Q. And it was about 15 to 20?
A. Yes. Approximately.
Q. And that's -- again, to make sure we're not taking past each other, that's total in any scenario; correct?
A. Yes. That's correct.
Q. Have you ever done an RSI mid-transport, whether ground or air or any -- where you're moving with the patient, you're not at a scene or in a hospital?
A. No, I have not.
Q. In your report you talk about how -- and I'll quote you from it.
You say that, "Barry Bartlett administered Ketamine." And then you say, "Immediately after the medication was administered REACH Paramedic Bartlett initiated the intubation."
Is it your opinion that Mr. Bartlett did not wait 60 seconds before -- after administering Ketamine before -- or after the Ketamine was administered before attempting intubation?
A. If I may, I've got the patient care report

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in front of me and I'm going to refer to it real quickly.
Q. That's fine.
A. (Witness reviews document.) The --
Q. Just refer to what page you're reading from.
A. Yes. Thank you. The Bates stamp number is 188.
Q. Okay.
A. It's the patient care report. It states that, "At 0018, it was Ronnie Lyons that administered the Ketamine, 180 milligrams intravenously." And I believe -- I'm reviewing it for a time stamp.
It says that in the report, there was a sixty-second pause for effect in the patient care report. I believe my opinions related to Ronnie Lyons and Barry Bartlett's testimony, that after giving the Ketamine, they initiated the intubation.
Q. It's not your testimony that it happened immediately; correct?
Let me rephrase. I'll withdraw that question.
You dispute that a sixty-second pause for effect occurred?
A. I'd have to review all of the testimony

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from Ronnie Lyons and from Barry Bartlett, whether they used the term immediately or not. But in the patient care report, it states there was a sixty-second pause for effect.
Q. Okay.
MR. BURTON: I don't know how long we've been going. Do you want to take a break or are you doing okay? I know that -- or does anybody else want a break?
THE WITNESS: Out of courtesy and consideration for everyone else, I'll be happy to take a break.
MR. BURTON: All right. Thanks.
(Recess taken from 3:59 p.m. to 4:06 p.m.)
BY MR. BURTON:
Q. Do you have an opinion on what constitutes an intubation attempt?
A. Yes.
Q. What is that opinion?
A. The attempt is the visualization of the airway with the intent to pass the tube. I understand that there are some differing opinions that have been offered by opposing experts, and so I relied on Mr. Lyons's representation of an intubation attempt.
Q. When you say "visualization of the airway,"

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is that visualizing the cords? What are you visualizing? Is it opening of the mouth? What are you talking about?
A. Utilizing the laryngoscope, or in this case the airway visualization device.
Q. Does it have to -- can you have an intubation attempt without the instrument entering the patient's mouth?
A. The instrument being the laryngoscope or visualization device?
Q. Yes.
A. Yes, that would not be an attempt.
Q. So for example, I can visualize a patient's airway with just their mouth open, but that's not an intubation attempt; correct?
A. That is correct.
Q. Are you aware if Nevada has any specific law on what constitutes an airway attempt -- or excuse me, not airway, intubation attempt?
A. I don't recall reading something specific related to Nevada in intubation attempts. Again, I've used my context, the standard of care context, and then Mr. Lyons's representation of an intubation.
Q. But you would agree -- let me ask you, do you know if there are states that specifically

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describe, for that state, what constitutes an intubation attempt?
A. There may be, yes.
Q. I'm asking if you know. I'm not -- not if there may be. Do you know, as you sit here today, if there are attempts at -- if there are states that specifically define what constitutes an intubation?
A. States -- I'm not aware of a state definition.
Q. Have you ever missed when trying to intubate a patient?
A. Yes.
Q. How many times do you think you've missed?
A. In my career, I would estimate a handful of times, in the beginning of my training.
Q. And I'm not talking about on a dummy or a cadaver, but on a real live patient.
Let me ask you this: If somebody told you that has done intubations that they've never missed, would you believe them? Isn't it common that people miss?
A. I don't think the word "common" is appropriate, but it would be uncommon if people haven't missed in their career.
Q. Do you have an opinion as to how many

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intubation attempts occurred with respect to Mr. Schwartz?
A. Yes.
Q. What is that?
A. I've reviewed Mr. Lyons's testimony. He represented there were at least 11.
Q. Was that -- is your opinion based on a review of the records or based on Mr. Lyons's testimony?
A. I relied on Mr. Lyons's testimony as a review of the records and my review of the records came up with similar numbers.
Q. Similar or identical?
A. Similar, because there is some discrepancy as to the possibility of them being more than 11.
Q. How many CRIC have you done in your career?
A. My career? In my training, I've performed them if I recall, but in the field environment, I have not performed a cricothyrotomy, certainly not in an interfacility transfer.
Q. And you've never performed it in the hospital, I assume?
A. When we say hospital, interfacility transfer; that's correct.
Q. I'm talking about have you ever

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performed -- I'll be more specific.
Have you ever performed a cricothyrotomy in an emergency department?
A. In my training, in the beginning of my career, I recall doing it but not since.
Q. Were you doing it or were you assisting in it being done?
A. I was part of doing the procedure. I was not the only one part of doing the procedure.
Q. Were you the one doing the actual cutting?
A. Yes.
Q. Okay.
When was that training?
A. It would have been at the beginning of my paramedic career, so '91, '92.
Q. And you've never done one in the field; correct?
A. That's correct.
Q. And you've never done one on an aircraft; correct?
A. Yes, that's correct.
Q. And you've never done one in the back of an ambulance?
A. Yes, that's correct.
Q. And you haven't done one in approximately

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30 years, however long ago 1991 was?
A. Yes. Correct.
Q. In this case, do you intend to offer an opinion as to when a cricothyrotomy should have occurred?
A. Yes.
Q. What is that opinion?
A. According to REACH policies and procedures, it is after -- it's considered within line of the crash airway or failed airway. And within the standard of care for patients with advanced airway failures, it's after the third attempt.
Q. Do you have an opinion as to whether or not a CRIC would have been successful if it would have been tried after the third failed airway attempt?
A. Standard of care for paramedics related to performing that procedure doesn't denote a guaranteed outcome. So regarding the believing of -- belief or opinion as to whether it would have been successful wasn't within the policies and procedures for REACH Air Medical transport. So, therefore, I don't intend to offer an opinion as to its likelihood of its success.
Q. Do you intend to offer any opinion as to how the outcome for Mr. Schwartz could have been different if the CRIC would have been tried after the

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third failed attempt?
A. That sounds like a causation opinion to me.
Q. I assume you're not offering any causation opinions.
A. That is correct.
Q. Okay.
That would have been a better way to ask that question. You've done this before I can tell.
Let me ask you this: Could you attempt intubation after a CRIC has been performed?
A. Can you attempt intubation? There is the passing of an endotracheal tube that can be done through a tracheotomy opening, using an inducer, basically a guide. So endotracheal intubation using the visualization of a laryngoscope after a cricothyrotomy procedure, I'm not familiar with that being done within the standard of care.
Q. And I should have been more specific. I was talking about endotracheal.
Once -- once you attempt a CRIC, you don't attempt to go through the mouth anymore; correct?
A. I have not heard of a scenario like that, nor have I seen that within the standard of care documents.
Q. So you would agree if -- if they would have

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done a CRIC after the third attempt, that they no longer could try endotracheal intubation or suction through the mouth; correct?
A. Who is "they," please?
Q. The crew. Those treating Mr. Schwartz in the ED, the medical team.
A. Well, the medical team to me is the REACH Air Medical crew. I want to make sure, that's why I ask.
Q. I'll be more specific.
All in the ED that were providing care for Mr. Schwartz, any provider; Dr. Garvey, nursing staff, the REACH team, whoever else is there.
The moment the CRIC occurs, they couldn't have tried endotracheal intubation; correct?
A. I don't intend to offer an opinion regarding Dr. Garvey.
Q. I'm not --
A. I don't intend to offer an opinion regarding the nurses within the hospital environment. I intend to offer an opinion related to the REACH crew, that that was the policy and procedures that was applicable to them at the time and within the standard of care, that the cricothyrotomy was the indicated intervention for them.

