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. 3 of 6

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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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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:

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CLAGGETT & SYKES LAW FIRM

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

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD, dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES,

THIRD AMENDED COMPLAINT (Medical Malpractice) and Wrongful Death)

L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

Plaintiff, DIANE SCHWARTZ, individually and as the administrator of the Estate of DOUGLAS SCHWARTZ, by and through her attorneys of record, CLAGGETT & SYKES LAW FIRM, for their causes of action against Defendants, DAVID GARVEY, M.D., individually; CRUM, STEFANKO, & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, REACH AIR MEDICAL SERVICES, L.L.C; DOES 1 through X; ROE BUSINESS ENTITIES X1 through XX; and each of them and alleges as follows:

1. At all times relevant herein, Plaintiff, DIANE SCHWARTZ, individually and as the Special Administrator on behalf of the Estate of DOUGLAS R. SCHWARTZ (hereinafter the "Plaintiff" or "Diane"), was and is a resident of Elko County, Nevada.

2. At all times relevant herein, Plaintiff DOUGLAS SCHWARTZ (hereinafter the "Plaintiff" or "Mr. Schwartz"), was a resident of Elko County, Nevada.

3. Upon information and belief, at all times relevant herein, Defendant, David Garvey, M.D. (hereinafter "Dr. Garvey" or "Defendant"), was and is a medical doctor licensed in the State of Nevada, and a resident of Elko County, Nevada.

4. Upon information and belief, at all times relevant herein, Defendant, CRUM, STEFANKO, & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE (hereinafter "Ruby Crest" or "Defendant"), was and is a domestic corporation existing

pursuant to the laws of Delaware, authorized to do business in Nevada, and doing business in the State of Nevada.

5. Upon information and belief, at all times relevant herein, Defendant, PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL (hereinafter "NNRH" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Nevada, authorized to do business in the State of Nevada, and doing business in the State of Nevada.

6. Defendant NNRH was and is at all times relevant operating as a medical care facility in Elko County, Nevada and was and is owned, operated, managed, and controlled as a medical care facility within the County of Elko, State of Nevada, and was held out to the public at large, including the Plaintiff herein, as a properly equipped, fully accredited, completely staffed by qualified and prudent personnel, and operating in compliance with standards of due care maintained by other properly equipped, efficiently operated and administered, accredited medical care facilities in said community, offering full, competent, qualified, and efficient health care services to the general public and to the Plaintiff herein; that Plaintiff herein is informed and believes and thereon alleges, that Defendant, NNRH, administered, governed, controlled, managed, and directed all the necessary functions, activities, and operations of said medical care facility, including its physician care, nursing care, interns, residents and health staff, and other personnel.

7. Upon information and belief, Defendant REACH AIR MEDICAL SERVICES, LLC, (hereinafter "Reach Air" or "Defendant") is a foreign limited liability company existing pursuant to the laws of California, authorized to do business in the State of Nevada, and doing business in the State of Nevada

8. That the true names or capacities, whether corporate, associate, individual or otherwise, of DOES I through X, inclusive, were and now are physicians, surgeons, registered nurses, licensed vocational nurses, practical nurses, registered technicians, aides, attendants, physician's assistants, CRNAs, or paramedical personnel holding themselves out as duly licensed to practice their professions under and by virtue of the laws of the State of Nevada, and were and are now engaged in the practice of their professions in the State of Nevada, and are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes, and thereon alleges, that each of the Defendants designated herein as a DOE is legally responsible in some manner for the events and happenings herein referred to and proximately caused injury and damages thereby to Plaintiff as hereinafter alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names and capacities of DOES I through X when the same have been ascertained and to join such Defendants in this action.

9. That the true names or capacities of Defendants, ROE BUSINESS ENTITIES XI through XX, inclusive, are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Defendants designated herein as ROE BUSINESS ENTITIES XI through XX, and each of them, are corporations, firms, partnerships, associations, other medical entities, including but not limited to nursing staffing companies and/or registry nursing companies, emergency physician services group, predecessors-in-interest, successors-in-interest, and/or agencies otherwise in a joint venture with, and/or serving as an alter ego of, any and/or all Defendants named herein; and/or are entities responsible for the treatment, diagnosis, surgery, and/or other

provision of medical care to Plaintiff herein, and/or otherwise responsible for the supervision of the individually named Defendants at the time of the events and circumstances alleged herein; and/or are entities employed by and/or otherwise directing the individual Defendants in the scope and course of their responsibilities at the time of the events and circumstances alleged herein; and/or are entities otherwise contributing in any way to the acts complained of and the damages alleged to have been suffered by the Plaintiff herein. Plaintiff is informed and, on that basis believes and thereon alleges, that each of the Defendants designated as a ROE BUSINESS ENTITY is in some manner negligently, vicariously, and/or statutorily responsible for the events and happenings referred to and caused damages to Plaintiff as herein alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names of such Defendants when the same have been ascertained.

10. Defendants are agents, servants, employees, employers, trade venturers, and/or partners of each other. At the time of the incident described in this Complaint, Defendants were acting within the color, purpose and scope of their relationships, and by reason of their relationships, Defendants may be jointly and severally and/or vicariously responsible and liable for the acts and omissions of their Co-Defendants.

GENERAL ALLEGATIONS

1. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

2. On June 22, 2016, Mr. Schwartz was struck as a pedestrian by a moving vehicle as he was exiting a local restaurant in the 400 block of Commercial Street in Elko, Nevada.

3. Paramedics were called to the scene at 8:17 p.m. and arrived at the scene within a few minutes.

4. Mr. Schwartz was placed in full C-spine precautions. During transport to the hospital, his vitals were within normal limits, 4L of oxygen was started routinely, a heart monitor was placed showing normal sinus rhythm.

5. Mr. Schwartz was transported by Elko County Ambulance to Northeastern Nevada Regional Hospital on a "non-emergent" transport mode arriving at approximately 8:48 p.m.

6. Dr. Garvey performed a physical examination of Mr. Schwartz upon arrival to the emergency department.

7. His assessment revealed that Mr. Schwartz had mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.

8. Mr. Schwartz had a normal heart rate and rhythm.

9. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout.

10. Mr. Schwartz's neurological status was normal.

11. Mr. Schwartz's abdominal evaluation was within normal limits.

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

13. Dr. Garvey contacted Dr. Ray at the University of Utah who accepted the patient for transfer.

14. The air ambulance crew from Reach Air arrived at NNRH to transport Mr. Schwartz to the airport for an air ambulance transport to the University of Utah Hospital.

15. Mr. Schwartz was not informed of the risks of undergoing an intubation. He was not informed of the alternatives to undergoing an intubation procedure.

16. Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.

17. Mr. Schwartz's vital signs were stable up until this point.

18. Barry Bartlett, first attempted intubation at 12:20 a.m., unsuccessfully, followed quickly by a deterioration of oxygenation and vital signs.

19. Intubation by Barry Bartlett, was again unsuccessful at 12:33 a.m. and a large aspiration of gastric contents was noted.

20. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered.

21. CPR continued and several subsequent intubation attempts were unsuccessful.

22. At 1:20 a.m. Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 1:33 a.m.

23. Barry Bartlett was an employee of Reach Air, and Reach Air has stipulated that Mr. Bartlett was acting in the course and scope of his employment at the time of the Subject Incident.

24. According to Reach Air, Mr. Schwartz was never its patient.

25. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

26. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

27. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

28. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

29. It was the standard of care for REACH AIR staff to obtain express or implied consent for the treatment of Mr. Schwartz. [1]

30. Defendant REACH AIR, through its employees Barry Bartlett and Ronnie Lyons, intended to, and did, make contact with Mr. Schwartz's body which was harmful to him.

31. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

32. It was the intention of Defendant REACH AIR to perform the intubation of Mr. Schwartz.

33. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

34. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

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[1] John Everlove Expert Report, p. 12, attached hereto as **Ex. "2."**

35. As a result of the unconsented to procedure, Mr. Schwartz experienced immediate anxiety, apprehension, and fear.

36. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, were undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

37. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

FIRST CLAIM FOR RELIEF

(PROFESSIONAL NEGLIGENCE/WRONGFUL DEATH)

DR. DAVID GARVEY, RUBY CREST, REACH AIR, AND NNRH

38. Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

39. Defendant Dr. GARVEY owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field.

40. Defendant Dr. GARVEY fell below the standard of care by deciding to intubate Mr. Schwartz without clinical indications for intubation.[2]

41. Defendant Dr. GARVEY fell below the standard of care by failing to request an anesthesiologist to perform the intubation due to the high risk of aspiration.[3]

[2] See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Ex. 3";** Dr. Womack Declaration, p. 22-23, attached hereto as **Ex. "1."**

[3] Id.

42. Defendant Dr. GARVEY fell below the standard of care by assigning an RN to perform a high risk, semi-elective intubation in a patient who he knew just ate a large meal.[4]

43. Defendant Dr. GARVEY fell below the standard of care by failing to obtain informed consent for Mr. Schwartz when he failed to advise him of the pros and cons of the procedure as well as other acceptable options (including not doing the procedure at all or having it done by an expert physician).[5]

44. Defendant Dr. GARVEY fell below the standard of care by electing to continue with the same plan of having an RN attempt intubation even after the initial intubation procedure was unsuccessful rather than trying it himself or supporting the patient with a bag-mask technique and/or by calling in an anesthesiologist as the standard of care would require.[6]

45. Defendant Dr. GARVEY thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[6]

46. Defendant REACH AIR through its employee BARRY BARTLETT, owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field. [7]

47. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by agreeing to attempt an intubation of Mr. Schwartz when

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[4] Id.

[5] Id.

[6] Id.

[7] Id.

he did not have clear indications for intubation and had a high risk of aspiration of gastric contents.[8]

48. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by not deferring to a qualified anesthesiologist.[9]

49. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by attempting a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician. [10]

50. Defendant REACH AIR through its employee BARRY BARTLETT, thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[11]

51. Defendant NNRH's and REACH AIR'S employees, agents, and/or servants, including BARRY BARTLETT, was acting in the scope of his employment, under Defendant's control, and in the furtherance of Defendant's interest at the time his actions caused injuries to Mr. Schwartz.

52. Defendant NNRH in the capacity of a medical hospital, providing medical care to the public owed Mr. Schwartz a non-delegable duty to employ medical staff including Dr. GARVEY to have adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical

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[8] Id.

[9] Id.

[10] Id.

[11] Id.

personnel practicing in the United States of America under the same or similar circumstances.

53. At all relevant times mentioned herein, Defendants knew or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature that, if it was not properly given, was likely to injure or cause death to the person to whom it was given.

54. Defendants, and each of them, fell below the standard of care for a health care provider who possesses the degree of professional learning, skill, and ability of other similar health care providers in failing to timely and properly treat Mr. Schwartz resulting in significant injuries and death. The allegations against Defendants are supported by the Declarations of Dr. Kenneth N. Scissors and Dr. Seth Womack, which are both attached hereto and incorporated herein by this reference.[12]

55. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

56. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff have incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

57. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did

[12]Id.

incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

58. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

59. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

60. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

61. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SECOND CLAIM FOR RELIEF

(Vicarious Liability, Corporate Negligence and Ostensible Agency)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

62. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

63. Employers, masters and principals are vicariously liable for the torts committed by their employees, servants and agents if the tort occurs while the employee, servant, or agent was acting in the course and scope of employment.

64. The Defendants were the employers, masters, principals, and/or ostensible agents of each other, the remaining Defendant, and other employees, agents, independent contractors and/or representatives who negligently failed through their credentialing and re-credentialing process to employ and or grant privileges to an emergency room physician with adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.[13]

65. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimately led to his death.

66. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries, damages and death in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

67. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

68. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care forherand did incur medical and incidental expenses thereby. The exact amount of such expenses is

[13] Id.

unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

69. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

70. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

71. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and a loss of earning capacity, in an amount to be proven at trial.

72. Defendants' failure to properly credential and/or re-credential Dr. Garvey or to otherwise assure that an emergency room physician had adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances caused Plaintiff to suffer and ultimately die as a result of his care.

73. The actions of the Defendants have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

THIRD CLAIM FOR RELIEF

(Negligent Hiring, Training, and Supervision)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

74. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

75. The Defendants, and each of them, hired, trained, supervised and/or retained employees to provide treatment to patients, to include Plaintiff, within the appropriate standard of care, which required Defendants to properly assess and recognize when intubation is needed.

76. The Defendants had a duty to hire, properly train, properly supervise, and properly retain competent employees, agents, independent contractors and representatives.

77. Upon information and belief, the Defendants, breached their duty by improperly hiring, improperly training, improperly supervising and improperly retaining incompetent employees regarding the examination , diagnosis, and treatment of patients.

78. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimatley lead to his untimely death.[14]

79. Plaintiff thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

80. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

[14] Id.

81. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

82. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for Mr. Schwartz and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff allege that she hassuffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

83. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

84. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

85. The actions of the Defendants have forced the Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

FOURTH CLAIM FOR RELIEF

(Lack of Informed Consent)

Against Defendant DAVID GARVEY, M.D.

86. The Plaintiff repeat and reallege the allegations in the preceding paragraphs herein, and incorporate the same herein by reference.

87. Informed Consent requires the attending physician explain to the patient or guardian(s) including but not limited to alternatives to the treatment or procedure and the reasonable risks of undergoing the procedure.[15]

88. Dr. Garvey did not explain to the Plaintiff the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician.

89. Dr. Garvey did not explain to Plaintiff the reasonable risks of the intubation procedure including the risk of aspiration due to a full stomach and that said aspiration, should it occur, could lead to death.

90. Plaintiff would not have opted to have the intubation procedure had they been informed by Dr. Garvey of the less invasive alternative and of the substantial risks involved with intubation.

91. As a result of Dr. Garvey's lack of informed consent, Mr. Schwartz experienced great pain, discomfort and ultimately suffered death.[16]

92. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

[15] See Affidavit of Kenneth N. Scissors, M.D. attached hereto as "**Ex. 3**"

[16] Id.

93. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

94. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

FIFTH CLAIM FOR RELIEF

(Loss of Consortium)

DIANE SCHWARTZ's Claim Against All Defendants

95. Plaintiff restate and reallege each and every allegation contained in the preceding paragraphs herein, and incorporate the same herein by reference.

96. Plaintiff, Diane Schwartz, is and at all times relevant herein, has been the spouse of Plaintiff Douglas R. Schwartz.

97. As a direct and proximate result of Defendants' negligence and carelessness, has lost and will continue to lose a degree of society, comfort and companionship of his spouse, all to her damage in an amount in excess of Fifteen Thousand Dollars ($15,000.00).

98. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

99. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

100. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

101. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

SIXTH CLAIM FOR RELIEF

(Medical Battery/ Battery)

Against REACH AIR

102. The Plaintiff repeats and realleges the allegations in the preceding paragraphs herein, and incorporates the same herein by reference.

103. According to Reach Air, Mr. Schwartz was never its patient.

104. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

105. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

106. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

107. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

108. It was the standard of care for REACH AIR staff to obtain express or implied consent for the treatment of Mr. Schwartz. [17]

109. Defendant REACH AIR, through its employees Barry Bartlett and Ronnie Lyons, intended to, and did, make contact with Mr. Schwartz's body which was harmful to him.

110. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

111. It was the intention of Defendant REACH AIR to perform the intubation of Mr. Schwartz.

112. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

113. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

114. As a result of the unconsented to procedure, Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

115. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

[17] John Everlove Expert Report, p. 12, attached hereto as **Ex. "2."**

116. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

117. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

118. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

119. Defendant Reach Air's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant Reach Air with willful and conscious disregard for the safety of Plaintiff.

120. Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

121. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

122. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

123. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

124. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SEVENTH CLAIM FOR RELIEF

(Assault)

Against REACH AIR

125. The Plaintiff repeats and realleges the allegations in the preceding paragraphs herein, and incorporates the same herein by reference.