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Q. Not my question. I'll make it a different question. See if we can get an answer to this one actually.
In a hypothetical situation, patient's being treated in the emergency department. A cricothyrotomy is attempted but unsuccessful.
Can the medical team providing care to that patient then attempt additional attempts for endotracheal intubation? Yes or no?
A. Can -- I don't know what can be done by a higher level of medical care providers, like anesthesiologist or, in this case, Dr. Garvey.
I don't know what was available to them, but for the REACH medical crew --
Q. I'm not asking -- this is a hypothetical, not specific to REACH. I want you to answer that question.
A. Specifically related to a hypothetical, where you have two separate entities, the providers of different levels of medical training, I can't offer you an answer to what they can do. Related to the standard of care, it would be outside of the standard of care to intubate someone repeatedly, or attempt to, and not do the cricothyrotomy indicated policies and procedures and in the medical journals and documentation.

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Q. And I'm not sure why this is such a struggle, Mr. Everlove. If it's on my part, I apologize. That's not at all my question. I'll try to be very specific and simple.

If the doctor tries a CRIC, in a hospital setting, in an emergency department, and the CRIC is unsuccessful, can the doctor, subsequent to the unsuccessful CRIC, attempt endotracheal intubation? Yes or no?

MS. BLAZICH: I'm just going to object that I think it's outside the scope of his expert opinions.

MR. BURTON: Well, a lot of it's outside of his scope but he's happy to go there.

BY MR. BURTON:

Q. Go ahead and answer.

MS. BLAZICH: Well, you're asking the questions, James.

BY MR. BURTON:

Q. Go ahead, Mr. Everlove. Do you understand my question or do I need to simply it for you?

A. I appreciate your question. I understand that you're now asking it related to the physician and I would feel uncomfortable offering an opinion regarding the scope of practice for the physician in that hypothetical.

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Q. Well, go ahead. And you have experience with airway management. Go ahead and answer my question.

A. I don't believe it would be appropriate for me to do that, because I don't understand -- I'm sorry. I understand your question. I don't have the applicable scope of practice, knowledge, to know what a physician can do in that situation.

Q. So are you refusing to answer my question?

MS. BLAZICH: Objection. It's argumentative. He has answered your question. It's asked and answered.

BY MR. BURTON:

Q. Go ahead, Mr. Everlove. Are you refusing to answer my question?

MS. BLAZICH: Same objections.

THE WITNESS: I'm offering you my best answer, under the penalty of perjury, as I sit here, to not answer a question for which I'm unfamiliar with the scope of practice.

BY MR. BURTON:

Q. All right, I'll make it more specific to you.

If a paramedic attempts a CRIC and is unsuccessful, would a paramedic be within the standard of care to subsequently attempt an endotracheal intubation after a failed CRIC?

A. I don't have knowledge that that's the case. I have not encountered a situation like that, nor have I encountered documentation related to a failed cricothyrotomy and the alternatives or opportunities to place an advanced airway past that, absent of a tracheostomy.

Q. Let me ask you this: In specific to Mr. Schwartz, once the CRIC failed, what were the options of the team, the REACH team?

MS. BLAZICH: Objection. Outside the scope. Well, maybe not if you're asking about the REACH team.

BY MR. BURTON:

Q. Go ahead.

A. I'm sorry, can you ask your question again, please.

Q. Once they were unable to secure an airway through a cricothyrotomy, what were the options to secure an airway available to the REACH team?

A. To the best of my knowledge, that was their option. Dr. Garvey or the hospital staff may have had other options, like the tracheostomy procedure. But within the policies and procedures that REACH had, that was their option.

Q. Meaning there was no subsequent option after that?

A. For the REACH team, I don't see anything within their policies and procedures of how to manage a failed cricothyrotomy.

Q. And so what do you do in that scenario? You've attempted intubation but it's unsuccessful. You attempt a CRIC, it's unsuccessful. What do you do then, as the REACH crew?

A. In this case specifically, you never put yourself in that position. It would be a primary care provider in a high-risk environment, for a patient that is in the emergency department and needs further interventions, such as a surgical intervention or advanced airway placement.

Q. All right, they're in that situation. What were their option after a failed CRIC? Were there any additional medical procedures or steps that the REACH crew could take after a failed CRIC?

A. Related to the advanced airway placement, I don't know that there were any.

Q. Would you agree that Mr. Schwartz was REACH's patient? You've already agreed to that; correct?

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A. Yes.
Q. I'm now going to focus on your opinions.
Explain to me what your first opinion is.
Summarize your first opinion for me, please. I don't want you to read it word for word. I want just kind of a summary of what it is.
A. Mr. Schwartz was under the patient care of REACH personnel and hospital staff during the subject event.
Q. You identified all factual support for your first opinion within your report?
A. That's correct. I listed all the materials I reviewed in developing my opinions.
Q. But I'm being more specific.
Under your actual opinion section, where you have number one, have you identified all the factual support upon which you're relying for that opinion?
A. I see. You're referring to the statements, not necessarily the documents themselves.
Q. Yes. The actual -- on page 10 of your report, starting with line 11. Is that the totality of your opinion and the support for your opinion for number one?
A. It is at the time of this report, yes.

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However, Dr. Osborn's deposition, for instance, reinforces the fact that this was a patient under the care of REACH.
Q. Well, but you would agree Dr. Osborn's testimony was not that the patient was under the sole control of REACH; correct?
A. Yes. That is correct, and my opinion reflects similar findings that Dr. -- I'm sorry, Mr. Schwartz was under the care of Northeastern Nevada Regional Hospital staff and REACH Air Medical Services personnel.
Q. All right.
Have you told me -- is there any other factual support for your opinion number one, besides what you've testified to during today's deposition?
A. Outside the reference I just made, the other documents that are available to me since this report, no, not that I can think of.
Q. In your report you talk about -- in your opinion, sorry, number one, you use the phrase "direct healthcare providers."
Do you recall that phrase?
A. Yes, I do.
Q. What does that mean, "direct healthcare provider"?

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A. They're directly caring for the patient.
Q. So are there indirect health care providers as well?
A. I believe the term I used was based on that direct patient care scenario. I don't know that I quantified what indirect would have been, but specifically related to this opinion, they were directly providing primary care to Mr. Schwartz.
Q. Identify for me all people who were direct providers -- direct health care providers of Mr. Schwartz during the intubation attempts.
A. The direct caregivers were -- in personnel were the REACH personnel, Ronnie Lyons and Barry Bartlett. They were the REACH transportation crew that were providing direct patient care to Mr. Schwartz as it relates to the advanced airway procedure, while Dr. Garvey was providing the care related to the chest tube or the intervention of chest tube.
An indirect care provider may have been a nurse or ancillary staff member who is assisting with going to get medications and bring them to the room, but may not be directly performing a patient intervention.
MR. BURTON: Sorry. I've got the cleaning crew to come in to get my trash. Come on in, please.

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BY MR. BURTON:
Q. Can you identify every individual who attempted intubation on Dr. -- on Mr. Schwartz?
A. Every individual? No. I can identify the REACH Air transport crew and I can identify Dr. Garvey.
Q. Do you know, as you sit here today, if there were others that also attempted intubation of Mr. Schwartz?
A. The record shows that at some point, an Elko ambulance paramedic also attempted an intubation.
Q. Was he a direct -- I don't know he or she, I don't know if it was a man or a woman.
Was that person a direct health care provider of Mr. Schwartz?
A. Using that procedure, yes.
Q. Dr. Garvey, when he attempted the intubation, was he a direct health care provider?
A. He was a -- yes, he was the direct health care provider for the hospital.
Q. And isn't it fair to say anybody who was attempting intubation, under your definition, would be a direct health care provider to Mr. Schwartz?
A. For the purposes of that specifically, yes. However, I am aware that there's a legal definition in the state of Nevada related to a health care provider.

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And so --
Q. I'm only asking in the context of your --
MS. BLAZICH: Let him answer the question.
MR. BURTON: No. No. I'm tired of going off on a tangent. That's not responsive to my question.
MS. BLAZICH: It is responsive to your question, and let the record reflect that you're cutting off the witness and not letting him finish his answer.
MR. BURTON: What I'm -- I'm not doing that. What I'm asking is, I'm not asking for Nevada's definition. My question -- I want him to be responsive to my question.
MS. BLAZICH: He is being responsive to your question and you are cutting him off.
BY MR. BURTON:
Q. Under your definition, this is your phrase, "direct healthcare provider," anybody who assisted with the intubation would be considered a direct health care provider as you use that phrase in your report; correct?
A. Assisted, no. That's not what I've said.
Q. Attempted. I meant to say "attempted."
A. Attempted, yes.

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Q. Okay. That was my question.
How many --
A. Now, in relation --
Q. How --
A. In relationship to the understanding that there is a different connotation of that, yes, for the purposes of my medical opinion, that is correct. I understand that there may be a legal connotation and in actuality, the state of Nevada lists the REACH Air Medical crews, the Elko Ambulance crews, and any of those personnel as attendants, not as health care providers.
Q. But you're not going to offer legal opinions to the jury; right? That's outside the scope of your expertise?
A. It is outside of the scope of my expertise, but it certainly applies to a term that may have some legal connotation to it. And, therefore, I wanted to make sure that my -- the record is clear and my report is clear.
Q. How many billing departments have you worked in for different EMS providers in your life, in your career?
A. Did I understand you to say "billing departments"?

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Q. Billing with a B. Billing.
A. I've worked for billing departments? I have not.
Q. Okay.
A. Worked in conjunction with billing departments, recognizing that when a bill is submitted to a patient and when --
Q. Move to strike this narrative nonresponsiveness, I want you to answer my question and not go off --
MS. BLAZICH: He is answering your question. Let the record reflect you're cutting him off.
MR. BURTON: No. My question was specific, how many departments and you said none. I'm moving on to my next question.
MS. BLAZICH: After cutting him off, go ahead and move on.
MR. BURTON: Well, the witness is not being responsive. He's obfuscating --
MS. BLAZICH: Then object that it's nonresponsive, but you don't get to cut him off and pretend like he doesn't have opinions, because he does.
MR. BURTON: Well, obviously, he does.
BY MR. BURTON:

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Q. Let's go to your second opinion, Mr. Everlove.
Do you know what a physician extender is?
A. I'm familiar with the term that was brought up by Dr. Osborn. I don't -- I'm not familiar with the context with which she used it. So when you say do I know what it is, as if it's a universal definition, my answer would be no.
Q. You've never heard the phrase before reading Dr. Osborn's deposition?
A. I have heard the phrase before. My answer was, as it relates to a universal understanding of that term, no, I don't understand what she means in regards to a physician extender for Mr. Schwartz.
I am familiar with the term as it applies to the standard of care in its -- what I believe to be the appropriate use of that term or connotation.
Q. What is your understanding, your understanding, of what a physician extender is?
A. As paramedics, we are physician extenders into the field for a medical director that oversees the on-line and off-line medical direction of care for patients in a nonclinical environment. It is done through policy and procedure. It may be standard orders, it may be a written form, or it may be in the

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connotation of making a phone call to a physician to receive medical direction on how to treat patients in the field.
Q. Is a nurse a physician extender of a physician?
A. My understanding of the physician extender relationship is based on what I just described to you. A nurse may have a different connotation related to that aspect of the standard of care.
Q. So can you answer that yes or no? Is a nurse a physician extender of a physician? Do you know?
MS. BLAZICH: He's answered the question.
MR. BURTON: Then I'll move on.
BY MR. BURTON:
Q. If you don't know, I'll move on.
Do you know if a nurse is a physician extender of a physician?
A. I just gave you my best answer.
Q. All right.
You would agree that the care provided by the REACH crew was not prehospital emergency medical services; correct?
A. That is correct.
Q. All right.

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Why, in your report, do you say that REACH deviated from the standard of care for prehospital emergency medical services?
A. Because paramedics and nurses in the medical transportation provider role are the prehospital services. They were not employed within the hospital, operating as an entity of the hospital.
Q. So is there no difference between -- is interfacility transfer, is that still considered prehospital, even if you're picking up a patient from the hospital?
A. It is considered part of the emergency medical services and prehospital care, which they also get. Interfacility transports are part of a prehospital medical transportation role. And in this case, they were not agents of the hospital. Therefore, the term I used was prehospital.
Q. And --
A. Based on their primary employment.
Q. And you believe that that term, "prehospital," is appropriate for the care here by the REACH crew?
A. It was the term I used to describe everything I just answered to you, that they were employed by a prehospital provider and performed scene calls and interfacility transports.
Q. That's not my question.
My question was: Do you believe that the term "prehospital" is appropriate to the care provided by the REACH crew here, prehospital?
MS. RIES-BUNTAIN: Hold on, Mr. Everlove, sorry. I got a text. Keith I think has been muted by the host so he hasn't been able to maybe unmute himself to place an objection or make some other statement on the record.
MS. BLAZICH: Keith, are you involuntary muted?
MR. BURTON: It worked.
THE COURT REPORTER: Are you able to unmute now, Keith?
(No audible response.)
(Discussion held off the record.)
MR. WEAVER: I do have a question. I was trying to ask a question or a clarification a moment ago. I missed the answer as to whether or not the witness considers a nurse to be a physician extender. I just didn't hear what the answer was. If it's an issue, I don't want to go back over it. I just didn't hear the answer.
MR. BURTON: I'll ask the question again.

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BY MR. BURTON:
Q. Mr. Everlove, do you consider a nurse to be a physician extender?
MS. BLAZICH: Objection. Foundation.
THE WITNESS: I think the best way for me answer that is to have the court repeater read my answer back.
BY MR. BURTON:
Q. I'm entitled to ask it to you again, Mr. Weaver has asked.
So my question to you is: Do you consider a nurse to be a physician extender?
MS. HUETH: Objection. It's asked and answered.
BY MR. BURTON:
Q. Go ahead.
MS. BLAZICH: Same objection. Foundation.
THE WITNESS: The physician extender question was related to a term that applies within the standard of care for a prehospital environment. As it relates to paramedics specifically, I'm unaware of how the standard of care or scope of practice may be affected for a nurse in that environment.
BY MR. BURTON:
Q. In your report, in opinion number two, you

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call it a "gross deviation from the standard of care."
Is there any significance to that word "gross," the phrase "gross deviation" focusing on "gross"?
A. There is significance to it that it was an extreme departure of the standard of care.
I also understand that there are legal terms that have legal merit, and as an expert witness it would be inappropriate for me to try to enter those legal terms in my report.
Q. Are you aware if there are any punitive damages claims that are at issue in this case?
A. I have not discussed anything with Ms. Blazich related to the nature of the claims, amounts, or anything of that nature.
Q. Is there, in your mind -- and this is your phrase, gross deviation, whatever you intend it to mean, is that different from just plain old regular deviation from the standard of care?
A. Yes.
Q. What is the difference?
A. The difference is, in this case, that the failure to obtain informed consent related to the nature of the high-risk procedure being performed by the REACH medical crew was a gross deviation of the

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standard of care. It was an extreme departure in the standard of care.
Q. If the jury determines that the REACH crew was a physician extender of Dr. Garvey, would you agree that they had consent, the REACH crew, to perform the intubation?
MS. BLAZICH: Objection. Asked and answered.
MR. BURTON: I haven't asked that question.
BY MR. BURTON:
Q. Go ahead.
A. I do not have an opinion as to what the jury's decision will mean related to my opinions. I will let the jury be the trier of fact to decide.
Q. But your job -- you would agree, your job as an expert is to be helpful to the jury; correct?
A. My job as an expert is to offer an unqualified, unbiased opinion.
Q. For purposes of assisting the jury; correct?
A. That is part of it, yes.
Q. So if the jury -- and I'm entitled to ask you hypotheticals. I'm entitled to ask you to assume things. That's what comes with being an expert.
I want you to assume that the jury

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determines that the REACH crew -- this is what we're going to argue, that the REACH crew was a physician extender of Dr. Garvey.
Are you with me so far?
A. I understand that's what you state you're going to argue.
Q. No, I'm asking you to assume that.
A. Oh, okay. All right. That's an assumption -- that isn't what you're going to argue, but it's an assumption for the hypothetical.
Q. I want you to assume that the jury determines that the REACH crew is a physician extender of Dr. Garvey.
Do you understand?
A. I understand.
Q. And I want you to then tell me -- you already determined that Dr. Garvey -- that you have an opinion -- let me rephrase that.
Based on my assumption, what I'm asking you to assume, was the REACH crew then authorized to perform the intubation if they're determined to be physician extenders of Dr. Garvey?
A. I don't understand what you mean by the word "authorized." You mean does it negate the standard of care for them? Does it negate the consent