126. According to Reach Air, Mr. Schwartz was never its patient.

127. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

128. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

129. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

130. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

131. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

132. It was the intention of Defendant REACH AIR to perform the intubation of Mr. Schwartz.

133. As a result of the unconsented to procedure, Mr. Schwartz experienced immediate anxiety, apprehension, and fear.

134. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

135. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

136. As a result of the unconsented to procedure, Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

137. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

138. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did

incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

139. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

140. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

141. Defendant Reach Air's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant Reach Air with willful and conscious disregard for the safety of Plaintiff.

142. Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

143. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

144. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

145. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

146. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

EIGHTH CLAIM FOR RELIEF

(False Imprisonment)

Against REACH AIR

147. The Plaintiff repeats and realleges the allegations in the preceding paragraphs herein, and incorporates the same herein by reference.

148. According to Reach Air, Mr. Schwartz was never its patient.

149. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

150. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

151. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

152. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

153. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

154. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

155. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

156. As a result of the unconsented to procedure, Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

157. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

158. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

159. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

160. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

161. Defendant Reach Air's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant Reach Air with willful and conscious disregard for the safety of Plaintiff.

162. Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

163. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

164. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

165. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

166. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

WHEREFORE, Plaintiff, DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased, expressly reserves her right to amend this Complaint at the time of trial, to include all items of damage not yet ascertained, demand judgment against Defendants, DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive and each of the defendants as follows:

1. For general damages, in an amount in excess of Fifteen Thousand Dollars ($15,000.00), to be set forth and proven at the time of trial;
2. For special damages in an amount in excess of Fifteen Thousand Dollars ($15,000.00), to be set forth and proven at the time of trial;
3. For punitive damages against Reach Air;
4. For reasonable attorney's fees;
5. For costs and disbursements of this suit; and
6. For such other relief as to the Court deems just and proper.

DATED this 28th day of June, 2021.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazic
Shirley Blazich, Esq.
Nevada Bar No. 008378
Attorneys for Plaintiff

CLAGGETT & SYKES LAW FIRM

Pursuant to FJDCR 19.1.A. DIANE SCHWARTZ, Plaintiff in this matter, is not in debt or bankruptcy.

/s/ Shirley Blazich
Shirley Blazich, Esq., Attorney for Plaintiff

CLAGGETT & SYKES LAW FIRM

Table of Exhibits

Exhibit "1"	Declaration of Dr. Womack	31 pages
Exhibit "2"	Expert Report of John Everlove	13 pages
Exhibit "3"	Affidavit of Dr. Scissors	5 pages

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 28th day of June, 2021, I caused to be served a true and correct copy of the foregoing **THIRD AMENDED COMPLAINT (MEDICAL MALPRACTICE) AND WRONGFUL DEATH)** on the following parties via e-mail only:

Tyson J. Dobbs, Esq. Richard De Jong, Esq. HALL PRANGE & SCHOOVELD, LLC 1140 North Town Center Drive, Suite 350 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc.* *dba Northeastern Nevada Regional Hospital*	Keith A. Weaver, Esq. Alissa Bestick, Esq. LEWIS BRISBOIS BISGAARD & SMITH, LLP 6385 S. Rainbow Blvd., Suite 600 Las Vegas, NV 89118 *Attorneys for Defendant, David Garvey, M.D.*
Todd L. Moody, Esq. HUTCHISON & STEFFEN, PLLC. 10080 West Alta Drive, Suite 200 Las Vegas, NV 89145 James T. Burton, Esq. Austin Westerberg, Esq. KIRTON MCCONKIE 36 S. State Street, Suite 1900 Salt Lake City, UT 84111 *Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees*	Robert C. McBride, Esq. Chelsea R. Hueth, Esq. MCBRIDE HALL 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113 *Attorneys for Defendant, Crum, Stefanko, & Jones, LTD dba Ruby Crest Emergency Medicine*

/s/ Jackie Abrego
An Employee of
CLAGGETT & SYKES LAW FIRM

CLAGGETT & SYKES LAW FIRM

EXHIBIT 1

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

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

Re: Douglas Schwartz

Introduction and Qualifications

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

Records Reviewed

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

1. Reach Air Medical Records (9pages)
2. Northeastern Nevada Regional Hospital (157 pages)
3. Police Report and Autopsy (30 pages)
4. Elk Count Ambulance Record (18 pages)
5. Elite Investigations Norther Nevada (19 pages)
6. Certificate of Death (1 page)
7. Workman's Compensation (4 pages)
8. Billing Statements from Northeastern Nevada Regional Hospital (7 pages)
9. Posts about Douglas Schwartz (4 pages)
10. 2013-2017 Tax Returns (59 pages)
11. Douglas Schwartz Work Contract (7 pages)
12. Costs for Funeral (3 pages)
13. 2013-2016 Paystubs (89 pages)
14. Plaintiff's First Supplement (8 pages)
15. Elko Police Report (8 pages)
16. Affidavit of Kenneth N. Scissors, M.D. (5 pages)
17. Schwartz Report from Elite Investigations (18 pages)
18. Complaint (Medical Malpractice and Wrongful Death) (24 pages)
19. Errata to Plaintiff's Complaint, Amended Complaint and Second Amended Complaint (12 pages)
20. Second Amended Complaint (Medical Malpractice and Wrongful Death) (22 pages)
21. Amended Complaint (Medical Malpractice and Wrongful Death) (22 pages)
22. Deposition of David James Garvey, M.D. (166 pages)
    i. June 25, 2019
23. Deposition of Carmen Gonzalez (26 pages)

i. March 4, 2019

24. Deposition of Susan Olson, R.N. (78 pages)
    i. March 4, 2019
25. Deposition of Dr. John Patrick Patton (67 pages)
    i. May 31, 2019
26. Deposition of Donna Kevitt, R.N. (111 pages)
    i. March 4, 2019
27. Deposition of Diane Schwartz (163 pages)
    i. January 23, 2019
28. Deposition of Kathleen Jane Dunn (176 pages)
    i. June 8, 2020
29. Deposition of Gary McCalla, MD (194 pages)
    i. June 8, 2020
30. Exhibits 1-4 of the Deposition of Gary McCalla, MD (656 pages)
31. Deposition of Tom Evers, RRT (84 pages)
    i. June 17, 2020
32. Exhibits 1-5 of the Deposition of Tom Evers, RRT (108 pages)
33. Deposition of Barry Bartlett with Exhibits 1-5 (154 pages)
34. Responses to Plaintiff's First Set of Request for Production of Documents (7 pages)
35. Answers to Plaintiff's First Set of Interrogatories (10 pages)
36. Plaintiff's Responses to Defendant David Garvey's First Set of Requests for Production (26 pages)
37. Plaintiff's Answers to Defendant David Garvey's First Set of Interrogatories (19 pages)
38. Plaintiff's Responses to Defendant Reach Air Medical Services' First Set of Interrogatories, Requests for Production and Requests for Admissions (22 pages)
39. Reach and Summit Documents (263 pages)
40. Reach Air Medical Services, LLC's Responses and Objections to First Set of Interrogatories, Requests for Admission, and Requests for Production to Plaintiff (54 pages)

41. Dr. Whimple's Clinic Notes on Douglas Schwartz (20 pages)
42. Dr. Garvey's Partial Motion for Summary Judgement (290 pages)
43. Dr. Garvey's Errata to Motion for Partial Summary Judgement (10 pages)
44. Mr. Schwartz's radiographic imaging studies (June 22, 2016)
    i. CT Brain without contrast
    ii. CT C-Spine without contrast
    iii. CT T-Spine without contrast
    iv. CT Chest with IV contrast
    v. CT Abdomen and Pelvis with IV contrast
45. Northeastern Nevada Regional Hospital Patient Safety Plan
46. Northeastern Nevada Regional Hospital Code Blue Procedure & Crash Cart Maintenance (14 pages)
47. Nevada Trauma Statute (NRS 41.503)
48. Northeastern Nevada Regional Hospital Provision of Care Event for the Unexpected Death of Douglas Schwartz (5 pages) (Evers Exhibit 5)

Facts

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

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

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

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

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

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

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

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

Dr. Garvey ordered CT scans on Mr. Schwartz.

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

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

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

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

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

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

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

2. No free air to suggest bowel perforation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

****

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

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

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

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

****

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

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

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

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

Q – Did you consider this specific intubation high risk?

A – Oh, yes.

Q – And why is that?

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

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

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

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

A – Multiple rib fractures, adjacent ribs fractured in multiple places. So, you've got a segment that is independent of the rest of the chest.

Q – And is it two ribs that are broken in two places or is it three ribs? How many ribs have to be broken to –

A – Two or more.

MR. WEAVER: Just let her get her whole question out before you answer.

Q – So is it two ribs broken in the same area?

A – Two or more ribs broken – broke – two or more adjacent ribs broken in multiple places, yes.

Despite Dr. Garvey knowing what ribs fractures are consistent with a flail chest, he still misdiagnosed Mr. Schwartz with a flail chest and based his decision to intubate Mr. Schwartz from an incorrect diagnosis.

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

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

[22] Pain control

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> If, however, the failed airway is because of a CICO situation, then there is little time left before cerebral hypoxia will result in permanent deficit, and immediate cricothyrotomy is indicated.

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

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

negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. The standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett's failed attempt at 12:23 am. After 12:23 am, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency oxygenation to Mr. Schwartz. According to the testimony[24] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.

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

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

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

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

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

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

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

A – No. I probably –

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

Mr. WEAVER: Join.

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

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

MR. WEAVER: Object as to form.

Q – Correct?

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

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

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

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

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

MS. MORALES: No, he didn't—

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

MR. BURTON: Several times.

MS. MORALES: -- directly answer

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

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

****

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

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

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

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

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

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

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Rebuttal to the Opinion of Dr. Barclay

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Seth P. Womack, MD FAEEM

Date: August 17, 2020

References

1. Henry Ahn, Jeffrey Singh, Avery Nathens, Russell D. MacDonald, Andrew Travers, John Tallon, Michael G. Fehlings, and Albert Yee. Journal of Neurotrauma. Aug 2011. 1341-1361.

2. Walls, Ron M., and Michael F. Murphy. *Manual of Emergency Airway Management*. third ed., Wolters Kluwer/Lippincott Williams & Wilkins, 2008.

3. Marx, J. A., et al. *Rosen's Emergency Medicine: Concepts and Clinical Practice (2 Volumes)*. Elsevier Saunders, 2014.

EXHIBIT 2

Acclaim Consulting & Educational Services, Inc.

Expert Report

Schwartz v. REACH Air Medical Systems et al.

CASE NO: CV-C-17-439

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

Prepared for:

Shirley Blazich, Esquire

Claggett & Sykes Law Firm

4101 Meadows Lane, Suite 100

Las Vegas, Nevada 89107

Prepared by:

John B. Everlove, Paramedic, B.A.

October 25, 2020

Introduction

The following is an expert report regarding the litigation between Douglas Schwartz v. REACH Air Medical Services et al. The opinions herein are based on my own knowledge. If called as a witness, I would and could competently testify to the following.

Qualifications

I am submitting this written report expressing my opinions and/or conclusions in the above-referenced matter. My comments and opinions are based upon the specifics of this case and my knowledge and abilities in this domain. I hold a national Paramedic license, Paramedic licenses in Michigan and Florida, as well as a State of California license where I am currently employed as a Paramedic, Allied Health Coordinator and EMT Program Director. During the past 30 years, I have treated and transported thousands of patients in various states of distress with emergent and non-emergent conditions during 911 calls for service and Inter-Facility Transfers (IFT). Serving as an Emergency Medical Technician (EMT), Paramedic, Paramedic Preceptor and Field Training Officer, I have trained and instructed prehospital caregiver personnel. As an EMT Program Director and Principal Instructor, I have educated, trained and evaluated EMT students regarding the standard of care and transportation of patients in accordance with the Department of Transportation (DOT) and National Highway Traffic Safety Administration (NHTSA) guidelines for Emergency Medical Services personnel. While in the position of Paramedic Associate Supervisor and Paramedic Operations Supervisor, my primary responsibilities included responding to emergency calls for service, as well as the supervision of all employees related to prehospital services and the implementation of training standards related to assessment, treatment and patient transportation. As a Clinical Manager, my duties included investigation of all incidents related to patient care and transportation, as well as the oversight and management of the Clinical Quality Assurance (CQA) and Clinical Quality Improvement (CQI) programs relevant to the

standard of care for EMTs and Paramedics during emergency medical responses and prehospital emergency care. I have personally responded to thousands of emergency and non-emergency calls for service and provided medical treatment and transportation involving IFT calls for service and emergency calls for service.

As an expert, I have been retained by attorneys representing both plaintiffs and defendants and have offered opinions on said topics in litigation and pre-litigation matters. I estimate my caseload to date has been approximately 60/40 between plaintiff and defense work. Attached hereto is a copy of my current curriculum vitae.

Limitation Statement

My opinions are based on the information available to me as of the date of this report. I reserve the right to supplement, amend and/or modify this report and my opinions in light of any additional information hereafter.

Materials Submitted for Review

1. Elko County Ambulance Medical and Billing Records: Douglas Schwartz- DOS 06/22/2016
2. Elko County Sheriff's Department
3. Northeastern Nevada Regional Hospital: Douglas Schwartz- DOS 06/22/2016
4. REACH Air Medical Services Medical and Billing Records: Douglas Schwartz- DOS 06/22/2016
5. Plaintiff's Amended Complaint: 10/20/2017
6. Plaintiff's Second Amended Notice of Taking the Videotaped Deposition of REACH Air Medical Services, L.L.C.'S N.R.C.P. 30(b)(6) Witnesses: 06/08/2020
7. Deposition Transcript of Ronnie Jay Lyons: 08/19/2020

8. Supplemental Document Production: 05/20/2020
9. Deposition Transcript of Barry Amos Ray Bartlett: 12/20/2019
10. Deposition Transcript of Dr. David Garvey: 06/25/2019
11. Deposition Transcript of Kathleen Jane Dunn: 06/08/2020
12. State of Nevada Emergency Medical Systems Program Policies and Procedures Manual; Division of Public and Behavioral Health
13. Expert Report of Dr. Seth P. Womack: 08/17/2020
14. REACH Air Medical Services Training Records for Barry Bartlett: 06/03/2016-06/04/2016
15. REACH Air Medical Services Policies and Procedures Records
16. Deposition Transcript of Dr. Gary McCalla: 06/08/2020
17. REACH Air Medical Services Liability Insurance Policy: 04/28/2016
18. REACH Air Medical Services Clinical Protocols
19. REACH Air Medical Services Run Reports: 271SM/REACH 58-06/22/2016
20. REACH Air Medical Services Flight Log: 01/23/2016-10/29/2016
21. State of Nevada Air Ambulance Attendant License: Barry Bartlett 03/31/2018
22. REACH Air Medical Services Email Communication: Barry Bartlett 05/09/2016-07/20/2016
23. REACH Air Medical Services Personnel Records: Barry Bartlett 10/20/2015
24. REACH Air Medical Services Personnel Records: Ronnie Lyons 10/20/2015-04/25/2018
25. REACH Air Medical Services Clinical Department Quality Improvement Plan 01/19/2016

26. National Highway Traffic Safety Administration. (2009). National Emergency Medical Services Education Standards.

27. Paramedic National Emergency Medical Services Education Standards. (2009). *Paramedic Instructional Guidelines.*

28. Sanders, M. J. (2012). *Mosby's Paramedic Textbook* (4th ed., Vol. 5). Jones & Bartlett Learning.

29. Limmer, D., & O'Keefe, M. (2016). *Emergency Care* (13th ed.). Pearson.

30. Bledsoe, B., Cherry, R., & Porter, R. (2017). *Paramedic care: principles & practice 5,* (5th ed.). Pearson.

31. National Registry of Emergency Medical Technicians Advanced Psychomotor Examination Sheets

Summary of Events

On June 22nd 2016 at approximately 2015 hours, Douglas and Diane Schwartz were leaving a restaurant in the City of Elko, Nevada, when Douglas Schwartz was struck by a vehicle traveling approximately 35 to 40 miles an hour on the roadway in front of the restaurant. A 911 call was placed for Mr Schwartz, a 58-year-old man, who was treated by a paramedic and an advanced emergency medical technician (AEMT) from the Elko County Ambulance Company. The prehospital care report (PCR) reveals details to Mr Schwartz's condition at the time he was assessed by the Elko County Ambulance Paramedic. The PCR states Mr. Schwartz was lying on his right side in the street at the time of the ambulance arrival, with a complaint of pain to his right shoulder, upper right portion of his chest and his right knee. Mr. Schwartz was having difficulty taking a deep breath due to the pain in his chest coming from his ribs. The Paramedic found Mr. Schwartz was alert and oriented to the questions asked by the Paramedic regarding the collision, although the record reveals that Mr. Schwartz was "a little fuzzy" about some details of the

collision. The primary assessment and secondary assessment performed by the Elko County Ambulance Paramedic did not reveal any other significant findings of traumatic injury on Mr. Schwartz. In addition to the pain described by Mr. Schwartz that was isolated mostly to the right side of his body, Mr. Schwartz had some minor abrasions, but otherwise was did not suffer critical injuries from the event. In fact, the PCR notes the treatment provided to Mr. Schwartz was an IV (Intravenous) saline lock without continuous fluids, pain medication, full spinal immobilization precautions, and medication to prevent nausea. The Paramedic who was treating Mr. Schwartz put Mr. Schwartz on a low dose of oxygen. Based on the Paramedic's PCR, Mr. Schwartz's condition was stable; and his injuries were considered non-life threatening for the duration of the patient care that was provided.