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aspect? I don't understand what you're referring to.
Q. You don't understand the word "authorize"?
A. If I understand with clarity, I don't ask. And in this case, authorized could mean several different things. Are we talking about authorized related to the clinical care? Authorized to deviate from the REACH policies? Authorized regarding consent? It just -- those things are all a factor -- or at issue, rather, within the fact pattern.
Q. I'm sorry that you don't understand the term "authorized." I'll try to pick a different word that hopefully you'll understand.
Under my assumption, Dr. Garvey -- if the REACH crew is determined to be a physician extender of Dr. Garvey, are you with me?
A. Yes. Thank you.
Q. Do you have any objection to the REACH crew not having consent to perform the intubation?
A. Any objection to the REACH crew not -- I'm going to ask you to rephrase the question, please.
Q. What don't you understand about my question?
A. You're saying something related to not -- it's a double negative. I want to make sure I understand what you're asking me. So if you would,

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please, I want to give you a fair answer.
Q. If Dr. Garvey had authorization to do the intubation, and the REACH crew is considered to be a physician extender, do you -- will it be your testimony that the REACH crew still did not have consent to do the intubation?
A. I'm going to testify to the jury that they did not have consent to perform the intubation. And that the nature of the term "physician extender" is a unique term in an interfacility transport process of this case. And that I'm unclear as to what that means, and that it's my opinion that that does not pertain to the fact pattern leading to the intubation.
Q. So even if the jury determines that Dr. Garvey had consent, are you with me?
A. Yes.
Q. And even if the jury determines that the REACH crew is a physician extender, are you with me?
A. Yes.
Q. You still won't agree that the REACH crew then was appropriate to do the intubation?
A. I don't know what situation that I would be asked to offer an opinion after a jury decision like that. So I'm -- I'm having trouble with how the hypothetical would apply.

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Q. And I'm sorry that you're having so many troubles. Maybe it's a Friday. Maybe it's my questions and I apologize, but you would agree that I could ask you those questions at trial, and if the jury makes that determination, that he's a physician extender, you will not agree today or at trial that, therefore, the REACH crew was appropriate to do the intubation? Is that your testimony?
A. My testimony to the jury will be exactly what I described earlier.
And if I may, out of great respect for the jury and their ability to determine facts, I would not -- I would not be put in a position to offer a secondary opinion after a verdict or decision by the jury like that.
Q. In your report you talk about, in your second opinion, how Mr. Schwartz could not have been informed of the potential risk and complications of the procedure.
Do you see that?
A. Which line, please?
Q. This is page 11, line 14.
A. Yes. It refers to the -- several lines above it, in which there was not consent obtained by Mr. Schwartz by the REACH Air Medical Services

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personnel.
Q. Is it your testimony that Dr. Garvey did not properly inform Mr. Schwartz of the potential risks and complications of the procedure?
A. That was a question you asked me earlier and I believe it relates to the disparaging facts and testimony related to whether it was or was not appropriate or informed or fully informed, and my answer remains the same.
Q. I want you to assume that Dr. Garvey did adequately inform Mr. Schwartz, to use your words, of the potential risks and complications of the procedure.
Are you with me?
A. Yes.
Q. The REACH crew wouldn't, then, need to reinform Dr. -- Mr. Schwartz of the same potential risks and complications; correct?
A. Absolutely, they would.
Q. For what purpose?
A. For the purpose of meeting the standard of care. For a legal consent. They're a separate entity. They're a medical transportation crew.
So as in your examples earlier of interfacility transport of patients for -- you know, to a convalescent home, that still requires consent.

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Any time I touch a patient, it requires consent. If it weren't the case, then Mr. Schwartz would not have had to receive any additional information regarding any care, because the Elko Ambulance crews' consent would have applied in totality to all of the caregivers.
That's not the case. They're two separate entities, specifically related to this high-risk procedure. If they're asked to do this procedure, first they should have said no, and secondarily, they should have received consent.
Q. Well, in the context of your report you characterized it for purposes of making Mr. Schwartz aware.
And I understand what you're saying, that your opinion is -- and obviously, I disagree with you and I think the standard disagrees with you, that they needed to get it for purposes of their participation. But I'm asking, from the lens of Mr. Schwartz's awareness, getting the same story from REACH wouldn't make Mr. Schwartz any more aware because they already got it from Dr. Garvey; right?
A. That's not the standard of care in facts specifically related to the consent. It is not just awareness, it's expressed and informed consent, which

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is what I read earlier.
Q. And I'm not talking about consent. You used the word "aware" in your report. Mr. Schwartz would have been no more aware of the risks in procedures if the REACH crew came in and just repeated what Dr. Garvey had already said; correct?
MS. BLAZICH: Objection. Calls for speculation.
THE WITNESS: I don't know that I can agree with that.
BY MR. BURTON:
Q. All right.
Give me the elements for false imprisonment in Nevada.
A. That I believe is a legal conclusion related to the state of Nevada so I don't know that I'd be comfortable doing that, but the standard of care related to paramedic care universally, within the United States, is the national standard for us applying the consent laws to providing medical care. And it's specifically outlined in the standard of care as to how that's quantified.
Q. And I'll move to strike your nonresponsive answer. My question is very specific. I'll make it more specific to help.

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Can you identify the elements of false imprisonment in the state of Nevada? Yes or no? Can you identify them?
A. I cannot.
Q. Can you identify the elements of assault in the state of Nevada?
A. I cannot.
Q. Can you identify the elements for battery in the state of Nevada?
A. I cannot.
Q. Based on Nevada law, can you identify what would make the REACH crew liable for false imprisonment? Again, based on Nevada law. Can you?
A. I'm sorry, say that again, please.
Q. Based on Nevada law, can you identify what would make the REACH crew liable for false imprisonment?
A. Based on Nevada law, I cannot.
Q. And same question with respect to assault and for battery. Based on Nevada law, can you identify what would make the crew liable for assault or battery?
A. Correct. I cannot.
Q. Based on Nevada law, can you identify any difference between false imprisonment and assault or battery?

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A. Based on Nevada law, no, I can't.
Q. All right.
Is there anything else with respect to your second opinion that is not contained in your report?
A. Just clarification that could not have been aware of the potential risks and complications, I think we covered that.
And the connection related to false imprisonment, assault and/or battery is clearly outlined in the standard of care, which was the reference.
Q. But that's not listed in your report; correct?
A. The standard of care related to what part?
Q. The standard of care for false imprisonment, assault or battery, that's not listed in your report; correct?
A. It is, page 11, line 15 through 17.
Q. And this is, "The paramedics who fail to obtain consent"? That's what you're saying, that's the totality of your opinion?
A. Yes, as it relates to the materials that I've cited. Specifically, for instance, "False imprisonment may be charged by a patient who is transported without consent or is restrained without

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proper justification or authority. It is defined as intentional and unjustifiable detention of a person without consent, or the legal authority, and may result in civil or criminal liability."
Q. You're not a lawyer; right?
A. That's correct, I am not.
Q. And you've not played one in all of your acting roles either; right?
A. It wouldn't apply if I did, correct. I'm not a lawyer.
Q. Opinion number three, have you fully explained your third opinion in your report?
A. Yes.
Q. Fully identified all support for your third opinion in your report?
A. Yes, as outlined in the materials reviewed.
Q. How would the care of Mr. Bartlett been different -- sorry, I just read the word Bartlett.
How would the care of Mr. Schwartz been different if the REACH crew had done the assessment that you say they didn't do?
MS. BLAZICH: Objection. Calls for speculation. Lacks foundation.
MR. BURTON: Well, let me back up. I'll be glad to lay some foundation here.

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BY MR. BURTON:
Q. This is your opining as an expert.
You say, "It was a gross deviation from the standard of care for prehospital emergency medical services personnel when REACH failed to assess Mr. Schwartz's airway anatomy prior to initiating the high-risk procedure of oral endotracheal intubation."
Do you see that?
A. Yes, I do.
Q. So if they'd done that, how would things have been different?
MS. BLAZICH: Same objection.
THE WITNESS: The standard of care calls for following the policies and procedures, based on the clinical medical evidence. I think what you're asking me is a causation statement, and I believe that would be outside of my scope.
BY MR. BURTON:
Q. So again, with respect to opinion three, you don't intend to offer any causation testimony; correct?
A. That's correct.
Q. In fact, you don't intend to offer any causation testimony for any of your opinions; is that right?

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A. Yes. That's correct, understanding the connection between the opinions related to the standard of care as they may impact an impression of causation, but I do not intend to offer a direct causation opinion; that's correct.
Q. Do you intend to offer a direct causation opinion?
A. Only what I just described, where I understand my opinions have a component to them related to the deviations of the standard of care that may connect to causation, but I'm not offering a causation opinion.
Q. In your opinion, did Mr. Schwartz need to be intubated?
A. I don't know that that was within the scope of my opinions that I was asked to offer. And, therefore, it's not a part of my report.
Q. All right.
So I must be very specific so I can pin you down on this.
At trial, do you intend to offer any opinion as to whether or not Mr. Schwartz should have been intubated?
A. I don't believe that will be a question that I will be asked to offer. I believe there are

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other experts that are offering that opinion.
Q. It's a question that's -- I mean I'm not asking if you're going to be asked that question. I'm asking if you're going to provide that opinion.
Do you intend to provide the opinion at trial whether or not Mr. Schwartz should have been intubated?
A. I do not intend to offer that opinion.
Q. Okay.
Do you have any opinion regarding whether or not Mr. Schwartz's anatomy made his airway difficult?
Sorry, that came out half the way I meant for it to.
Do you have any opinion as to whether or not Mr. Schwartz's anatomy made it obtaining an airway difficult?
A. I don't intend to offer an opinion related to information that wasn't determined at the time of the intubation. And my opinion is there was no assessment of Mr. Schwartz's anatomy sufficient to making a judgment as to whether it would interfere with intubation or not.
Q. In your report you said, "They determined that Mr. Schwartz's airway anatomy is difficult to

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properly place an advanced airway."
What about Mr. Schwartz's anatomy made it difficult?
A. I believe the testimony -- and I'm trying to recall exactly what Mr. Bartlett said or Mr. Lyons said. I believe it was Mr. Bartlett that talked about once attempting the intubation, that Mr. Schwartz had a difficult -- had an anatomy that made intubation difficult.
Q. Was it an anatomy or laryngospasms?
A. I don't recall specifically clarifying between the two. I recall the term "anatomy."
Q. Was it the anatomy or was it the vomit that made it difficult to obtain an airway?
A. Again, I'm referring to Mr. Bartlett's testimony and I recall him using the word "anatomy." Certainly, vomitus makes airway management more difficult.
Q. Is it your testimony that REACH was operating under its policies, protocols and procedures while in the emergency department at Northeastern Nevada Regional Hospital?
A. My answer to your question, it goes back to the two scenarios. Either they were operating under their policies and procedures, in which they violated

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the standard of care, or they were not operating under their policies and procedures and deviated from the standard of care, violating the standard of care.

So in answer to your question, whether they were or were not, I think that's a dispute of fact.

Q. What trumps, policies and procedures or the direction of a physician?

A. Direction of a physician outside of the scope of practice is the part of the hypothetical that applies here.

Q. Let me ask if you agree with this statement: "The standard of care calls for adherence to policies, procedures and protocols. Exceptions to the adherence of policies, procedures and protocols requires medical direction."

Do you agree with that statement?

A. I do, specifically in the context of what medical direction is.

Q. Okay.

A. In the statement that you just read, that's a very familiar term to me in the literature. And it relates specifically to on-line or off-line medical direction that we discussed in a prehospital environment or in that scene environment that we talked about.

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Q. And it's not your opinion that it applies in the hospital setting?

A. "It" being the standard of care related to policies and procedures?

Q. No, meaning the exception can be medical direction. Can that medical direction be received in the hospital setting?

A. Exceptions related to the statement that you just read would not apply in that environment that the REACH crew found themselves in. In other words, exceptions to the standard of care may -- I'm sorry, exceptions to policies and procedures may apply to a county that somebody is working in, but would have to still be within the scope of practice for that provider.

I wouldn't be able to have an exception to a policy or procedure that asked me to do something that was outside of my scope of practice or standard of care.

Q. All right, let's be more specific to this case. And that quote I'm reading is from a deposition you gave in a different case.

A. That's why it's familiar to me, because it's the same quote I highlighted for this case, but it's actually part of a larger context. It

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specifically relates to obtaining consent and having physicians on scene of medical calls that may be asking you to do something different than what's within your policies or procedures.

Q. Is intubation outside of a paramedic's scope of practice?

A. When performed properly with consent, no, it is not.

Q. All right.

Let's be very specific to this case.

Was Dr. -- was the REACH crew acting appropriately when they followed the instructions of Dr. Garvey during the failed intubation attempts?

A. In the hypothetical that they were following the direction of Dr. Garvey?

Q. Well, it's not a hypothetical, but go ahead.

A. In the multiple intubation attempts, I believe it's a dispute of the facts as to whether they were following Dr. Garvey's direction to continue to try to intubate. That's what I'm referring to.

However, following Dr. Garvey's request for an advanced airway intervention, for a patient that is on their gurney, yes, that was a violation of the standard of care. And in context of what it takes to

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confirm placement of advanced airways and then a chest tube, a surgical procedure on their gurney, Mr. Schwartz would have had to have a post-intubation x-ray performed to confirm placement. I find it difficult to believe that that would have occurred on the REACH Air Medical transport gurney as well.

Q. And that's -- but you would agree that a post- intubation x-ray to confirm placement, that's far afield from your experience or scope of practice?

A. In the interfacility transport realm, it is within my scope of practice. In fact, it's often that agencies will require it. And if they don't, that we will require the post-intubation x-rays to confirm placement based on the high-risk nature of transporting patients that are intubated and the possibility of esophageal -- I'm sorry, displacement of the endotracheal tube.

Q. Let me ask you this: What, then, should the REACH crew have done? Dr. Garvey says, "We're going to intubate. You're going to intubate, Mr. Bartlett," what should he have done?

A. Standard of care would have called for them to say no.

Q. So it's your testimony you intend to tell the jury that Mr. Bartlett should have said, "No, I'm

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not going to do that"?
A. Yes. It's my testimony that the standard of care called for Mr. Bartlett not to do that, that it is a high-risk procedure. They're within the hospital. It is fraught with significant complications. Without an airway, patients die. It's a known risk. And, therefore, the nature of that request should have been met with a "no."
Q. Would you agree that of all the people in the room, the person with the most skill and the most experience in RSI intubation attempts was Barry Bartlett?
MS. BLAZICH: Objection. Lacks foundation.
MR. BURTON: All right, I'll back up.
BY MR. BURTON:
Q. Who in the room had attempted more RSIs than Mr. Bartlett? Do you know?
A. Mr. Bartlett testified that he thought he had, but he wasn't sure because he didn't know how many Dr. Garvey had attempted.
Q. You've now read Dr. Garvey's transcript. Between the two of them, who had done it more?
A. Barry Bartlett asserts he had done it more.
Q. Okay.
I'm asking you, did Dr. Garvey -- did he

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give a number in his depositions as to how many he had attempted? Do you recall?
A. I don't recall the exact number.
Q. As you sit here today, do you have anything in your memory that says Dr. Garvey said he did it more than Mr. Bartlett?
A. No, I don't have -- it's my recollection to the contrary, that Barry Bartlett said he had more experience than anyone else in the room.
Q. And it's your testimony -- let's -- we've kind of bled over a little bit to your fourth opinion, and I think that they're very similar. I want to wrap up your third opinion on policies.
Is it going to be your testimony at trial that the REACH crew acted inappropriately when they strayed from what their policies said because of physician direction?
A. Again, going back to the two scenarios we discussed, straying from their policies is a deviation of the standard of care. They cannot deviate the standard of care based on a physician from another entity directing them to do so, and be within the standard of care.
Q. All right.
I understand that's your opinion. Let's be

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specific.
Your testimony earlier was that the REACH protocol says three attempts, go to a cervical airway.
That was your testimony; right?
A. Yes. That's correct.
Q. So if Dr. Garvey says, "No, we're going to try a fourth attempt," was it a violation of the standard of care for REACH to say, "No, we're going to go to a CRIC" -- or I'm sorry, for REACH to not say, "No, we're going to a CRIC"?
A. I think your hypothetical again is predicated on the fact that they had already deviated from the standard of care by agreeing to perform the intervention without consent, in that moment. In that moment that they've done that, now finding themselves in a position the patient needs a surgical airway, that is something that they -- it's within their policies and procedures. So I guess the challenge for the hypothetical is which scenario applies?
Q. All right.
Let me ask you this: If the REACH crew had said, "No, Dr. Garvey, there's no way, we're not doing it. We're going to stand here and watch you do it," and Dr. Garvey attempts an intubation and vomitus comes up, we have the same fact scenario that we have here.