From the initial time of patient contact with Mr. Schwartz by the ambulance personnel to the time of arrival at the Northeast Nevada Regional Hospital, Mr Schwartz's condition did not deteriorate. Mr. Schwartz's vital signs were stable and within normal limits. In fact, the transportation of Mr. Schwartz from the scene of the initial incident to the Northeast Nevada Regional Hospital Emergency Department was provided without the Elko County Ambulance personnel activating their emergency lights and siren during the transport process. The ambulance transportation to the hospital was "non-emergency", according to the PCR completed by the Elko County Ambulance Paramedic.

Upon arrival at the Northeast Nevada Regional Hospital Center Emergency Department, Mr. Schwartz's care was turned over from the Elko County Ambulance Paramedic and AEMT to the emergency department nurse, Dona Kevitt. According to the nursing records, Mr. Schwartz complained of pain in his right supraclavicular area, his diaphragm area, and the right upper chest. Mr. Schwartz appeared to have diminished breath sounds in the right posterior middle and lower

lobes of his right lung. According to Nurse Kevitt's records, Mr. Schwartz's presentation was consistent with the PCR completed by Elko County Ambulance personnel. Mr. Schwartz was awake, alert, speaking in complete sentences and not confused at the time of his arrival at the emergency department.

The attending physician in the emergency department at Northeast Nevada Regional Hospital that evening was Doctor David Garvey, who was also an associate medical director for REACH Air Medical Services. The complaints Dr. Garvey noted in his charting for Mr. Schwartz were chest pain, back pain, and abrasions with pertinent negatives regarding any other traumatic injuries from the collision. The assessment by Dr. Garvey of Mr Schwartz is noteworthy, based on the recorded findings that Mr Schwartz had normal respirations, breath sounds that were clear and normal throughout and no signs or symptoms of respiratory distress. Moreover, Mr. Schwartz was pleasant, laughing, and cooperative throughout his contact with Dr. Garvey. At the conclusion of the assessment of Mr. Schwartz, Doctor Garvey noted, "At their worst, the symptoms were moderate." Mr. Schwartz's condition remained unchanged while in the emergency department. Upon completion of the assessment in the emergency department, Dr. Garvey ordered several radiological exams of Mr. Schwartz and pain medication, as well as another dose of medication to prevent nausea.

At 2336 hours, REACH Air Medical Services (REACH) dispatch was notified of a request to transfer Mr, Schwartz by air from Northeast Nevada Regional Hospital to the University of Utah Medical Center. At 2345 hours REACH was enroute to Northeast Nevada Regional Hospital. They arrived at the hospital at 2355 hours, and the REACH Air Medical Services Prehospital Care Report (REACH PCR) shows they were at Mr. Schwartz's bedside at 2357 hours. The next

timestamp is at 0139 hours on 06/23/2016 when REACH left the hospital, approximately 1 hour and 42 minutes from the time they arrived.

Once at the emergency department, REACH Paramedic Barry Bartlett, a new REACH Paramedic and the trainee of REACH Nurse Ronnie Lyons, entered the patient room where Mr. Schwartz had been receiving treatment in the emergency department. REACH Nurse Lyons contacted the nurses who oversaw Mr Schwartz's care and according to the testimony and records, REACH Nurse Lyons received the transfer of care report, including the charting paperwork for Mr. Schwartz. REACH Paramedic Bartlett introduced himself to Mr. Schwartz as the transporting Paramedic with REACH; and REACH Nurse Lyons entered the room and testified, he saw REACH Paramedic Bartlett speaking with Mr. Schwartz. According to REACH Paramedic Bartlett, the assessment by REACH personnel of Mr. Schwartz consisted of an assessment for Mr. Schwartz's level of consciousness and his lung sounds. The testimony of REACH Nurse Ronnie Lyons revealed that this was the beginning of patient relationship between Mr. Schwartz and REACH personnel.

During that interaction between Mr. Schwartz and REACH Paramedic Bartlett, the patient was being prepared for transport by REACH personnel and Elko Ambulance personnel, was placed on the transport monitor and moved to the transportation gurney from Elko County Ambulance. The transport gurney from the Elko County Ambulance would be used to facilitate the transfer of Mr. Schwartz to the awaiting aircraft.

Prior to the transfer request being made by NNVH to REACH, Doctor Garvey spoke with a physician at the University of Utah regarding Mr. Schwartz's condition and received approval to transfer Mr. Schwartz to the specialized facility. Upon completion of that phone call, Doctor

Garvey entered Mr. Schwartz's room and advised Mr. Schwartz, the Schwartz family, and the REACH crew of the intention to intubate Mr. Schwartz prior to the departure from the emergency department. Doctor Garvey also advises his intent to place a chest tube prior to Mr. Schwartz's is departure. According to the REACH PCR completed by REACH Nurse Lyons, Mr. Schwartz was on the transport gurney, on the transport monitor, and all the equipment used on Mr. Schwartz in regard to intubation and airway management belonged to REACH.

According to REACH Paramedic Bartlett, he had no conversation with Doctor Garvey regarding who was going to perform the intubation of Mr. Schwartz. Instead, REACH Paramedic Bartlett initiated the intubation preparation with REACH Nurse Lyons because REACH Paramedic Bartlett stated in his deposition that it is customary for the transport Paramedic to intubate patients. According to the testimony of both REACH Paramedic Bartlett and REACH Nurse Lyons, no information was exchanged with Mr. Schwartz or the Schwartz family regarding REACH personnel intubating Mr. Schwartz, no consent was ever received for the intubation procedure by REACH personnel, and no consent was ever received from the Mr. Schwartz regarding the administration of medications that would temporarily paralyze Mr. Schwartz to intubate him.

As Doctor Garvey completed the preparation for placing a chest tube in Mr. Schwartz, REACH Paramedic Bartlett and REACH Nurse Lyons initiated the rapid sequence induction (RSI) intubation of Mr Schwartz that included the administration of Ketamine by REACH Nurse Lyons. Prior to the administration of the sedative medication and initiation of the intubation procedure, neither REACH Paramedic Bartlett nor REACH Nurse Lyons performed an assessment of Mr Schwartz's airway or ever performed a comprehensive primary and secondary assessment of Mr. Schwartz's condition. The medications REACH Nurse Lyons used on Mr. Schwartz came from the REACH Air Medical Services equipment bag that was brought into the hospital for the

interfacility transfer (IFT). The airway management equipment for the intubation of Mr. Schwartz, provided by REACH Air Medical Services, included a video airway visualization device and multiple advanced airway devices.

REACH Nurse Lyons administered the dose of Ketamine to Mr. Schwartz at 0018 hours, 21 minutes after the arrival at the emergency department. Immediately after the medication was administered, REACH Paramedic Bartlett initiated the intubation of Mr. Schwartz by placing the video airway visualization device in Mr. Schwartz's mouth. Although REACH has a policy to record the intubation attempts on all patients, in this case REACH Paramedic Bartlett did not record the procedure. Immediately after insertion of the airway visualization device, Mr. Schwartz began to vomit profusely and requires extensive suctioning.

According to multiple records and accounts of the subject event, multiple intubation attempts, surgical airway procedures and advanced airway placement procedures continued for another 1 hour and 5 minutes. During this time, REACH Paramedic Bartlett and Doctor Garvey performed an estimated 11 intubation attempts on Mr. Schwartz, without success. It is documented that REACH Paramedic Bartlett utilized airway visualization devices in his attempts to intubate Mr. Schwartz, as well as "digital intubation techniques."

After numerous failures to properly secure the airway of Mr. Schwartz, at 0102 hours Doctor Garvey and REACH Paramedic Bartlett attempted a surgical airway on Mr. Schwartz. They were unable to secure an airway in Mr. Schwartz. After a second attempt at 0106 hours, the surgical airway procedure was again unsuccessful. At this point, approximately 48 minutes had passed since Mr Schwartz received medications to inhibit movement and muscular control of his breathing. Mr. Schwartz was now presenting with signs of severe hypoxemia, decreasing vital

signs and system failure. The next time that is documented on the REACH PCR is 0117 hours, 59 minutes from the initial intubation attempt by REACH Paramedic Bartlett and REACH Nurse Lyons, when Mr. Schwartz heart stops beating, and CPR was initiated. The CPR was unsuccessful in resuscitating Mr. Schwartz. Mr. Schwartz was pronounced dead at 0133 hours on June 23, 2016.

Shortly after the death of Mr. Schwartz, REACH Air Medical Services issued a bill for services to Mrs. Schwartz in the amount of $18,200 for a "Base Rate Fixed Wing" fee. According to REACH Air Medical Services the charges regarding Mr. Schwartz were unknown with no explanation for what services were provided.

Opinions

1) Mr. Schwartz was a patient in the care of Northeast Nevada Regional Hospital staff and REACH Air Medical Services personnel at the time of the subject event. REACH Air Medical Services personnel made patient contact with Mr. Schwartz, established a patient-caregiver relationship with Mr. Schwartz, utilized REACH Air Medical Services equipment during the care of Mr. Schwartz, and performed portions of a patient assessment of Mr. Schwartz's condition. The care initiated by REACH Air Medical Services Paramedic Bartlett was based on the establishment of the relationship in which REACH Air Medical Services personnel were also direct healthcare providers of Mr. Schwartz. Moreover, REACH Air Medical Services personnel completed a Prehospital Care Report documenting their care of Mr. Schwartz throughout the subject event and although REACH Air Medical Services personnel claim that Mr. Schwartz was never their patient, REACH

Air Medical Services billed the Schwartz family. The process of submitting a bill to a patient for transportation services that were never provided, is considered fraudulent.

2) It was a gross deviation from the standard of care for prehospital emergency medical services personnel when REACH Air Medical Services personnel failed to obtain expressed and informed consent for care from Douglas Schwartz. Mr. Schwartz was a competent adult with capacity to consent to, or withhold consent for, emergency medical assessment, treatment, and transportation. REACH Air Medical Services personnel made patient contact with Mr. Schwartz, established a patient-caregiver relationship with Mr. Schwartz, utilized REACH Air Medical Services equipment during the care of Mr. Schwartz, and performed portions of a patient assessment of Mr. Schwartz's condition. At no time did REACH Air Medical Services Paramedic Bartlett or Nurse Lyons receive informed and expressed consent from Mr. Schwartz or the Schwartz family for any care, including the Rapid Sequence Intubation of Mr. Schwartz. Therefore, Mr. Schwartz could not have been aware of the potential risks and complications of the procedure, considering his status as a high-risk patient. Paramedics who fail to obtain consent for treatment from a patient prior to initiating such care may be liable for false imprisonment, assault and/or battery.

3) It was a gross deviation from the standard of care for prehospital emergency medical services personnel when REACH Air Medical Services personnel failed to assess Mr. Schwartz's airway anatomy prior to initiating the high-risk procedure of oral endotracheal intubation. After repeated failed attempts at oral endotracheal intubation by the REACH Air Medical Services personnel, they determined that Mr. Schwartz's airway anatomy made it difficult to properly place an advanced airway device. The preassessment process

is required, specifically for this reason, to prevent negative patient outcomes regarding advanced airway management. In this case, REACH Paramedic Bartlett performed multiple intubation attempts, on Mr. Schwartz outside of applicable protocols, policies, and procedures in gross deviation from the clinical standard of care.

4) It was a gross deviation from the standard of care for prehospital emergency medical services personnel to follow any instructions from other healthcare providers that directly violates patient clinical care treatment guidelines, policies, procedures, and protocols. Mr. Schwartz was stable, at low risk for deterioration based on his condition, and did not meet criteria for Rapid Sequence Intubation based on his condition. In fact, Mr. Schwartz's presentation was not discussed between Dr. Garvey and REACH Paramedic Bartlett prior to the intubation, based on the deposition testimony. Additionally, based on his testimony, REACH Paramedic Bartlett initiated the Rapid Sequence Induction and intubation of Mr. Schwartz, without any discussion related to the indications, complications, contraindications, side effects and risks associated with the procedures related to Mr. Schwartz's presentation. As identified above, there were numerous failed advanced airway placement attempts by REACH Paramedic Bartlett on Mr. Schwartz, who needed a secure airway and was hypoxic during the subject event.

Based upon my review and analysis of the facts outlined supra, my cumulative knowledge, training and experience, and based on a reasonable degree of medical certainty regarding the standard of care for emergency medical services personnel, it is my professional opinion REACH Air Medical Services and REACH Air Medical Services Paramedic Barry Bartlett grossly deviated from the standard of care ordinarily required of emergency medical services personnel and the acts and omissions represented a reckless disregard for Mr. Schwartz.

EXHIBIT 3

AFFIDAVIT OF KENNETH N. SCISSORS, M.D.

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

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

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

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

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

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

Documents Reviewed

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

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

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

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

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

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

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

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

Deviations from the Standard of Care.

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

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

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

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

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

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

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

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

Nurse Barry violated the standard of care in two instances:

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

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

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

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

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

Further Affidant Sayeth Not.

Dated this 21 day of June, 2017

KENNETH N. SCISSORS, M.D.

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

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

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

TYSON J. DOBBS, ESQ.
Nevada Bar No. 11953
RICHARD D. DE JONG, ESQ.
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Attorneys for Defendant
PHC-Elko, Inc., dba Northeastern Nevada Regional Hospital

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

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., 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.; DOE BARRY, R.N.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

CASE NO. CV-C-17-439
DEPT NO. 1

DEFENDANT PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT

COMES NOW, Defendant, PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL (hereafter "NNRH"), by and through the law offices of HALL PRANGLE & SCHOONVELD, LLC, and hereby submits its Motion for Partial Summary Judgment.

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

This Motion is made and based upon the papers and pleadings on file herein, the points and authorities attached hereto and such argument of counsel which may be adduced at the time of hearing such Motion.

DATED this 15th day of September, 2021.

HALL PRANGLE & SCHOONVELD, LLC

By: /s/ Richard D. De Jong
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DECLARATION OF RICHARD DE JONG, ESQ IN SUPPORT OF NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT

Richard D. De Jong, Esq., declares as follows:

1. I am a duly licensed Nevada attorney and member of the bar of this Court practicing with the law firm of Hall Prangle & Schoonveld, LLC, at 1140 North Town Center Drive, Suite 350, Las Vegas, Nevada 89144, counsel of record for NORTHEASTERN NEVADA REGIONAL HOSPITAL.
2. Attached as Exhibit A is a true and accurate copy of Plaintiff's Third Amended Complaint.
3. Attached as Exhibit B is a true and correct copy of June 3, 2021, Court Order.
4. Attached as Exhibit C is a true and correct copy of Deposition of Seth Womack.
5. Attached as Exhibit D is a true and correct copy of Deposition of Jonathan Burroughs.
6. Attached as Exhibit E is a true and correct copy of Deposition of John Everlove.
7. Attached as Exhibit F is a true and correct copy of Elko County Ambulance Record.
8. Attached as Exhibit G is a true and correct copy of NNRH Records Bates NEN000018.