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Is it your testimony that the REACH crew should have stood against the wall the entire time and just watched?
A. Well, it's my testimony that the REACH crew had an obligation to say no to the procedure. Playing out that hypothetical could go in multiple directions.
Q. I want to be very specific, which direction it's going. They've already done what you said in this hypothetical. They've already said, "No, we're not going to do it." The next step is Dr. Garvey tries, the same result occurs and the patient vomits.
And they attempt a couple of airways and Dr. Garvey turns to Barry Bartlett and he says, "Hey, you've done this a thousand times in the field, can you help?" In that scenario, should Barry Bartlett still have said, "No, Dr. Garvey, I'm going to stand here and watch you treat this patient"?
MS. BLAZICH: Objection. Calls for speculation. Incomplete hypothetical.
THE WITNESS: I don't feel giving you an off-the-cuff opinion on that.
BY MR. BURTON:
Q. What about that don't you understand?
A. It's not a lack of understanding. It's actually a lack of understanding much more to your

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hypothetical related to the standard of care or the implications of that type of event, which isn't related to the facts that I reviewed.

Q. I'll see if I can --

A. I wouldn't give you an off-the-cuff opinion, just based on the details related to that.

Q. Fine. Let me see if you can actually answer this question.

My question is: Is there a scenario where the REACH crew should have ever provided assistance in the intubation attempt to Mr. Schwartz in Northeastern Nevada Regional Hospital's emergency department?

A. I can't create a hypothetical -- or I'm sorry, an answer to your scenario based on that hypothetical. Simply based on the opinion that I offered, which was they should not have accepted any responsibility to perform critical interventions or surgical -- assist with surgical procedures for Mr. Schwartz.

Q. Give me just one second. I'm going to push mute for one second.

Sorry about that. All right.

With respect to your third opinion, is it fully contained within your report?

A. Yes.

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Q. And all the factual support is identified in your report as well?

A. Yes, with the clarification about the testimony that I think I referred to earlier from Dr. Osborn.

Q. All right, we're almost done.

Your fourth opinion, how long had Dr. Garvey been treating Mr. Schwartz before the REACH crew arrived?

A. I would have to review the record to give you an exact time. I don't recall the exact time, but sufficient time to perform several diagnostic tests and for him to develop an opinion regarding the diagnosis.

Q. Who was better informed to make the decision regarding care of Mr. Schwartz, Dr. Garvey or the REACH crew?

A. Dr. Garvey, which is exactly to support why they should have said no.

Q. And you agree that Dr. Garvey had the benefit of diagnostic testing and information?

A. Yes, he did.

Q. And also more training?

A. As it relates to the intubation or in general medical training as a physician?

Q. Medical training.

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A. Yes. He is a higher medical professional than the REACH crew.

Q. What qualifies you, as a paramedic, to second-guess -- you're not qualified as a paramedic to second-guess the decisions of a physician; correct?

A. Yes, I am.

Q. But --

A. In fact, it's a routine -- I shouldn't say routine.

It is part of the responsibility, working for a transport provider, that you understand what's being asked of you is within your standard of care or your scope of practice.

For example, there are times where we are asked to transport patients that are either unstable or patients that are on certain medications, and the physician and the nurses may not know what the scope of practice is for you as a prehospital care provider or an interfacility transport provider in context of EMS. And, therefore, we routinely have to have conversations to clarify that that's not within our scope of practice and, therefore, we can't do it.

Q. In your report you say that, "Mr. Schwartz is at low risk for deterioration based on his condition."

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Who's better to make that assessment, you or Dr. Garvey?

A. Dr. Garvey was the treating physician and had the benefit of the diagnostic tests.

Based on Mr. Schwartz's presentation for being at the hospital, for the period of time that he was, his condition had not changed. And, therefore, the basis for my decision -- or I'm sorry, opinion, was the low risk for deterioration based on that timeframe.

Q. That's not my question.

Who's in a better position to make that determination, you or Dr. Garvey?

MS. BLAZICH: Objection. Asked and answered.

BY MR. BURTON:

Q. Go ahead.

A. I think in the context of the opinions that I have offered, it is a reasonable opinion.

Q. Are you not able to answer my question whether you identified either yourself or Dr. Garvey as to who is better positioned to make the determination as to whether the patient was at low risk for deterioration?

A. Certainly, Dr. Garvey is a doctor and I'm not a doctor.

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I agree that as a physician, he was in the care and had all the benefits. Based on my analysis after the fact, I'm offering the opinion that Mr. Schwartz's condition had not changed over the extended period of time. Therefore, the risk of deterioration further at that point was not probable.

Q. Should the REACH crew have transferred Mr. Schwartz without him being intubated first?

A. That is not an opinion that I'm offering. Based on the lack of experience I have transporting patients by air, I don't think it would be appropriate for me to offer that opinion. However, because this patient never left the hospital and it was a transfer of care issue, it did not fall within my opinion.

Q. Would it have been better to have -- realizing that neither is good, I want to say that for the record, but would it have been better to have a failed airway attempt in the ED or mid-flight?

A. Yes, I agree, neither one would be good. And failed airway attempts are something you can prepare for. Certainly, the policies and procedures for REACH don't specify or differentiate between in air, in ground or in the hospital.

Q. That's not even close to my question.

If you had to choose between a failed air

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attempt happening in the hospital or in a flight or in an aircraft, where is the better location for that to occur?

MS. BLAZICH: Objection. It calls for speculation.

THE WITNESS: In this case or in a hypothetical?

BY MR. BURTON:

Q. In a hypothetical. Let's start with that, and then we'll be specific to this case.

Let me ask it this way: Isn't it true, Mr. Everlove, that if you're going to have a failed attempt, you're better to do it in the hospital, where there are more hands to assist, more equipment, multiple suction machines, multiple people that can come in and switch people out, than in the back cramped space of an aircraft, where you have two people and limited equipment?

A. Absolutely. If you're the REACH crew, you definitely want to do it in the hospital. However, as I stated earlier, that's the REACH crew. It's actually better to have a failed airway attempt when you have a physician, an anesthesiologist or some other advanced airway expert in the hospital or available to you, plus a full support team to provide that care, and not

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trying to perform that procedure as a two-man crew working outside of your scope of practice.

Q. Okay.

Mr. Schwartz had a pneumothorax. You would agree with that?

A. Yes, that's the diagnosis.

Q. Are you familiar with Boyle's law? I assume you are as a flight paramedic.

A. Yes, I am.

Q. Explain to me what you understand Boyle's law to be.

A. Changes in pressure affect oxygenation and the ability for patients to oxygenate. And certainly, with a pneumothorax, the ability for the lung to expand or potentially effects in pressure on that pneumothorax.

Q. And Boyle's law poses a potential problem to a patient being transferred via an aircraft with a pneumothorax, you would agree?

A. Yes, although clarifying the difference between a pressurized aircraft and nonpressurized aircraft and altitude.

Q. Well, even in a pressurized aircraft, there's still a risk for expansion, wouldn't you agree?

A. Yeah. I believe this dovetails back into

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the opinion of whether Mr. Schwartz should have been intubated or transferred. And I, again, understand that that's an opinion being offered by other experts.

Q. And not by you?

A. Correct. I'm not offering it -- an opinion as to whether Mr. Schwartz should have been transferred.

Q. It's your opinion in your report that Mr. Schwartz did not meet the criteria base for RSI. Do you agree with that?

A. Yes. It's in my report; correct.

Q. What qualifies you as a paramedic to opine on whether a hospital patient qualifies for RSI?

A. It's the transfer of the hospital patient that qualifies me. And the transfer of care for Mr. Schwartz, that if he required or qualified for RSI, he would have been intubated prior to their arrival.

Had he qualified for RSI, it would have been an intervention provided for the crew and not a responsibility of the crew as a third-party entity.

Q. Who is more qualified to make the determination whether he met the criteria for RSI, a physician or a paramedic?

A. I think I just gave the answer, that it would be the qualifications of the physician to

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intervene and provide that intervention and treatment prior to the flight medical crew arriving, and not the responsibility of the flight crew to make that determination.

Q. So is it your testimony in this case that Mr. Schwartz should have been intubated before REACH arrived?

A. It is my opinion and testimony that the standard of care called for not having a medical transportation provider, on an interfacility transport, provide a critical intervention like airway management in the context of the fact pattern of this case.

Q. In your years of experience, have you ever refused a physician's order in the emergency department?

A. Yes.

Q. Give me an example of when you did.

A. I've had physicians ask me to do things that were outside of the scope of practice, like suture patients.

I've had physicians that have asked me to do things outside of the scope of practice or training, like utilization of an airway device that wasn't within our scope of practice. So a certain type like maybe a -- maybe it was within our scope of practice

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nationally, but not locally within our protocols.

Those are a couple of examples that, yes, there is absolutely cases in which medical providers, who aren't aware of your scope of practice or standard of care, may ask you to do something that is in direct deviation from the standard of care.

Q. Let me ask you this: Assume that Barry Bartlett got what you view as informed and written consent. Are you with me?

A. Yes.

Q. Is it your testimony it still would have been improper for him to do the intubation in the Northeastern Nevada Regional ED?

A. Yes.

Q. All right.

Have you ever had a patient vomit during an intubation attempt?

A. Yes.

Q. How do you respond when a patient vomits during an intubation attempt?

A. Generally speaking, you do the best you can to clear that airway, which involves movement of the patient, suctioning devices, and ensuring to the best of your ability that the patient doesn't aspirate.

Q. Those are things that were done in this

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case; correct?

A. Yes. That's my understanding.

Q. Do you intend to offer any criticism of the response to the vomit by Mr. Schwartz, by the REACH crew at trial?

A. I do not.

Q. Okay.

Do you intend to offer any criticism at trial regarding the decision to intubate, knowing Mr. Schwartz for four or five hours earlier, when -- I guess it would be about four hours earlier, had just finished a meal?

A. I intend to offer the opinion that that was not part of the assessment by Ronnie Lyons and Barry Bartlett, in accordance with the standard of care prior to performing an intervention, like advanced airway management.

And if I may, to clarify, this is a very unique situation in which your patient is alert, oriented, responsive, has capacity and is communicating effectively, such that you can get this information prior to performing the intervention. Therefore, it was an opportunity and within the standard of care for them to do the relevant assessment, which would have included that.

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Q. But they could get that information from the nursing staff as well; correct?

A. Yes, they could get that information, but as it relates to the procedure, if they were, in the hypothetical, not in the emergency department and the patient was able to answer them, that would be information they would get.

In the scenario in which they are in the emergency department, the nurses have the information, as you've stated in the hypothetical, the doctor has the information in the hypothetical. It is more support for not performing advanced intervention without sufficient information, to understand the patient anatomy and risks and complications.

Q. And I'm not quite sure why you keep qualifying all of this as a hypothetical, and that's fine.

Let me ask it this way: Is there anything in the record that supports the idea that Ronnie Lyons and Barry Bartlett did not know that Mr. Schwartz had eaten a meal immediately prior to being hit by a car?

A. I don't know when they knew that information, prior to the intubation attempt, or during the intubation attempt, or at some point in the transfer of care. So when you say immediately, when he

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had the meal, I don't know at what point they knew that information related to Mr. Schwartz.
Q. Don't you teach all your students to assume that a patient has a full stomach?
A. We teach all of our students to follow the standard of care of assessment, which may include, in a situation like this, being able to ask your patient regarding meals. And we offer as reference the PO versus NPO status of the patients that go in for surgery, and the known complication to sedatives, other pain medications and the administration of an airway device into the patient that can stimulate vomiting.
So always teaching our students that, in the context of all of the other standard of care items, that is part of it.
Q. I remember from my experience, when I was learning how to intubate, that we were taught to assume that there was a full stomach because you want to be prepared that there may be vomit.
Do you disagree with that?
A. I don't disagree. In fact, that's exactly the type of information that's discussed in the -- the -- the term is escaping me right now, but in the timeout that was discussed, that's exactly the type of information that's identified, this is high risk

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because of these things. What will we do to intervene?
I think your training is absolutely correct, that the advanced airway technique has a high risk for complications and can compromise somebody's ability to breathe regardless of their condition.
Q. In fact, the safest approach is to assume that, so you have all of your equipment and training and thought processes ready to go in case they do vomit?
A. Actually, I would disagree that the safest process is to not intubate patients that don't require it. And to make sure that your procedural timeout is well-informed, well-discussed, and that the caregivers that are appropriately managing that procedure are the ones that are in charge.
Q. Fair enough.
If you've made the determination to intubate, the safest approach is to assume the patient has a full stomach so you're prepared for vomitus?
A. That is part of what I had answered earlier, yes.
Q. All right.
Have you fully identified all of your opinions with respect to number four in your report?
A. Yes, I believe I have.

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Q. And you've identified all the factual support knowing that you identified some additional materials that you've read since your report?
A. Yes. That's correct.
Q. Have you -- are there any other opinions that you intend to offer at trial that we have not discussed today?
A. I intend to offer rebuttal opinions to Mr. Byrd's report, specifically related to some of his conclusions.
Q. All right. I want you to itemize all the rebuttal opinions you intend to identify.
MR. BURTON: We've been going for another hour. I know it's late, I'm happy to keep going, but I'll let the group decide if they want to take a five-minute break.
MS. BLAZICH: I'm okay, but I'll defer to the rest.
MS. RIES-BUNTAIN: Yeah, I'd like to just get it done.
MS. HUETH: Same.
MR. WEAVER: I agree. Thanks.
MR. BURTON: All right.
BY MR. BURTON:
Q. All right, Mr. Everlove, if you would,

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identify all the opinions that you intend to rebut in Mr. Byrd's report.
A. Mr. Byrd offers the opinion, regarding my qualifications to offer an opinion, he is incorrect. And the lack of critical care transports, interfacility transports, and specifically related to the transfer of care and interventions provided during the Schwartz subject event, the notations that he's made are incorrect.
I think we've clarified a lot of those. However, it is appropriate that Mr. Schwartz was on the ground, in an emergency department, with a transfer of care to a private transportation company, which is all well within my area of expertise.
Mr. Byrd brings up my failure to note legitimate possibility of decline. I think we've covered that, but the opinions related to potential decline didn't apply to the interventions, the lack of informed consent or the care that was accepted by the REACH crew that shouldn't have been under the subject event.
And also, Mr. Byrd advocates that -- or offers the opinion that the refusal to follow what almost sounds like a direct order in a military connotation request, outside of the standard of care by

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a physician, would have been subject -- would have made Ronnie Lyons and Barry Bartlett subject to some regulatory or oversight agency disciplinary process, I disagree.

In fact, it was within their standard of care to refuse it, not to -- to follow any direction as related in the fact pattern regarding a critical intervention in a surgical procedure.

Q. Anything else, regarding your rebuttal to Mr. Byrd's report? Sorry, Dr. Byrd.

A. Yeah, I apologize. That was my fault. I referred to him as "Mr. Byrd." It is Dr. Byrd.

Q. He'll be all right.

A. I hope so.

He discusses the complication of airway attempts related to vomiting. I concur that that is a complication, but as you described in the training that you received, and it is true, this is a known complication for which it is predictable and preventable to manage an airway for patients that have vomited.

So as you described and we have discussed, I've had plenty of cases in which those patients that have vomited created an airway compromise that required intervention. But the follow-up to that was, after

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suctioning and proper positioning and understanding that that was going to be a potential risk, we were able to be successfully manage the patient and intubate them successfully.

Q. All right, let me ask you that, and I want you to push pause.

How, then -- once the vomiting occurred, what could the REACH crew have done differently to secure the airway from -- or to secure Mr. Schwartz's airway? And I understand you -- let me back up.

I understand you have a correlation, they never should have done it, I have all that. I'm saying the vomiting has started. What could the REACH crew have done differently to secure the airway?