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9. Attached as Exhibit H is a true and correct copy of Deposition of David Garvey, M.D.

10. Attached as Exhibit I is a true and correct copy of NNRH Records Bates NEN000005.

11. Attached as Exhibit J is a true and correct copy of Deposition of Diane Schwartz.

12. Attached as Exhibit K is a true and correct copy of Deposition of Barry Bartlett.

13. Attached as Exhibit L is a true and correct copy of Ronnie Lyons.

14. Attached as Exhibit M is a true and correct copy of Consent for Services and Financial Responsibility contained in the NNRH Medical Records (Bates NEN000030-32).

15. Attached as Exhibit N is a true and correct copy of the Expert Report of Jonathan Burroughs.

FURTHER DECLARANT SAYETH NAUGHT

DATED this 15th day of September, 2021.

HALL PRANGLE & SCHOONVELD, LLC

By: /s/ Richard D. De Jong
RICHARD D. DE JONG, ESQ.
Nevada Bar No. 15207

No notary required per NRS 53.045

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

Plaintiff's Complaint arises out of medical care and treatment rendered to Douglas Schwartz at NNRH after he was struck by a car driven by a drunk motorist on June 22, 2016. *See* Third Amended Complaint, attached hereto as **Exhibit A**. Parties have engaged in extensive discovery and Plaintiff's claims against NNRH are now ripe for summary judgment.

First, NNRH renews the request for summary judgment regarding the application of the Nevada Trauma Statute (NRS 41.503) given there is no genuine issue of material fact based upon Plaintiff's now-completed expert depositions that Mr. Schwartz suffered from a traumatic injury.

Next, NNRH also requests summary judgment as to each of Plaintiff's three claims for relief asserted against it. The First Claim for Relief – Professional Negligence – does not include

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any allegations that NNRH itself was negligent. The allegations are limited to professional negligence by Dr. Garvey and Barry Bartlett. Therefore, any attempt to assert a claim for relief against NNRH within this cause of action is redundant of Plaintiff's Second Claim for Relief, which is premised on vicarious liability.

Plaintiff's Second Claim for Relief – "Vicarious Liability, Corporate Negligence and Ostensible Agency" – is a derivative claim, premised exclusively on Dr. Garvey's alleged negligence, with the theory of liability against NNRH being ostensible agency and negligent credentialing. Plaintiff's ostensible agency claim fails because Dr. Garvey was not an employee of NNRH and there is no competent evidence that Mr. Schwartz held any belief that Dr. Garvey was a hospital employee. The negligent credentialing theory fails because negligent credentialing is not a recognized cause of action in Nevada. Nevertheless, there is no evidence to support the claim given it is undisputed that Dr. Garvey was a "well-trained and qualified emergency physician."

Additionally, summary judgment is appropriate as to Plaintiff's Third Claim for Relief, Negligent Hiring/Training/Supervision. This is because there is no evidence that any hospital employee was negligently hired, trained, or supervised, let alone any evidence that any such employee committed malpractice that caused an injury.

Finally, any remaining claims against NNRH, including any derivative claims arising out of the alleged negligence of Dr. Garvey, are inextricably intertwined with the underlying professional negligence which is alleged to have caused Mr. Schwartz's death. Therefore, NNRH requests summary judgment as to the application of NRS 41A to all Plaintiff's claims against it, regardless of the titles to the causes of action chosen by Plaintiff.

II.

STATEMENT OF UNDISPUTED FACTS

A. Plaintiff's injury was the Result of Trauma or a Trauma Related Condition.

On June 22, 2016, at 8:17 paramedics arrived on the scene of the 400 Block of Commercial Street in Elko, Nevada responding to a call that Douglas Schwartz had been struck by a car while walking out of a restaurant. *See* **Exhibit A**. When paramedics arrived on the

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scene, they found Mr. Schwartz lying on his right side in the street with towels under his head. *See* Elko County Ambulance Record Page 3 attached hereto as **Exhibit F**. A bystander reported that Mr. Schwartz was struck by a car which was traveling approximately 35 – 40 mph. *Id.* Mr. Schwartz was struck by the car and thrown up on to the hood, he rolled along the windshield up onto the roof and then fell to the ground. *Id.* Positive "trauma" was noted to his right shoulder, upper chest, ribs, and knee where Mr. Schwartz also described pain. *Id.* He was transported to NNRH in a full C-spine collar on a backboard. *Id.* Plaintiff's emergency room standard of care expert Dr. Womack testified "this was a traumatic injury" and "he had traumatic injuries". *See* **Exhibit C** Pg. 103 Ln. 9-12 and Pg. 108 Ln. 25. Likewise, Plaintiff's standard of care paramedic expert testified "... the causation of the injury was a traumatic injury, or a traumatic event rather.". *See* **Exhibit E** Pg. 57 Ln. 12-13. Plaintiff's administrative expert Dr. Burroughs likewise testified "[t]his was a trauma" and Mr. Schwartz "required a surgeon skilled in trauma." *See* **Exhibit D**. Pg. 83 Ln. 1 and Pg. 231 Ln. 16-17. Dr. Burroughs expert report also states "this case is about a normal victim of blunt trauma who did not receive the benefit of normal trauma team activation . . . ." *See* **Exhibit N** Bates Schwartz 000487.

Mr. Schwartz's diagnoses at NNRH consisted of "multiple trauma" including multiple right rib fractures with flail segment (ribs detached from the chest wall), right pulmonary contusions, closed head injury with loss of consciousness, right pneumothorax, hemoperitoneum (blood in the peritoneal cavity). *See* NNRH Records Bates NEN000018 attached hereto as **Exhibit G**. Dr. Garvey testified that after the diagnostic imaging results came back, Mr. Schwartz' condition went from "serious to critical . . . [b]ecause a flail chest is an immediate life threat." *See* Deposition of David Garvey, M.D. attached hereto as **Exhibit H** at Pg. 97 Ln. 2-9. Dr. Garvey discussed Mr. Schwartz condition with Dr. Ray at the University of Utah who accepted the patient transfer. *Id.* Dr. Ray requested that a chest tube be placed and possibly intubation prior to air medical transport due to flail segment, pulmonary contusions, low 02 stats, and a traumatic right pneumothorax. *Id.*

Dr. Garvey elected to place a chest tube while members of Codefendant REACH Air attempted intubation. *See* **Exhibit I** at NEN000005. On the second intubation attempt, Mr.

Schwartz (who was sedated) vomited and aspirated a large amount of gastric contents. *Id.* Suctioning was difficult due to large food particles occluding the suction devices. *Id.* Mr. Schwartz had eaten a steak, baked potato, salad, and had numerous refills of soda prior to being hit by the car. *See* deposition of Diane Schwartz Pg. 53 Ln. 3, attached hereto as **Exhibit J**. Numerous additional intubation attempts were made and a cricothyrotomy was performed, but all of these interventions were thwarted by the large amounts of gastric contents that filled the tubes. *See* **Exhibit I** at NEN000005. The gastric contents prevented all efforts to oxygenate Mr. Schwartz and he was pronounced dead at 1:33 am. *Id.*

B. Dr. Garvey, Barry Bartlett, and Ronnie Lyons were not employees of Defendant Northeast Nevada Regional Medical Center.

Dr. Garvey is not an employee of NNRH and never has been. *See* Deposition Transcript of David Garvey, M.D., Pg. 10 Ln. 11 – Pg. 11 Ln. 6 attached hereto as **Exhibit H**. On the contrary, Dr. Garvey was an independent contractor for Ruby Crest which in turn scheduled him to work at the emergency department at NNRH. *Id.* at Pg. 11 Ln. 1 – Pg. 12 Ln. 18. Ruby Crest is owned by three doctors Robert Stefanko, Dan Jones, and Donald Crum. *Id* at Pg. 13 Ln. 5-11. Barry Bartlett was employed by REACH Air at the time of the occurrence. *See* Deposition of Barry Bartlett attached hereto as **Exhibit K** Pg. 15 Ln. 18. Ronnie Lyons was also an employee of REACH Air. *See* Deposition Transcript of Ronnie Lyons attached hereto as **Exhibit L** Pg. 14 Ln. 3.

C. Northeast Nevada Regional Medical Center did not select Dr. Garvey to act as Plaintiffs' physician.

At the time of the occurrence, Dr. Garvey would give Ruby Crest the days he was available to work for any given month and if they needed him during that month Ruby Crest would schedule him at NNRH. *Id.* at Pg. 11 Ln. 22 – Pg. 12 Ln. 11. He estimated he would provide approximately twenty days he was available each month and Ruby Crest would assign him to work usually around five of those days. *Id.* That arrangement was consistent throughout Dr. Garvey's entire tenure with Ruby Crest including the time of the occurrence. *Id.* Dr. Garvey was never employed by NNRH. *Id* at Pg. 10 Ln. 1-14. Dr. Garvey independently made the key medical decision making without input or instruction from anyone at NNRH. *Id.* at 137:9-25.

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NNRH did not dictate any of the medical decisions. *Id.* NNRH does not select or schedule the emergency room physicians that are staffed any given day. Ruby Crest makes the schedule and provides the physicians at NNRH. *Id.* at Pg. 11 Ln. 22 – Pg. 12 Ln. 11.

D. Mr. Schwartz knew or should have known that Dr. Garvey was not an employee of Renown Regional Medical Center.

At no point during his care and treatment of Mr. Schwartz did Dr. Garvey represent that he worked for NNRH. *See* deposition of Diane Schwartz attached hereto as **Exhibit J**. In fact, the only information that Diane Schwartz had relating to Dr. Garvey's employment status was contained in a consent that she signed which stated:

> RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS / OTHER HEALTH CARE PROVIDERS: **I understand that most of 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 agent of the hospital. Likewise, most physician's 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 contactors.

See Consent for Services and Financial Responsibility contained in the NNRH medical records (Bates NEN000030-32) attached hereto as **Exhibit M** (emphasis added).

Mrs. Schwartz testified unequivocally that she signed this consent. *See* **Exhibit J** at 148:14-20. The only evidence in this case relating to Dr. Garvey's employment is that he was an independent contractor affiliated with Ruby Crest and that NNRH unambiguously informed him and Mrs. Schwartz that Dr. Garvey was likely not an employee of NNRH.

E. Dr. Garvey is was a well-trained and qualified emergency physician.

There is no evidence that Dr. Garvey should not have been granted credentials to practice medicine at NNRH. In fact, Plaintiff's own expert, Dr. Jonathan Burroughs' expert report states: "I have seen the credentials material for Dr. Garvey, and he obviously looks like a fairly well

qualified emergency physician." *See* Expert Report of Jonathan Burroughs, attached hereto as **Exhibit N**.

III.

STANDARD OF REVIEW.

Summary judgment is appropriate where the pleadings, depositions, answers to interrogatories, admissions, and affidavits on file show that there is no genuine issue as to material fact and the moving party is entitled to judgment as a matter of law. *Bird v. Casino Casa Royale West*, 97 Nev. 67, 624 P.2d 17 (1981), *Montgomery v. Ponderosa Construction, Inc.*, 101 Nev. 416, 705 P.2d 652 (1985). Summary judgment does not involve resolution of factual issues but seeks to discover if any real issue of fact exists. *Daugherty v. Wabash Life Insurance Co.*, 87 Nev. 32, 482 P.2d 814 (1971). The proceedings pierce the formality of the pleadings and test whether, based on the uncontroverted facts, one party is entitled to judgment as a matter of law. *Dredge Corp. v. Husite Co.*, 78 Nev. 69, 369 P.2d 676 *cert. denied* 371 U.S. 821 (1962); *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986). A party opposing summary judgment must demonstrate to the Court something which indicates the existence of a viable issue of fact and must set forth the specific facts showing that there is a genuine issue for trial. *Hickman v. Meadow Wood Reno*, 96 Nev.782 (1980).

Under Nevada Rule of Civil Procedure 56, a party seeking summary judgment must satisfy two substantive requirements: (1) There must be no genuine issue as to any material fact; and (2) The moving party must be entitled to judgment as a matter of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1985). A material fact is one which will affect the outcome of the action. *Id.* at 248. Here, no issues of material fact exist with respect to Plaintiff's claims of agency in relation to Dr. Garvey and Defendant NNRH is entitled to judgment as a matter of law.

IV.

ARGUMENT

A. Summary Judgment as to the application of the trauma cap is warranted because there is no genuine issue of material fact that Plaintiff suffered a traumatic injury.

There is no genuine issue of material fact as to whether Mr. Schwartz suffered from a traumatic injury. This Court previously considered NNRH's motion to apply NRS 41.503 and

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after careful deliberation found that there was a genuine issue of material fact only as to whether Mr. Schwartz suffered from a traumatic injury.[1] *See* **Exhibit B** Pg. 4 Ln. 11-14. Now that the requisite fact and expert discovery has been completed, there is no dispute that Mr. Schwartz suffered from a traumatic injury. In fact, all of Plaintiff's standard of care experts have testified that Mr. Schwartz suffered from a traumatic injury. *See* Deposition of Seth Womack, MD Pg. 103 Ln. 9 – 12, Pg. 108 Ln. 25 – Pg. 109 Ln. 10, and Pg. 262 Ln. 19-20 attached hereto as **Exhibit C**; *See* Deposition of Jonathan Burroughs, MD Pg. 55 Ln. 8-9, Pg. 75 Ln. 14-16, Pg. 83 Ln. 1, Pg. 208 Ln 14-15, and Pg. 269 Ln 7-8 attached hereto as **Exhibit D;** and *See* Deposition of John Everlove Pg. 57 Ln. 10-13 attached hereto as **Exhibit E**.

Dr. Womack testified that Mr. Schwartz "... had traumatic injuries" and that he was not critical of Dr. Garvey for transferring Mr. Schwartz to a trauma center because "This was a traumatic injury". *See* **Exhibit C** Pg. 108 Ln. 25 – Pg. 109 Ln. 10. He also testified "Mr. Schwartz had trauma. Mr. Schwartz had traumatic injuries". *Id.* Pg. 262 Ln. 19-20. Likewise, Mr. Everlove, Plaintiff's retained paramedic expert testified "... the causation of the injury was traumatic, or a traumatic event rather.". *See* **Exhibit E** Pg. 57 Line 10-13. He also agreed that Mr. Schwartz's injuries were secondary to trauma. *Id.* at Pg. 58 Ln. 18. Dr. Burroughs also consistently testified that Mr. Schwartz "had moderate trauma." *See* **Exhibit D** Pg. 269 Ln. 7-8. He even volunteered that "[a] 58-year-old died of moderate trauma because of massive aspiration. *Id.* Pg. 208 Ln. 14-15. Dr. Burroughs' report even states that "[a]t its core, this case is about a normal victim of blunt trauma who did not receive the benefit of normal trauma team activation . . . ." *See* **Exhibit N** Bates Schwartz 000487. Note that none of these experts said the only traumatic injury was flail chest but that there were plural traumatic "injur(ies)." *See* **Exhibit E** Pg. 57 Line 10-23 and *See* **Exhibit D** Pg. 231 Ln. 1-2. Dr. Burroughs even commented on the significance of Mr. Schwartz's head injury and the possibility of an

[1] NNRH incorporates its Motion That all of Plaintiff's Claims Against Northeastern Nevada Regional Hospital are Subject to the Requirements and Limitations of NRS 41.503 (The "Trauma" Statute), Plaintiff's Opposition, and NNRH's Reply as if set forth verbatim, however for the purposes of this Motion for Partial Summary Judgment it will only address the issues raised by this Court in its ruling on said pleadings.

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abdominal injury and Mr. Everlove discussed Mr. Schwartz's musculoskeletal problems. *See* **Exhibit D** Pg. at 88 Ln 3-4 and **Exhibit E** Pg. 55 Ln. 24.

Although this Court previously ruled "that there was a genuine issue of material fact as to whether the decedent suffered a traumatic injury," Plaintiff's standard of care experts have all since testified that Mr. Schwartz was suffering from a traumatic injury after he was hit by a car. Accordingly, there is now no genuine issue of material fact that Mr. Schwartz suffered from a traumatic injury pursuant to NRS 41.503(4)(b). Therefore, NRS 41.503 applies to the facts of this case and liability should be capped at $50,000.