A. According to their policies and procedures, it called for them to perform a cricothyrotomy --

Q. All right.

A. -- or for a CRIC to be performed on the patient.

Q. And that was ultimately done, and I understand you have a quarrel that it wasn't done after the third attempt. If they would have done a CRIC after the third attempt, do you intend to offer any opinion that they would have successfully secured an airway?

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A. I believe that goes back to the causation conversation we had earlier. My opinions will relate to the standard of care for policies and procedures, not to causation.

Q. Which I understand that, but when you say, "Listen, I've had patients vomit and I've been able to secure an airway," that creates the presumption that the REACH crew blew it because they couldn't secure the airway here.

So do you intend to say that the REACH crew blew it because once the vomit occurred, they could have still secured the airway?

A. I appreciate the correlation. That wasn't my intention.

Q. Okay.

A. It was partly that had they been more prepared, in accordance with the standard of care, that it would have included all of the things that we have discussed over this last several hours.

Q. Okay.

Then tell me, if they would have been more prepared under the standard of care, what should they have had with them, once the vomiting occurred, to secure the airway? Because, again, this is what -- I understand you say you're not going to do causation,

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but every time you say this, you then say, "but if you add this, it would have been different." So what could they have done differently?

A. That wasn't my intent. It was merely that we described several things related to the procedural timeout and to the aspects of having all of the equipment available within the standard of care. That's what the procedural timeout in preparation and assessment would have included, identifying that he may have been too high risk for the procedure.

That's what my intent of the conversation is. I don't intend to offer a causation opinion as to the nature of the vomiting somehow related to Mr. Schwartz's overall outcome.

Q. What equipment did they not have available that they should have had available?

A. Well, again, it goes back to had they said no in the first place, then that -- that's a whole separate issue. But Dr. Garvey, in a hospital with staff, with the additional crew member -- I'm sorry, with the additional staff members, anesthesiologist, that sort of thing, may have had additional equipment, all I can speak to is the standard of care for the management of a patient like Dr. Schwartz -- Mr. Schwartz, rather, would have required all of those

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things to be in place.
Q. But when they --
A. So suction equipment was included. They attempted to use their suction equipment while Mr. Schwartz was being intubated by their personnel and their gurney and it was not successful.
Q. But you also know, too, Mr. Everlove, very well, from reviewing the record, that they used multiple suction machines, that they were getting suction machines from other rooms. So when you say other equipment may have been available, what equipment wasn't available that you think would have made a difference?
A. I was unclear in the records as to the availability of the cricothyrotomy or surgical airway trays necessary to perform the surgical airway intervention.
Q. Any other equipment that you think should have been available that wasn't?
A. I believe there are other opinions from other experts. I don't have other opinions related to that.
Q. Okay.
Any other -- and I kind of stopped you on the Byrd rebuttal stuff.

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Anything else on the Byrd rebuttal that you intend to offer as an opinion?
A. No. I believe I've given you my opinions.
Q. Have you had the chance to disclose all of the opinions that you intend to provide at trial?
A. Yes, I have, as of today, given discovery materials I have available to me.
Q. And have you had the chance today to fully disclose all factual support for the opinions you intend to offer at trial?
A. Yes, I have.
Q. And do you have any other opinions beyond those that you've identified today?
A. No, I do not.
Q. Do you have any other factual support beyond that which you've identified today?
A. The materials I've identified, obviously, there are several points where I didn't read into the record all of the excerpts that I relied upon, but yes, I have all the materials available to me for the factual support and I have provided them to you.
Q. All right.
MR. BURTON: I have no further questions. I think some others may and I'll reserve the right to follow-up if they do. If I don't, thank you,

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Mr. Everlove, and I appreciate your time.
THE WITNESS: Thank you, Mr. Burton. I appreciate it.
EXAMINATION
BY MR. WEAVER:
Q. Good afternoon, Mr. Everlove. My name is Keith Weaver. Do you understand I represent Dr. Garvey in this action?
A. I do now. Good afternoon, Mr. Weaver.
Q. Good afternoon.
I'm thinking and hoping this is going to be quick and easy, and maybe hoping more than thinking, but as I understand your testimony, at least so far, at the time of trial, you don't intend to offer any opinions in any way, shape or form relating to Dr. Garvey's care and treatment of Mr. Schwartz or his medical judgments relating to Mr. Schwartz. Am I correct about that?
A. Yes, you are correct about that.
MR. WEAVER: I don't have any additional questions. Thank you, sir.
THE WITNESS: Thank you, Mr. Weaver.
MS. BLAZICH: Wow, that was easy, Keith.
MR. WEAVER: I think that has probably been, in ten years, the first time I've only had one

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question.
MS. BLAZICH: All right. Anyone else?
MS. RIES-BUNTAIN: No questions.
MS. HUETH: No questions.
MS. BLAZICH: No questions from Chelsea. Jennifer, I'm sorry, I didn't hear you.
MS. RIES-BUNTAIN: No questions.
MR. BURTON: Are you going to ask questions, Shirley?
MS. BLAZICH: Yes, just a couple.
MR. BURTON: All right.
EXAMINATION
BY MS. BLAZICH:
Q. Mr. Everlove, would you please give us a brief summary of your education and training.
A. Yes.
I am a paramedic. I have been a paramedic field training officer, paramedic educator, a paramedic supervisor and a clinical manager. Throughout the roles I've trained numerous people related to the standard of care for paramedics and prehospital providers and emergency services personnel.
I have extensive experiences in the determination of root cause analysis or investigation of cases under the umbrella of unusual occurrences or

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sentinel events, in which there were negative patient outcomes related to some event or contributing factor to an event.

And also, educating paramedics and different prehospital providers related to the interaction between medical caregivers and aspects of consent, just to say those related to this type of fact pattern.

Q. Do you currently hold any professional licenses or certifications?

A. Yes. I'm a nationally certified paramedic. I hold licenses in three different states, and follow the national scope of practice for all of my education.

Q. Have any of your licenses ever been revoked or suspended?

A. No, they have not.

And if I can clarify also, I hold an advanced cardiac life support provider card, a pediatric events life support card, a basic cardiac life support card, and several other licenses related to, for instance, national education standards for the emergency medical services field.

Q. How many years have you worked as a paramedic providing direct patient care?

A. This is my 30th year.

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Q. Have all of your opinions today been to a reasonable degree of probability as required of emergency medical service personnel?

A. Yes, it is.

MS. BLAZICH: I don't have any other questions.

MR. BURTON: Thanks, everybody.

Rockie, we'll take our electronic.

And then what I'll do, I think I only marked one exhibit, which was his CV. I'll send that to you, Rockie.

THE COURT REPORTER: Great, sounds good. Is an electronic copy good for everyone?

MS. HUETH: Yes, please. This is Chelsea.

MS. RIES-BUNTAIN: Good for me, please. This is Jennifer.

THE COURT REPORTER: Okay.

MS. BLAZICH: Good for me as well. I would also like a condensed copy and a word index, please.

MR. WEAVER: I'll have what Shirley is having. Thank you.

(Concluded at 6:33 p.m.)

(Exhibit 1 marked.)

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STATE OF UTAH)
) ss.
COUNTY OF SALT LAKE)

I, ROCKIE E. DUSTIN, Certified Shorthand Reporter for the State of Utah, certify:

That the foregoing deposition of JOHN EVERLOVE was taken before me pursuant to Notice at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed under my direction;

I FURTHER CERTIFY that I am neither counsel for nor related to any party to said action nor in anywise interested in the outcome thereof.

Certified and dated this 23rd day of February, 2021.

Rockie Dustin

ROCKIE E. DUSTIN, CCR, RPR
Certified Court Reporter
for the State of Utah

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Case: Schwartz v. Garvey
Reporter: Rockie E. Dustin, CSR, RPR

WITNESS CERTIFICATE

STATE OF _____)
) ss.
COUNTY OF)

I, JOHN EVERLOVE, Hereby declare: That I am the witness referred to in the foregoing testimony taken on February 19, 2021; that I have read the transcript and know the contents thereof; that with these corrections I have noted this transcript truly and accurately reflects my testimony.

PAGE	LINE	CORRECTION	REASON
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____ No corrections were made.

_____
JOHN EVERLOVE

SUBSCRIBED and SWORN to before me this
____day of _____ , 2021.

_____
Notary Public

F

Q