B. Summary Judgment is warranted as to Plaintiff's First Claim for Relief – Professional Negligence.

Plaintiff's First Claim for Relief is titled "Professional Negligence" but references no allegations of active negligence by NNRH. Rather, the only active tortfeasors referenced in the First Claim for Relief are Dr. Garvey and Barry Bartlett. Accordingly, the relief, if any, contemplated by the First Claim for Relief is derivative and redundant of Plaintiff's Second Claim for Relief, which, as set forth below, also fails.

Nevertheless, it is undisputed that neither Dr. Garvey nor Barry Bartlett was an "employee or agent" of NNRH. Additionally, Plaintiff's attempt to subject NNRH to liability pursuant to a "non-delegable duty" in paragraph 52 of the Third Amended Complaint is a blatant misstatement of Nevada law. This is because the Nevada Supreme Court very clearly declined to impose a non-delegable duty on Nevada hospitals. *Renown Health v. Vanderford*, 126 Nev. 221, 224, 235 P.3d 614, 616 (2010) (stating "we decline to impose an absolute nondelegable duty on hospitals based upon public policy"). The Court then referenced the doctrine of ostensible agency, as set forth in *Schlotfeldt v. Charter Hosp. of Las Vegas*, 112 Nev. 42, 910 P.2d 271 (1996), as a limited exception to the general rule that "hospitals are not vicariously liable for the acts of independent contractor doctors." *Id.*

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C. Summary Judgment is warranted as to Plaintiff's Second Claim for Relief – Vicarious Liability, Corporate Negligence, and Ostensible Agency.

Although Plaintiff's Second Claim for Relief references "Corporate Negligence" in its title, it is premised exclusively on ostensible agency and negligent credentialing in relation to Dr. Garvey. Specifically, Plaintiff's Second Claim for Relief alleges that NNRH

> failed through their credentialing and re-credentialing process to employ and or grant privileges to an emergency room physician with adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.

See Exhibit A at ¶ 64.

However, as set forth below, both theories fail because (1) there is no recognized cause of action for negligent credentialing in Nevada; (2) there is no evidence to support a negligent credentialing theory claim; and (3) there is no genuine issue of material fact that Dr. Garvey was neither an agent nor ostensible agent of NNRH.

1. Negligent Credentialing is not a recognized cause of action in Nevada.

Plaintiff's Second Cause of Action alleges that NNRH was negligent in credentialing Dr. Garvey and that NNRH failed to ensure that he had the requisite training to perform as a competent emergency department physician. However, the Nevada Supreme Court has never recognized a cause of action for negligent credentialing. *See, e.g. Nogle v. Beech St. Corp.*, No. 2:10-CV-01092-KJD, 213 WL 1182680, at *3 (D. Nev. Mar. 20, 2013) (stating that "no [Nevada] authority has specifically recognized a cause of action for negligent credentialing"), *aff'd*, 619 F. Appx. 639 (9th Cir. 2015). Since the elements of such a cause of action have not been established, Plaintiff's attempt to plead such a cause of action necessarily fails.

2. There is no evidence to support a Negligent Credentialing Claim.

Even if this Court were to consider Plaintiff's negligent credentialing claim appropriately pled under Nevada law, there is no evidence to suggest that Dr. Garvey should not have been granted privileges by NNRH to practice medicine as an emergency department physician. This is apparent from the undisputed fact that Plaintiff's retained hospital administration expert, Jonathon Burroughs, states in his expert witness report: "Dr. Garvey is well-trained and qualified

emergency physician." *See* **Exhibit N** Bates Schwartz 000487. Therefore, even if a claim for negligent credentialing is recognized for the first time in Nevada by this Court, Summary judgment is warranted because there is no evidence to support a negligent credentialing claim.

3. There is no genuine issue of material fact that Dr. Garvey was neither an agent, or ostensible agent of NNRH.

The general rule of vicarious liability is that an employer is liable for the negligence of its employee but not the negligence of an independent contractor. *McCroskey v. Carson Tahoe Regional Medical Center*, 133 Nev. Adv. Op 115 (Nev. 2017); *see, also Oehler v. Humana, Inc.*, 105 Nev. 348, 775 P.2d 1273 (Nev. 1989) and *Schlotfeldt v. Charter Hospital of Las Vegas*, 112 Nev. 42, 910 P.2d 271 (Nev. 1996).

A doctor's mere affiliation with a hospital is not sufficient to hold a hospital vicariously liable for the doctor's negligent conduct. *Schlotfeldt* 112 Nev. 42 (*citing to Hill v. St. Claire's Hospital,* 490 N.E.2d 823 (New York 1986)). Moreover, merely because a physician or surgeon is on a hospital's staff does not necessarily render that physician an employee of the hospital. *Schlotfeldt* 112 Nev. 42 *(citing to Evans v. Bernhard*, 23 Ariz. App. 413, 533 P.2d 725 (Ariz. 1975).

While the existence of an agency relationship (ostensible agency or vicarious liability) may present a question of fact for the jury, ". . . a question of law exists as to whether sufficient competent evidence is present to require that the agency question be forwarded to the jury. . ." *Schlotfeldt*; *see also* 3AmJur2d Agency Section 362 (1986). The Nevada Supreme Court has stated that determining whether an issue of fact exists for a jury is similar to determine whether an issue of fact is present to preclude summary judgment. *Schlotfeldt, supra.* When determining whether there is an issue to be sent to the jury, a court must consider these typical questions of fact for the jury to consider (1) whether a patient entrusted himself to the hospital; (2) whether the hospital selected the doctor to serve the patient; (3) whether a patient reasonably believed the doctor was an employee or agent of the hospital; and (4) whether the patient was put on notice that a doctor was an independent contractor. *Id.*

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In *Oehler v. Humana, Inc.*, 105 Nev. 348, 775 P.2d 1273 (Nev. 1989), the Nevada Supreme Court affirmed a summary judgment order which found, as a matter of law, that agency did not exist between a hospital and a doctor. The *Oehler* court stated that:

> " . . . a hospital is not vicariously liable for acts of physicians who are neither employees nor agents of the hospital. . . ." (*Oehler (cited in Schlotfeldt)*.

In this case, to succeed on their ostensible agency claims against NNRH, Plaintiff must establish Dr. Garvey was the ostensible agent of NNRH. As set forth in detail below, the evidence is sufficiently clear to dispel ostensible agency as a matter of law and there are no questions of fact for a jury.

i. NNRH did not select Dr. Garvey to treat Plaintiff.

The initial question as to whether ostensible agency applies in this case is whether NNRH selected Dr. Garvey to serve as Mr. Schwartz emergency room physician. It is undisputed that NNRH did not select Dr. Garvey to serve as Plaintiff's physician and therefore the ostensible agency doctrine is inapplicable. Ruby Crest contracted with NNRH and arranged scheduling and then provided Dr. Garvey to NNRH to serve as the emergency room physician at the time Mr. Schwartz was treated. *See* **Exhibit H** at Pg. 11 Ln. 22 – Pg. 12 Ln. 11. NNRH does not schedule emergency room physicians, rather Dr. Garvey provided his availability to Ruby Crest and they provided the physician staffing in the emergency department. *Id.* Thus, the doctrine of ostensible agency is inapplicable because NNRH had no part in selecting Plaintiffs' physician.

ii. Plaintiff did not entrust himself to NNRH.

Mr. Schwartz was taken to the nearest hospital after he was struck by a drunk driver. *See* **Exhibit A** generally. Once he arrived at NNRH he was treated by Dr. Garvey. *Id.* Mr. Schwartz did not entrust himself to NNRH and NNRH did not select Dr. Garvey to care for him. As has clearly been established, NNRH did not play any role in scheduling emergency room doctors, and it was not the role of NNRH to provide a specific doctor to emergency room patients at NNRH. Mr. Schwartz did not seek out care at NNRH or have some sort of special relationship with the facility. Instead, Mr. Schwartz was struck by a drunk driver and paramedics took him to

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the closest hospital. Accordingly, it was not a matter of Mr. Schwartz specifically requesting the facility or demanding his treatment be completed at NNRH because of some reliance on the hospital, rather NNRH was convenient and available. This is not akin to entrustment. Further, once Mr. Schwartz arrived at NNRH he and his wife were specifically informed of the independent contractor relationship Dr. Garvey had with NNRH via the Consent for Services and Financial Responsibility. This signed consent estops Plaintiff from now claiming that Mr. Schwartz entrusted NNRH to care for him. Clearly, Mr. Schwartz entrusted Dr. Garvey, the physician, with his care after he arrived at NNRH.

iii. Plaintiff was on notice of Dr. Garvey's independent contractor status and it was not reasonable to suspect he was employed by Northeastern Nevada Regional Hospital.

Mrs. Schwartz signed a consent which clearly indicated emergency room providers were not likely employees of the hospital. The third and fourth of the *McCroskey* factors deal with the reasonableness of Plaintiff's belief in the employment status of the physician and the notice given to the Plaintiff relating to the physician's agency status. Both of these factors favor NNRH and warrant summary judgment. At deposition, Mrs. Schwartz's acknowledged her signature on the Consent for Services and Financial Responsibility document which establishes that she and her husband knew, or should have known, that the medical practitioners who treated Mr. Schwartz were not agents or employees of NNRH. *See* **Exhibit M**. The presence of this consent form mitigates any testimony that Mr. Schwartz reasonably believed that Dr. Garvey was an agent of the hospital as NNRH actively disavowed an agency or employment relationship with Mr. Schwartz.

Clearly, Mr. and Mrs. Schwartz were under notice, or at the very least constructive notice, of the independent contractor status of Dr. Garvey. Mrs. Schwartz' failure to read the consent does not excuse her from understanding the terms therein. *CVSM, LLC v. Doe Dancer V,* 435 P.3d 659 (2019); *See Also, 1 Wilson on Contracts* Section 4:19 (4th Ed). It is therefore not reasonable to now claim that Mr. Schwartz was unaware of Dr. Garvey's employment status. Due notice was given and any claim that Mr. Schwartz believed Dr. Garvey was an employee of NNRH is not reasonable.

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Plaintiff's ostensible agency allegations are not supported by any evidence. The only evidence on these issues favors dismissal of the ostensible agency claims. Plaintiff is unable to establish evidence on any of the *McCroskey* factors and therefore NNRH is entitled to summary judgment on the issue of the ostensible agency of Dr. Garvey.

D. Summary Judgment is warranted as to Plaintiff's Third Claim for Relief – Negligent, Hiring, Training, and Supervision – since there is no evidence that any employee of the hospital was negligent, or negligently hired, trained, or supervised.

Plaintiff's Third Claim for Relief includes vague allegations that NNRH improperly hired, trained, and supervised its employees and independent contractors. First, the vague inclusion of independent contractors within the allegation is improper given "[i]t is a basic tenet that for an employer to be liable for negligent hiring, training, or supervision of an employee, *the person involved must actually be an employee.*" *Rockwell v. Sun Harbor Budget Suites*, 112 Nev. 1217, 1226, 925 P.2d 1175, 1181 (1996) (emphasis added).

More importantly, there is no evidence that any *employee* of NNRH was negligently hired, trained, or supervised. There is also no expert support for any professional negligence of a hospital employee, rendering a negligent hiring, training, supervision claim an impossibility given there is no causal connection between any hypothetical failure in the hiring/supervision process, and Plaintiff's death.

E. Any and all remaining claims against NNRH, if any, are subject to NRS 41A, regardless of the titles given them by Plaintiff.

To the extent any of Plaintiff's claims survive summary judgment, NNRH is entitled to summary judgment as to the application of NRS 41A to all of Plaintiff's claims, notwithstanding Plaintiff's characterization of the claims as wrongful death, negligent credentialing, negligent supervision, or corporate negligence.

This is because all of Plaintiff's claims against NNRH sound in "professional negligence" under NRS 41A.017, which is defined as "the failure of a provider of health care, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care." A "provider of health care" is specifically defined to include physicians, nurses, and ***hospitals***. Nev. Rev. Stat.

41A.017 (emphasis added). Providers of health care are entitled to protection under NRS 41A, including several liability, abolishing the collateral source rule, and capping non-economic damages at $350,000.

The Nevada Supreme Court has consistently held that these protections are warranted as to claims sounding in professional negligence, as well as those inextricably linked to underlying professional negligence. For example, In *Zhang, M.D. v. Barnes*, 832 P.3d 878, Nev. Unpub. Disp., WL 4926325, Docket No. 67219, Filed September 12, 2016 (holding affirmed in the *Estate of Mary Curtis, et al., v. Life Care Center of So. Las Vegas, et. al*), 466 P.3d 1263 (Nev. 2020), the Nevada Supreme Court stated that when negligent hiring, training, and supervision claims are inextricably linked to the underlying professional negligence, such claims "...cannot be used as a channel to allege professional negligence against a provider of healthcare to avoid the statutory caps on such actions...". *Id.* at *7.

In addition, in *Curtis,* the Nevada Supreme Court held that claims of wrongful death and tortious breach of the implied covenant of good faith and fair dealing, alleging negligent mismanagement, understaffing, training, budgeting and negligent operation of a nursing home,[2] were subject to NRS § 41A. The Court found that all these claims were "inextricably linked" to the underlying claim of professional negligence (failure to monitor the patient) involving "medical diagnosis, judgment and treatment" and the need for expert testimony. 466 P.3d at 1267. Specifically, the Nevada Supreme Court stated, "if the underlying negligence did not cause Curtis's death, no other factual basis was alleged for finding [the healthcare facility] liable for negligent staffing, training, and budgeting." *Id.* Moreover, the *Curtis* Court cited with approval cases affirming the finding of professional negligence to claims where a professional exercises medical judgment. *Id.* at 1268 (*citing Smith ex rel. Smith v. Gilmore Mem'l Hosp., Inc.*, 952 So. 2d 177, 180-82 (Miss. 2007) (addressing a nurse's failure to inform a patient's family that the

[2] In fact, in *Curtis* the direct claims against the nursing home were subject to NRS 41A even though the nursing home was *not* a provider of health care as defined by NRS 41A.017. Here, however, NNRH – a hospital – *is* expressly identified as provider of health care subject to the protections set forth in NRS 41A.

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doctor had operated on the wrong body part and concluding expert testimony was required to determine whether the nurse's judgment call breached the standard of care)).

In *Zang* and *Curtis*, the plaintiffs' claims of negligent operation, hiring, training, credentialing, supervising, monitoring, educating, and budgeting were all asserted to blame the hospital for alleged incompetent and negligent staff and professional judgment which caused the plaintiffs' negligent medical treatment and injury. *Id.* All such claims were deemed to be interdependent on the underlying professional negligence claim and governed by NRS § 41A. *Id.* The Court held that to hold otherwise would contradict the Nevada Supreme Court's prior holdings.

Analyzing what such "interdependence", *Zhang* cites favorably to a Texas case whose holding is illustrative in this matter.

> There would have been no injury in this case and no basis for the [plaintiffs'] lawsuit without the negligent rendering of professional medical treatment. Stated more specifically, Erica's death could not have resulted from the negligent hiring, training, and supervision or from the negligent failure to institute adequate policies and procedures without the negligent rendering of professional medical services. The negligent acts and omissions were not independent and mutually exclusive; rather, they were related and interdependent. Therefore, the professional services exclusion operated to exclude coverage not only for the claims of negligence in rendering the professional services but also for the related allegations of negligent hiring, training, and supervision....
> *7 *Id.* at 791–92.

Zhang v. Barnes, 382 P.3d 878 (Nev. 2016), citing *Duncanville Diagnostic Ctr., Inc. v. Atl. Lloyd's Ins. Co. of Texas* 875 S.W.2d 788, 791 (Tex. App. 1994), writ denied (Dec. 1, 1994).

Just as above, Mr. Schwartz's injury "could not have resulted from the negligent...training...supervision or from the negligent failure to institute adequate policies and procedures without the negligent rendering of professional medical services." *Id.*

Thus, there can be no misunderstanding, the Nevada Supreme Court stated and clarified that when direct claims against a facility are tied to an underlying professional negligence claim, as is the case here, then these allegations are all "professional negligence" claims and subject to all the restrictions set forth in NRS 41A. Therefore, even if any of Plaintiff's claims survive

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summary judgment, they are professional negligence claims subject to NRS 41A regardless of how they are characterized by Plaintiff in the Complaint or otherwise.

V.

CONCLUSION

For the foregoing reasons, Northeastern Nevada Regional Hospital respectfully requests this Court enter and Order granting this Motion for Summary Judgment in its favor and against Plaintiff.

AFFIRMATION
Pursuant to NRS239B030

The undersigned does hereby affirm that the preceding document does not contain the Social Security Number of any person.

DATED this 15th day of September, 2021.

HALL PRANGLE & SCHOONVELD, LLC

By: /s/ Richard D. De Jong
TYSON J. DOBBS, ESQ.
Nevada Bar No. 11953
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Index of Exhibits:

Third Amended Complaint, attached hereto as **Exhibit A.**

June 3, 2021, Court Order attached hereto as **Exhibit B.**

Deposition of Seth Womack attached hereto as **Exhibit C**

Deposition of Jonathan Burroughs attached hereto as **Exhibit D**

Deposition of John Everlove attached hereto as **Exhibit E.**

Elko County Ambulance Record attached hereto as **Exhibit F.**

NNRH Records Bates NEN000018 attached hereto as **Exhibit G.**

Deposition of David Garvey, M.D. attached hereto as **Exhibit H.**

NNRH Records Bates NEN000005 attached hereto as **Exhibit I.**

Deposition of Diane Schwartz attached hereto as **Exhibit J.**

Deposition of Barry Bartlett attached hereto as **Exhibit K.**

Deposition of Ronnie Lyons attached hereto as **Exhibit L.**

Consent for Services and Financial Responsibility contained in the NNRH medical records (Bates NEN000030-32) attached hereto as **Exhibit M.**

Expert Report of Jonathan Burroughs attached hereto as **Exhibit N**

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 15th day of September, 2021, I served a true and correct copy of the foregoing **DEFENDANT PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT** via electronic service to the following:

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REACH Air Medical Services, LLC
And for its individually named employees

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/s/ Arla Clark
An employee of HALL PRANGLE & SCHOONVELD, LLC

EXHIBIT A

EXHIBIT A

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CLAGGETT & SYKES LAW FIRM

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

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD, dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES,

THIRD AMENDED COMPLAINT (Medical Malpractice) and Wrongful Death)

L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

Plaintiff, DIANE SCHWARTZ, individually and as the administrator of the Estate of DOUGLAS SCHWARTZ, by and through her attorneys of record, CLAGGETT & SYKES LAW FIRM, for their causes of action against Defendants, DAVID GARVEY, M.D., individually; CRUM, STEFANKO, & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, REACH AIR MEDICAL SERVICES, L.L.C; DOES 1 through X; ROE BUSINESS ENTITIES X1 through XX; and each of them and alleges as follows:

1. At all times relevant herein, Plaintiff, DIANE SCHWARTZ, individually and as the Special Administrator on behalf of the Estate of DOUGLAS R. SCHWARTZ (hereinafter the "Plaintiff" or "Diane"), was and is a resident of Elko County, Nevada.

2. At all times relevant herein, Plaintiff DOUGLAS SCHWARTZ (hereinafter the "Plaintiff" or "Mr. Schwartz"), was a resident of Elko County, Nevada.

3. Upon information and belief, at all times relevant herein, Defendant, David Garvey, M.D. (hereinafter "Dr. Garvey" or "Defendant"), was and is a medical doctor licensed in the State of Nevada, and a resident of Elko County, Nevada.

4. Upon information and belief, at all times relevant herein, Defendant, CRUM, STEFANKO, & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE (hereinafter "Ruby Crest" or "Defendant"), was and is a domestic corporation existing

pursuant to the laws of Delaware, authorized to do business in Nevada, and doing business in the State of Nevada.

5. Upon information and belief, at all times relevant herein, Defendant, PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL (hereinafter "NNRH" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Nevada, authorized to do business in the State of Nevada, and doing business in the State of Nevada.

6. Defendant NNRH was and is at all times relevant operating as a medical care facility in Elko County, Nevada and was and is owned, operated, managed, and controlled as a medical care facility within the County of Elko, State of Nevada, and was held out to the public at large, including the Plaintiff herein, as a properly equipped, fully accredited, completely staffed by qualified and prudent personnel, and operating in compliance with standards of due care maintained by other properly equipped, efficiently operated and administered, accredited medical care facilities in said community, offering full, competent, qualified, and efficient health care services to the general public and to the Plaintiff herein; that Plaintiff herein is informed and believes and thereon alleges, that Defendant, NNRH, administered, governed, controlled, managed, and directed all the necessary functions, activities, and operations of said medical care facility, including its physician care, nursing care, interns, residents and health staff, and other personnel.

7. Upon information and belief, Defendant REACH AIR MEDICAL SERVICES, LLC, (hereinafter "Reach Air" or "Defendant") is a foreign limited liability company existing pursuant to the laws of California, authorized to do business in the State of Nevada, and doing business in the State of Nevada

8. That the true names or capacities, whether corporate, associate, individual or otherwise, of DOES I through X, inclusive, were and now are physicians, surgeons, registered nurses, licensed vocational nurses, practical nurses, registered technicians, aides, attendants, physician's assistants, CRNAs, or paramedical personnel holding themselves out as duly licensed to practice their professions under and by virtue of the laws of the State of Nevada, and were and are now engaged in the practice of their professions in the State of Nevada, and are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes, and thereon alleges, that each of the Defendants designated herein as a DOE is legally responsible in some manner for the events and happenings herein referred to and proximately caused injury and damages thereby to Plaintiff as hereinafter alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names and capacities of DOES I through X when the same have been ascertained and to join such Defendants in this action.

9. That the true names or capacities of Defendants, ROE BUSINESS ENTITIES XI through XX, inclusive, are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Defendants designated herein as ROE BUSINESS ENTITIES XI through XX, and each of them, are corporations, firms, partnerships, associations, other medical entities, including but not limited to nursing staffing companies and/or registry nursing companies, emergency physician services group, predecessors-in-interest, successors-in-interest, and/or agencies otherwise in a joint venture with, and/or serving as an alter ego of, any and/or all Defendants named herein; and/or are entities responsible for the treatment, diagnosis, surgery, and/or other

provision of medical care to Plaintiff herein, and/or otherwise responsible for the supervision of the individually named Defendants at the time of the events and circumstances alleged herein; and/or are entities employed by and/or otherwise directing the individual Defendants in the scope and course of their responsibilities at the time of the events and circumstances alleged herein; and/or are entities otherwise contributing in any way to the acts complained of and the damages alleged to have been suffered by the Plaintiff herein. Plaintiff is informed and, on that basis believes and thereon alleges, that each of the Defendants designated as a ROE BUSINESS ENTITY is in some manner negligently, vicariously, and/or statutorily responsible for the events and happenings referred to and caused damages to Plaintiff as herein alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names of such Defendants when the same have been ascertained.

10. Defendants are agents, servants, employees, employers, trade venturers, and/or partners of each other. At the time of the incident described in this Complaint, Defendants were acting within the color, purpose and scope of their relationships, and by reason of their relationships, Defendants may be jointly and severally and/or vicariously responsible and liable for the acts and omissions of their Co-Defendants.

GENERAL ALLEGATIONS

1. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

2. On June 22, 2016, Mr. Schwartz was struck as a pedestrian by a moving vehicle as he was exiting a local restaurant in the 400 block of Commercial Street in Elko, Nevada.

3. Paramedics were called to the scene at 8:17 p.m. and arrived at the scene within a few minutes.

4. Mr. Schwartz was placed in full C-spine precautions. During transport to the hospital, his vitals were within normal limits, 4L of oxygen was started routinely, a heart monitor was placed showing normal sinus rhythm.

5. Mr. Schwartz was transported by Elko County Ambulance to Northeastern Nevada Regional Hospital on a "non-emergent" transport mode arriving at approximately 8:48 p.m.

6. Dr. Garvey performed a physical examination of Mr. Schwartz upon arrival to the emergency department.

7. His assessment revealed that Mr. Schwartz had mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.

8. Mr. Schwartz had a normal heart rate and rhythm.

9. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout.

10. Mr. Schwartz's neurological status was normal.

11. Mr. Schwartz's abdominal evaluation was within normal limits.

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

13. Dr. Garvey contacted Dr. Ray at the University of Utah who accepted the patient for transfer.

14. The air ambulance crew from Reach Air arrived at NNRH to transport Mr. Schwartz to the airport for an air ambulance transport to the University of Utah Hospital.

15. Mr. Schwartz was not informed of the risks of undergoing an intubation. He was not informed of the alternatives to undergoing an intubation procedure.

16. Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.

17. Mr. Schwartz's vital signs were stable up until this point.

18. Barry Bartlett, first attempted intubation at 12:20 a.m., unsuccessfully, followed quickly by a deterioration of oxygenation and vital signs.

19. Intubation by Barry Bartlett, was again unsuccessful at 12:33 a.m. and a large aspiration of gastric contents was noted.

20. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered.

21. CPR continued and several subsequent intubation attempts were unsuccessful.

22. At 1:20 a.m. Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 1:33 a.m.

23. Barry Bartlett was an employee of Reach Air, and Reach Air has stipulated that Mr. Bartlett was acting in the course and scope of his employment at the time of the Subject Incident.

24. According to Reach Air, Mr. Schwartz was never its patient.

25. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

26. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

27. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

28. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

29. It was the standard of care for REACH AIR staff to obtain express or implied consent for the treatment of Mr. Schwartz. [1]

30. Defendant REACH AIR, through its employees Barry Bartlett and Ronnie Lyons, intended to, and did, make contact with Mr. Schwartz's body which was harmful to him.

31. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

32. It was the intention of Defendant REACH AIR to perform the intubation of Mr. Schwartz.

33. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

34. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

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[1] John Everlove Expert Report, p. 12, attached hereto as **Ex. "2."**

35. As a result of the unconsented to procedure, Mr. Schwartz experienced immediate anxiety, apprehension, and fear.

36. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, were undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

37. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

FIRST CLAIM FOR RELIEF

(PROFESSIONAL NEGLIGENCE/WRONGFUL DEATH)

DR. DAVID GARVEY, RUBY CREST, REACH AIR, AND NNRH

38. Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

39. Defendant Dr. GARVEY owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field.

40. Defendant Dr. GARVEY fell below the standard of care by deciding to intubate Mr. Schwartz without clinical indications for intubation.[2]

41. Defendant Dr. GARVEY fell below the standard of care by failing to request an anesthesiologist to perform the intubation due to the high risk of aspiration.[3]

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[2] See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Ex. 3"**; Dr. Womack Declaration, p. 22-23, attached hereto as **Ex. "1."**

[3] Id.

42. Defendant Dr. GARVEY fell below the standard of care by assigning an RN to perform a high risk, semi-elective intubation in a patient who he knew just ate a large meal.[4]

43. Defendant Dr. GARVEY fell below the standard of care by failing to obtain informed consent for Mr. Schwartz when he failed to advise him of the pros and cons of the procedure as well as other acceptable options (including not doing the procedure at all or having it done by an expert physician).[5]

44. Defendant Dr. GARVEY fell below the standard of care by electing to continue with the same plan of having an RN attempt intubation even after the initial intubation procedure was unsuccessful rather than trying it himself or supporting the patient with a bag-mask technique and/or by calling in an anesthesiologist as the standard of care would require.[6]

45. Defendant Dr. GARVEY thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[6]

46. Defendant REACH AIR through its employee BARRY BARTLETT, owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field. [7]

47. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by agreeing to attempt an intubation of Mr. Schwartz when

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[4] Id.
[5] Id.
[6] Id.
[7] Id.

he did not have clear indications for intubation and had a high risk of aspiration of gastric contents.[8]

48. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by not deferring to a qualified anesthesiologist.[9]

49. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by attempting a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician. [10]

50. Defendant REACH AIR through its employee BARRY BARTLETT, thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[11]

51. Defendant NNRH's and REACH AIR'S employees, agents, and/or servants, including BARRY BARTLETT, was acting in the scope of his employment, under Defendant's control, and in the furtherance of Defendant's interest at the time his actions caused injuries to Mr. Schwartz.

52. Defendant NNRH in the capacity of a medical hospital, providing medical care to the public owed Mr. Schwartz a non-delegable duty to employ medical staff including Dr. GARVEY to have adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical

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[8] Id.

[9] Id.

[10] Id.

[11] Id.

personnel practicing in the United States of America under the same or similar circumstances.

53. At all relevant times mentioned herein, Defendants knew or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature that, if it was not properly given, was likely to injure or cause death to the person to whom it was given.

54. Defendants, and each of them, fell below the standard of care for a health care provider who possesses the degree of professional learning, skill, and ability of other similar health care providers in failing to timely and properly treat Mr. Schwartz resulting in significant injuries and death. The allegations against Defendants are supported by the Declarations of Dr. Kenneth N. Scissors and Dr. Seth Womack, which are both attached hereto and incorporated herein by this reference.[12]

55. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

56. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff have incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

57. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did

[12] Id.

incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

58. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

59. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

60. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

61. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SECOND CLAIM FOR RELIEF

(Vicarious Liability, Corporate Negligence and Ostensible Agency)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

62. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

63. Employers, masters and principals are vicariously liable for the torts committed by their employees, servants and agents if the tort occurs while the employee, servant, or agent was acting in the course and scope of employment.

64. The Defendants were the employers, masters, principals, and/or ostensible agents of each other, the remaining Defendant, and other employees, agents, independent contractors and/or representatives who negligently failed through their credentialing and re-credentialing process to employ and or grant privileges to an emergency room physician with adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.[13]

65. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimately led to his death.

66. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries, damages and death in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

67. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

68. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care forherand did incur medical and incidental expenses thereby. The exact amount of such expenses is

[13] Id.

unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

69. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

70. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

71. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and a loss of earning capacity, in an amount to be proven at trial.

72. Defendants' failure to properly credential and/or re-credential Dr. Garvey or to otherwise assure that an emergency room physician had adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances caused Plaintiff to suffer and ultimately die as a result of his care.

73. The actions of the Defendants have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

THIRD CLAIM FOR RELIEF

(Negligent Hiring, Training, and Supervision)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

74. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

75. The Defendants, and each of them, hired, trained, supervised and/or retained employees to provide treatment to patients, to include Plaintiff, within the appropriate standard of care, which required Defendants to properly assess and recognize when intubation is needed.

76. The Defendants had a duty to hire, properly train, properly supervise, and properly retain competent employees, agents, independent contractors and representatives.

77. Upon information and belief, the Defendants, breached their duty by improperly hiring, improperly training, improperly supervising and improperly retaining incompetent employees regarding the examination , diagnosis, and treatment of patients.

78. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimatley lead to his untimely death.[14]

79. Plaintiff thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

80. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

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[14] Id.

81. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

82. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for Mr. Schwartz and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff allege that she hassuffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

83. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

84. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

85. The actions of the Defendants have forced the Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

FOURTH CLAIM FOR RELIEF

(Lack of Informed Consent)

Against Defendant DAVID GARVEY, M.D.

86. The Plaintiff repeat and reallege the allegations in the preceding paragraphs herein, and incorporate the same herein by reference.

87. Informed Consent requires the attending physician explain to the patient or guardian(s) including but not limited to alternatives to the treatment or procedure and the reasonable risks of undergoing the procedure.[15]

88. Dr. Garvey did not explain to the Plaintiff the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician.

89. Dr. Garvey did not explain to Plaintiff the reasonable risks of the intubation procedure including the risk of aspiration due to a full stomach and that said aspiration, should it occur, could lead to death.

90. Plaintiff would not have opted to have the intubation procedure had they been informed by Dr. Garvey of the less invasive alternative and of the substantial risks involved with intubation.

91. As a result of Dr. Garvey's lack of informed consent, Mr. Schwartz experienced great pain, discomfort and ultimately suffered death.[16]

92. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

[15] See Affidavit of Kenneth N. Scissors, M.D. attached hereto as "**Ex. 3**"

[16] Id.

93. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

94. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

FIFTH CLAIM FOR RELIEF

(Loss of Consortium)

DIANE SCHWARTZ's Claim Against All Defendants

95. Plaintiff restate and reallege each and every allegation contained in the preceding paragraphs herein, and incorporate the same herein by reference.

96. Plaintiff, Diane Schwartz, is and at all times relevant herein, has been the spouse of Plaintiff Douglas R. Schwartz.

97. As a direct and proximate result of Defendants' negligence and carelessness, has lost and will continue to lose a degree of society, comfort and companionship of his spouse, all to her damage in an amount in excess of Fifteen Thousand Dollars ($15,000.00).

98. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

99. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

100. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

101. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

SIXTH CLAIM FOR RELIEF

(Medical Battery/ Battery)

Against REACH AIR

102. The Plaintiff repeats and realleges the allegations in the preceding paragraphs herein, and incorporates the same herein by reference.

103. According to Reach Air, Mr. Schwartz was never its patient.

104. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

105. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

106. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

107. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

108. It was the standard of care for REACH AIR staff to obtain express or implied consent for the treatment of Mr. Schwartz. [17]

109. Defendant REACH AIR, through its employees Barry Bartlett and Ronnie Lyons, intended to, and did, make contact with Mr. Schwartz's body which was harmful to him.

110. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

111. It was the intention of Defendant REACH AIR to perform the intubation of Mr. Schwartz.

112. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

113. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

114. As a result of the unconsented to procedure, Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

115. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

---

[17] John Everlove Expert Report, p. 12, attached hereto as **Ex. "2."**

116. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

117. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

118. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

119. Defendant Reach Air's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant Reach Air with willful and conscious disregard for the safety of Plaintiff.

120. Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

121. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

122. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

123. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

124. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SEVENTH CLAIM FOR RELIEF

(Assault)

Against REACH AIR

125. The Plaintiff repeats and realleges the allegations in the preceding paragraphs herein, and incorporates the same herein by reference.

126. According to Reach Air, Mr. Schwartz was never its patient.

127. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

128. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

129. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

130. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

131. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

132. It was the intention of Defendant REACH AIR to perform the intubation of Mr. Schwartz.

133. As a result of the unconsented to procedure, Mr. Schwartz experienced immediate anxiety, apprehension, and fear.

134. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

135. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

136. As a result of the unconsented to procedure, Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

137. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

138. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did

incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

139. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

140. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

141. Defendant Reach Air's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant Reach Air with willful and conscious disregard for the safety of Plaintiff.

142. Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

143. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

144. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

145. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

146. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

EIGHTH CLAIM FOR RELIEF

(False Imprisonment)

Against REACH AIR

147. The Plaintiff repeats and realleges the allegations in the preceding paragraphs herein, and incorporates the same herein by reference.

148. According to Reach Air, Mr. Schwartz was never its patient.

149. According to Reach Flight Nurse Ronnie Lyons, Mr. Schwartz was never Reach's patient.

150. According to Reach's expert, Lesley Osborne, M.D., Mr. Schwartz was never Reach's patient.

151. However, on or about June 23, 2016, Defendant Reach Air, through its Flight Nurse Ronnie Lyons, administered Rocuronium and Ketamine to Mr. Schwartz without his express or implied consent.

152. Defendant REACH AIR made repeated intubation attempts upon Mr. Schwartz without his express or implied consent.

153. It was the intention of Defendant REACH AIR to administer Rocuronium and Ketamine to Mr. Schwartz.

154. Prior to Defendant REACH AIR administering the paralytics, Mr. Schwartz was awake and aware of his surroundings.

155. After administering paralytics, Mr. Schwartz was paralyzed and sedated and unable to move, speak or breath on his own.

156. As a result of the unconsented to procedure, Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

157. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

158. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

159. The actions of Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

160. Defendant Reach Air ratified the conduct of its employees when it frauduently billed Mr. Schwartz's family $18,200 despite their claim that Mr. Schwartz was never their patient.

161. Defendant Reach Air's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant Reach Air with willful and conscious disregard for the safety of Plaintiff.

162. Defendant Reach Air, through its emplyees Barry Bartlett and Ronnie Lyons, outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

163. Pursuant to NRS 42.007, Defendant Reach Air is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

164. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

165. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

166. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

WHEREFORE, Plaintiff, DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased, expressly reserves her right to amend this Complaint at the time of trial, to include all items of damage not yet ascertained, demand judgment against Defendants, DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive and each of the defendants as follows:

1. For general damages, in an amount in excess of Fifteen Thousand Dollars ($15,000.00), to be set forth and proven at the time of trial;
2. For special damages in an amount in excess of Fifteen Thousand Dollars ($15,000.00), to be set forth and proven at the time of trial;
3. For punitive damages against Reach Air;
4. For reasonable attorney's fees;
5. For costs and disbursements of this suit; and
6. For such other relief as to the Court deems just and proper.

DATED this 28th day of June, 2021.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazic
Shirley Blazich, Esq.
Nevada Bar No. 008378
Attorneys for Plaintiff

CLAGGETT & SYKES LAW FIRM

Pursuant to FJDCR 19.1.A. DIANE SCHWARTZ, Plaintiff in this matter, is not in debt or bankruptcy.

/s/ Shirley Blazich
Shirley Blazich, Esq., Attorney for Plaintiff

CLAGGETT & SYKES LAW FIRM

Table of Exhibits

Exhibit "1"	Declaration of Dr. Womack	31 pages
Exhibit "2"	Expert Report of John Everlove	13 pages
Exhibit "3"	Affidavit of Dr. Scissors	5 pages

CLAGGETT & SYKES LAW FIRM

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 28th day of June, 2021, I caused to be served a true and correct copy of the foregoing **THIRD AMENDED COMPLAINT (MEDICAL MALPRACTICE) AND WRONGFUL DEATH)** on the following parties via e-mail only:

Tyson J. Dobbs, Esq. Richard De Jong, Esq. HALL PRANGE & SCHOOVELD, LLC 1140 North Town Center Drive, Suite 350 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc.* *dba Northeastern Nevada Regional Hospital*	Keith A. Weaver, Esq. Alissa Bestick, Esq. LEWIS BRISBOIS BISGAARD & SMITH, LLP 6385 S. Rainbow Blvd., Suite 600 Las Vegas, NV 89118 *Attorneys for Defendant, David Garvey, M.D.*
Todd L. Moody, Esq. HUTCHISON & STEFFEN, PLLC. 10080 West Alta Drive, Suite 200 Las Vegas, NV 89145 James T. Burton, Esq. Austin Westerberg, Esq. KIRTON MCCONKIE 36 S. State Street, Suite 1900 Salt Lake City, UT 84111 *Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees*	Robert C. McBride, Esq. Chelsea R. Hueth, Esq. MCBRIDE HALL 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113 *Attorneys for Defendant, Crum, Stefanko, & Jones, LTD dba Ruby Crest Emergency Medicine*

/s/ Jackie Abrego
An Employee of
CLAGGETT & SYKES LAW FIRM

CLAGGETT & SYKES LAW FIRM

EXHIBIT B

EXHIBIT B

CASE NO.: CV-C-17-439

DEPT. NO.: 1

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased;

Plaintiff,

V.

DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., 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 MEDICAL SERVICES, L.L.C., DOES 1 through X; ROE BUSINESS ENTITIES XI through XX, inclusive.

Defendants.

ORDER DENYING:

1. DEFENDANT PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION THAT ALL OF PLAINTIFF'S CLAIMS AGAINST NORTHEASTERN NEVADA REGIONAL HOSPITAL ARE SUBJECT TO THE REQUIREMENTS AND LIMITATIONS OF NRS 41.503 (THE "TRAUMA" STATUTE) (filed July 6, 2020);
2. DEFENDANT DAVID GARVEY, M.D.'S MOTION FOR PARTIAL SUMMARY JUDGMENT TO STATUTORILY LIMIT DAMAGES (filed July 27, 2021);
3. DEFENDANT DAVID GARVEY, M.D.'S MOTION TO STRIKE THE DECLARATION OF SETH WOMACK, M.D.; *and*
4. DEFENDANT DAVID GARVEY, M.D.'S MOTION TO STRIKE THE DECLARATION OF SHIRLEY BLAZICH, ESQ.

This is a civil action in which Plaintiff Diane Schwartz has brought a claim arising from an allegation of professional negligence occurring on June 22, 2016, at Northeastern Nevada Regional Hospital in Elko, Nevada.

I. Facts

Douglas Schwartz ("Schwartz"), a 58-year-old man, was struck by a vehicle as he left a local Elko dining establishment. Schwartz was transported to Northeastern Nevada Regional Hospital via ambulance

where he was treated by Defendant David Garvey, MD (hereinafter "Garvey"). Schwartz passed away in the process of being prepared for transportation to the University of Utah Hospital via air ambulance. This suit followed.

II. Procedural Background

On July 6, 2020, Defendant PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital ("NNRH") filed its motion asking the Court to find that the cap on traumatic damages ("trauma cap") created in NRS 41.503 applies to Plaintiff's claims in this case. Defendants REACH Air Medical Services, LLC. ("REACH"), Team Health Holdings, Inc., dba Ruby Crest Emergency Medicine ("Ruby Crest"), and Garvey joined NNRH's motion. Plaintiff opposed NNRH's motion on July 14, 2020. NNRH replied to the opposition on July 22, 2020. Defendants REACH and Ruby Crest then joined NNRH's reply.

On July 27, 2020, Garvey then filed a motion for partial summary judgment; that motion was later joined by Ruby Crest, NNRH, and REACH. Garvey then filed an errata to the motion for partial summary judgment on August 3, 2020; that errata was joined by Ruby Crest. Plaintiff opposed the motion and errata on August 18, 2020. Garvey replied to the opposition on September 8, 2020. That same date, Garvey filed two additional motions to strike the declarations of Shirley Blazich and Seth Womack which had been attached to Plaintiff's opposition. REACH and NNRH joined Garvey's reply; REACH also separately joined both of Garvey's motions to strike. Oral argument was heard on March 5 and 18, 2021.

IV. Legal Analysis

Under Nevada Rule of Civil Procedure 56, the Court shall grant summary judgment when there are no genuine issues of material fact as to a given claim or defense. NRCP 56. A party moving for summary judgment must support its assertion that there are no genuine issues of material fact by referring to particular materials in the record, or by showing that the materials cited by an opposing party do not establish the presence or absence of a genuine issue. NRCP 56(c). When ruling on a motion for summary judgment, the Court may consider all materials in the record, not just those cited in the parties' briefs. NRCP 56(c)(3). Although the Court reviews the pleadings and other proof in the light most favorable to the nonmoving party, the nonmoving party must still show "by affidavit or otherwise [...] specific facts

demonstrating the existence of a genuine issue for trial or have summary judgment entered against him." Wood v. Safeway, Inc., 121 Nev 724, 729-731 (2005).

In this Motion, Defendants claim that there is no genuine issue of material fact as to the applicability of the "trauma cap" statute, NRS 41.503. The "trauma cap" statute states that a covered hospital, hospital employee, physician, or dentist ("medical professional") as defined under NRS 41.503(1) who

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

NRS 41.503(1).

This limitation on liability does not apply to any act or omission by the medical professional which occurs after the patient is stabilized and capable of receiving treatment as a non-emergency patient, nor does it apply if the act or omission by the medical professional is unrelated to the original traumatic injury. NRS 41.503(2).

For purposes of the statute, a traumatic injury is defined as "any acute injury which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities." NRS 41.503(4)(b). All parties agree that the decedent in this case, Douglas Schwartz, was hit by a car on June 22, 2016, which led to him being brought via ambulance to NNRH. Defendants contend that Schwartz suffered a traumatic injury from this car accident, to wit: a bilateral flail chest injury. Plaintiff contends that Schwartz did not have a flail chest injury. All parties agree that a bilateral flail chest injury is life-threatening. Both Plaintiff and Defendants cite to various doctors' affidavits and medical opinions as to whether Schwartz had a flail chest injury or not.

In support of her assertion that Schwartz did not suffer a traumatic injury or that he was otherwise stabilized before Garvey attended to him, Plaintiff cites to observations made by herself and hospital staff that Schwartz was alert and oriented to person, place, and time after being admitted to the hospital; the fact that the ambulance taking Schwartz to the hospital did not have its emergency lights on and was driving

at or below the speed limit; and that, prior to Schwartz meeting with Garvey, NNRH's patient record for Schwartz indicated that his vital signs, airway, heart rate, and breathing were all within normal limits.

Defendants cite to Schwartz's radiology findings, to his low oxygen saturations, to Garvey's own observations of Schwartz's breathing pattern, and to Garvey's decision to send Schwartz to the University of Utah's trauma center via air ambulance to support their assertion that Schwartz had suffered a life-threatening, and therefore traumatic, injury from the car accident.

There are even contradictory statements as to whether Schwartz was talking and laughing after being admitted to the hospital: Plaintiff contends that she and some members of NNRH hospital staff saw and heard him doing so, while Defendants' expert, Dr. David Barcay, opines that Schwartz could not possibly have been doing so while wearing a full-face mask and struggling to breathe from the flail chest injury.

As Defendants and Plaintiff have both supported their versions of the state of Schwartz's injuries at the time he was brought to NNRH with reference to materials in the record, the Court finds that a genuine issue of material fact exists as to whether the decedent suffered a traumatic injury, and thus there is also a genuine issue of material fact as to whether the trauma cap applies.

THEREFORE, the Motion for Partial Summary Judgment is DENIED. Further, as there remains a genuine question as to whether the trauma cap statute applies, NNRH's Motion that all of Plaintiff's Claims against Northeastern Nevada Regional Hospital are Subject to the Requirements and Limitations of NRS 41.503 (the "Trauma" Statute), is also DENIED. As the Court is denying Defendants' partial summary judgment motion on grounds unrelated to Plaintiff's two attached declarations, Defendants' motions to strike those declarations are also DENIED as moot.

DATED this 2nd day of June, 2021.

KRISTON N. HILL
District Judge / Dept. 1

CERTIFICATE OF MAILING

Pursuant to NRCP 5(b), I hereby certify that I am an employee of the Fourth Judicial District Court, Department 1, and that on this 3rd day of June, 2021, I deposited for mailing in the U.S. mail at Elko, Nevada, postage prepaid, a true file-stamped copy of the foregoing order to:

Sean K. Claggett, Esq.
Jennifer Morales, Esq.
CLAGGETT & SYKES LAW FIRM
4101 Meadows Lane, Suite 100
Las Vegas, NV 89107

Casey W. Tyler, Esq.
James W. Fox, Esq.
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Keith A. Weaver, Esq.
Danielle Woodrum, Esq.
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8329 W. Sunset Rd., Suite 260
Las Vegas, NV 89113

EXHIBIT C

EXHIBIT C

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

Case No. CV-C-17-439

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 SETH P. WOMACK, MD FAAEM

[via web videoconference]

Taken on Monday, March 1, 2021
by a Certified Court Reporter
At 9:01 a.m.

Reported by: Ellen A. Goldstein, Nevada CSR 829

12:10 a.m. after Dr. Garvey had made the decision to intubate and had begun assembling his team and equipment to do so. Pre-oxygenation with a non-rebreather is a part of this process. The Reach team arrived and observed this assembly per the medical record.

Dr. Garvey testified, page 113 of his deposition, that intubation was already planned before talking to Dr. Ray; hence the reason Dr. Garvey asked Reach to come early and was already preparing to intubate. Mr. Schwartz's pulse ox readings were stable and within normal limits for what is expected in a trauma patient with rib fractures and a pneumothorax.

Reach arrived at 11:57 p.m. during which the time -- during which time the team and equipment is being assembled in the room and Garvey is getting off the phone with Dr. Ray. Ronnie Lyons testified he said he was going to intubate after he hung up the phone.

Mr. Schwartz was 97 percent on a non-rebreather at 12:10 a.m. for pre-oxygenation, not for respiratory deterioration.

No. 10, Dr. Barcay's opinion of objective proof using an alveolar arterial oxygen ratio is based on the flawed assumption that Mr. Schwartz was receiving exactly 40 percent oxygen with a venturi mask and a hundred percent oxygen with a non-rebreather mask. The amount

just going to review some parts of Dr. Lineback's deposition and ask you whether you agree with his testimony or not.

On page 92 of Dr. Lineback's deposition I asked him: "Question: You don't have any quarrel, would you, over the fact that Mr. Schwartz was transferred to a trauma center, do you, was going to be transferred to a trauma center?"

Dr. Lineback said no.

"Question: It was a wise decision, don't you agree, to call University of Utah, request transfer, and for that transfer to be objected [sic]?"

Then Ms. Blazich had an objection.

And the witness, Dr. Lineback, said: "I agree with that."

Do you agree with Dr. Lineback's testimony that it was appropriate and a wise decision for Dr. Garvey to believe Mr. Schwartz needed to be transferred and to arrange for that transfer?

A I have no criticisms of Dr. Garvey's decision to transport Mr. Schwartz to a trauma center.

Q Why do you think that was a wise decision on Dr. Garvey's part?

MS. BLAZICH: Objection; form.

THE WITNESS: He had traumatic injuries.

BY MR. WEAVER:

Q What is it about the fact that Mr. Schwartz had traumatic injuries that caused Dr. Garvey to exercise good judgment in transferring him?

MS. BLAZICH: Objection; calls for speculation.

THE WITNESS: Mr. Schwartz's injuries and his possible injuries that -- the ones that were there and maybe were or were not there, it was appropriate for him to be transferred to a trauma center. This was a traumatic injury.

BY MR. WEAVER:

Q Do you think most emergency-medicine physicians acting reasonably would have done what Dr. Garvey did, which was arrange for transfer?

MS. BLAZICH: Objection; calls for speculation.

THE WITNESS: Yes.

BY MR. WEAVER:

Q When you're testifying against emergency-medicine physicians in medical-malpractice cases, is it fair to say, Dr. Womack, that one of your mantras is, quote, "Emergency-medicine physician has a duty to rule out potentially life-threatening conditions"?

A I wouldn't call it a mantra. I do think that's a duty of emergency-medicine physicians.

Q Have you performed endotracheal intubation of a patient using RSI techniques?

A Yes.

Q On about how many occasions?

A Hundreds.

Q Have all of your opinions here today been to a reasonable degree of medical probability?

A Yes.

Q I don't have any other questions.

MR. WEAVER: Shirley, how much time do I have left per your allowance?

MS. BLAZICH: About eight minutes.

MR. WEAVER: Okay, thank you.

FURTHER EXAMINATION

BY MR. WEAVER:

Q Dr. Womack, do you agree Mr. Schwartz had major trauma?

A No. Mr. Schwartz had trauma. Mr. Schwartz had traumatic injuries.

Q Right, but Advanced Trauma Life Support principles classify into categories; right? They don't just say trauma is trauma is trauma is trauma. They classify it into categories. Do you understand that?

A I currently don't remember those categories.

EXHIBIT D

EXHIBIT D

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

****

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

VS NO: CV-C-17-439

DAVID GARVEY, M.D., an individual, TEAM HEALTH HOLDINGS, INC., d/b/a RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., d/b/a NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada, REACH AIR MEDICAL SERVICES, LLC, DOE BARRY, R.N., DOES I through X, ROE BUSINESS ENTITIES XI through XX, inclusive.

****

DEPOSITION OF JONATHAN BURROUGHS, MD

This virtual videoconference deposition taken by agreement of counsel, on March 15, 2021, commencing at 12:09 p.m.

My concern in that whole section, (audio glitch) so we can put this in proper context is that trauma is a team-based specialty. If you read anything about trauma in the literature of the American College of Surgeons, et cetera, it is team-based, and that was my concern in this particular case is basically, you have a trauma, which was a moderate trauma, run by an emergency physician, assisted by a paramedic and nurses, and I didn't see a whole lot of people involved in it.

That was the point I was trying to make the entire part of my report. When you become certified, it is not the certification that is important, frankly, whether you are labeled a level 3 or level 4, et cetera. That is not the issue. What is important is that you learn to do team-based care. Because what you do, you learn to rely on other specialties, other areas of expertise that elevate your care and performance. That is the main issue I want to get at in this

Trauma team activation is something that does not happen every day. You don't have to staff for trauma team activation every day. What happens is, and I will give you my hospital as an example that I worked at years ago, we were a 25-bed hospital, less than half the size of your hospital, and by the way, our community only had 3,500 people, although we drew from an area 20,000 people. We were smaller than you were.

Now, did the surgeon hang out every day at the hospital for trauma? No, not at all. They were on call. But when I got a significant trauma, and I would describe Mr. Schwartz as a moderate trauma, when we got a moderate trauma, we would activate the trauma team, which means the surgeon would come in from home. The nurse anesthetist would come in from home. The respiratory therapist would come in from home. They would be on call at home, day or night, and they would come in, and we would have a team-based approach to patients like Mr. Schwartz.

This was a trauma. Where was the surgeon? There was a surgeon on call 24/7. In fact, your client's website advertises about all of its wonderful surgical specialties that are represented there, which I was very impressed with.

Where were they? They should have been front and center. So a general surgeon is more than qualified to manage trauma at a community-based hospital. You do not need a subspecialty trauma surgeon to do that.

Q Dr. Burroughs, in terms of the trauma surgeon, you would agree a trauma surgeon spends additional years training for trauma fellowship in comparison to a general surgeon, true?

A True, and they work at a quaternary or tertiary care center like the University of Utah or University or the University of Nevada at Las Vegas, and they see the worst of the worst of the worst.

What you want out of a general surgeon is someone who can stabilize traumatic

who is called in by Dr. Garvey, and say, I have someone coming in who may have a bunch of fractured ribs, who may have a head injury, who may have a chest or abdominal injury. I would like you to see the patient with me.

That is what such a protocol would have required. I can tell you, having practiced emergency medicine for 30 years, every time we had a patient like Mr. Schwartz come in, I always called in the general surgeon to evaluate the patient with me.

Q So it is the emergency room physician that decides if it is a trauma, and I believe the words you used is moderate trauma versus severe trauma, who makes that decision and who decides a surgeon should come in, true?

A No, you are misstating my testimony. Again, you are good at that, Counselor. I will have to learn from you.

What I said was you have a policy, a policy that guides physicians in decision-making. Think of a doctor as an automobile on a highway in Nevada. You have

you have any clinical administrative opinions on whether or not Mr. Schwartz' death met the Nevada statutory definition of a sentinel event?

A That is an easy one because that is far broader than the Joint Commission. The Joint Commission, you are going to have to debate whether you follow the natural course of the illness or not, and of course, defense experts are going to want to say yes, and plaintiff experts are going to want to say no. I get that. I will let them duke it out.

Under the Nevada statute, it is easy. A 58 year old died from moderate trauma because of massive aspiration. That has to be reported 100 percent. I don't think anyone would interpret that statute as to say we don't have to report this one. It is definitely a sentinel event as defined by the State of Nevada.

Q Have you seen any evidence in this case to show that NNRH did, in fact, report Mr. Schwartz' death as a sentinel event?

Mr. Schwartz had serious traumatic injuries. I am going to let the clinical experts duke it out. All I am going to say for the record as a fact witness, I took care of hundreds of people like Mr. Schwartz when I was in clinical practice, and I handled them with the general surgical staff in our critical access rural hospital.

Required intubation and chest tube placement, I am going to again let the experts duke that out. I have my own personal opinions based on my own personal experience. I will let them duke it out.

Required a trauma surgeon. No, he did not require a trauma surgeon. He required a surgeon skilled in trauma. That is different.

Transferring Mr. Schwartz was the only option. It is not the only option. Dr. Womack would not have written what he did in his expert report if that was the only option.

The traumatic injuries were a significant risk to life. I will let the

activation. Are you aware of that?
A Yes, I am.
Q So what would, based on his injuries, what was his criteria?
A He had --
Q First of all -- go ahead, sorry.
A He had moderate trauma. He had moderate trauma. He had the fractured ribs. He had the question of a head injury with minor galeal injuries. He had a minor abdominal injury, et cetera. So I would classify him as moderate trauma for the American College of Surgeons, and they should activate -- they should have activated some type of team-based approach where the general surgeon came in, nurse anesthetist came in, like a respiratory therapist came in, et cetera, to assist Dr. Garvey in the care of the patient, because I felt that Dr. Garvey should not have been there alone. He shouldn't have been there with a paramedic managing that case alone at that point in time.
Q Sure. You don't sound familiar with the term

EXHIBIT E

EXHIBIT E

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)

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

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?

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

EXHIBIT F

EXHIBIT F

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 defomity/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

EXHIBIT G

EXHIBIT G

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:

EXHIBIT H

EXHIBIT H

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

DIANE SCHWARTZ, individual and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased, Plaintiff, vs. DAVID GARVEY, M.D., an individual; 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.	Case No. CV-C-17-439 Dept. No. 1

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

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.

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.

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?

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,

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

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.

EXHIBIT I

EXHIBIT I

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

EXHIBIT J

EXHIBIT J

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

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

Plaintiff,

vs.

NO. CV-C-17-439

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, etc., et al.,

Defendants.

DEPOSITION OF DIANE SCHWARTZ

LAS VEGAS, NEVADA

VOLUME 1

REPORTED BY:
KENDALL D. HEATH
NEV. CCR NO. 475
CALIF. CSR NO. 11861
JOB NO.: 2959290
PAGES 1 - 163

Q Did he talk to the nurses, the police officer?

A Well, not really. The only one thing that I do remember about the police officers, Doug was at one point, he started saying that he felt nauseous. They were asking him how much he eaten and drank that night, so he told them he just ate a steak and baked potato and salad, and had several refills of soda or couple refills of soda. And he was also complaining that he needed to go to the bathroom. So they were trying to help him. They were like, "Hang tight, and we'll let you relieve yourself in a minute."

So the police officer when Doug started complaining about being nauseous was trying to find some kind of a pan he could throw up in, if he had to.

Q Did he find some type --

A Yeah, he just found a pan and just sat it next to the bed.

Q Did Doug ever throw up?

A No. It subsided.

Q Do you recall the police officer's name?

A I want to say Shane Daz, but I might be wrong. I'm probably wrong. I should have reviewed all this stuff, sorry.

Q About how long between the time that the

right?

A Yes, yes.

Q What I handed you is, it's called a "Consent for Services and Financial Responsibility." You see that?

A Uh-huh.

Q At the bottom right-hand corner we've got Bates numbers. And the Bates numbers on this are the page numbers, and this one is NEN000030, and it goes through NEN40.

I just wanted to, if you could, turn to page 32 of that document. Right there.

A Uh-huh.

Q Before I go on, do you remember signing this record?

A No. Obviously I did, but ...

Q And you say obviously you did. Why do you say that?

A Because it's my signature, but I mean, you just sign papers when they bring them.

Q That's what I wanted to know. Is the signature on page 32, is that indeed your signature?

A Yes.

Q But you don't have a recollection of actually signing this document?

EXHIBIT K

EXHIBIT K

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

---o0o---

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

Plaintiff,

vs. Case No. CV-C-17-439

DAVID GARVEY, M.D., an individual; BARRY BARTLETT, et al., Dept. No. 1

Defendants.

_____/

VIDEOTAPED DEPOSITION OF BARRY AMOS RAY BARTLETT

DECEMBER 20, 2019

RENO, NEVADA

Reported by: JULIE ANN KERNAN, CCR #427, RPR

Job No. 581741

A In 1983.

Q Any lapses in that certification?

A Never.

Q Are there different rankings for paramedics?

A There are not.

Q Can you tell me five years prior to 2016 where you worked as a paramedic?

A American Medical Response.

Q Anywhere else?

A No.

Q So you went from AMR to Reach Air? Or were you working for both?

A I was working for both.

Q How long did you work for both companies?

A For AMR, close to 19 years. And for Reach, close to six months.

Q When did you begin working for Reach Air?

A In March or April, 2016.

Q And how did you come to find Reach Air or did they find you?

A I forged around and Reach, since they were a new program in California, I worked with a lot of their crew members because many of them worked on our team.

Q And back in June of 2016, what -- can you tell me what your schedule looked like between the two

EXHIBIT L

EXHIBIT L

In the Matter Of:

Schwartz, Diane, et al. vs Garvey, David, M.D., et al.

RONNIE JAY LYONS

August 19, 2020

Job Number: 641397

10:40:02 A. Yes.

10:40:02 **Q. When did you work for Reach Air?**

10:40:11 A. April 2015 to August 2018.

10:40:24 **Q. In April 2015, was it Reach Air or was it a**
10:40:28 **different company?**

10:40:29 A. The -- I've actually been through four buyouts
10:40:33 down there. Summit was the company I worked for before
10:40:36 Reach bought them. So I was part of the crew that came
10:40:39 over from Summit to Reach.

10:40:40 **Q. Summit Air Ambulance?**

10:40:42 A. Correct.

10:40:44 **Q. When was that that you came over to Reach from**
10:40:49 **Summit Air Ambulance?**

10:40:51 A. I believe April of 2015 is when the buyout was
10:40:55 official. It started a few months before.

10:40:57 **Q. And then once you began working for Reach Air,**
10:41:02 **did you continue to work for Reach until August of 2018?**

10:41:07 A. Yes.

10:41:08 **Q. There was no other buyout after?**

10:41:11 A. No.

10:41:12 **Q. All right. Would you mind briefly giving me**
10:41:17 **your educational history, starting with finishing high**
10:41:21 **school and any post high school education and training**
10:41:24 **that you've had.**

10:41:24 A. Uh-huh. Finished high school at Hobbs High in

EXHIBIT M

EXHIBIT M

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: 05/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: CARVEY 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 Pa... Deane 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

Deas

SCHWARTZ DOUGLAS P HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 00033096?7 PT #: 6139781

EXHIBIT N

EXHIBIT N

BURROUGHS

HEALTHCARE CONSULTING NETWORK

EXPERT REPORT

In the matter of

Dianne Schwartz, individual and as Special Administrator of the Estate of Douglas R. Schwartz, Deceased;

v.

PHC-Elko Inc. d/b/a/ Northeastern Nevada Regional Hospital, David Garvey, MD, Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine; Reach Air Medical Services LLC., Does I through X, Roe Business Entities XI through XX inclusive

Prepared for

Shirley Blazich, Esq.
Claggett & Sykes Law Firm
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107

November 5, 2020

Jonathan H. Burroughs, MD, MBA, FACHE, FAAPL
President and CEO, The Burroughs Healthcare Consulting Network, Inc.

TABLE OF CONTENTS:

A. Professional Training and Background of

Jonathan Burroughs, MD, MBA, FACHE, FAAPL, Healthcare professional with:

- **30-year experience as an emergency physician**
- **16-year management experience as medical director of three emergency departments and increasing physician leadership roles**
- **9-year experience on a governing board of a not for profit healthcare entity**
- **16-year experience as a healthcare consultant with > 1,500 clients in all 50 states focusing on all areas of the physician/healthcare executive interface, population health, clinical integration, and healthcare transformation**
- **Author of "Redesign the Medical Staff Model-A Collaborative Approach" published in 2015 by Health Administration Press and winner of the 2016 James A. Hamilton Award for outstanding healthcare management book of the year**
- **Author/Editor of "Essential Operational Components for High Performing Healthcare Enterprises" published by Health Administration Press in 2019 and winner of the 2020 James A. Hamilton Award for outstanding healthcare management book of the year**
- **Participant as a healthcare administrative expert in 130 legal cases since 2010 (see attached CV for details)**
- Johns Hopkins University, Baltimore, MD (BA-1972; graduated first in class senior year)
- Case Western Reserve School of Medicine, Cleveland, OH (MD-1977)
- University of California, Davis Medical Center, Sacramento, CA (Resident in Family Medicine-1977-1980)
- University of Massachusetts Affiliated Hospitals, Pittsfield, MA (Resident in General Surgery-1980-1981)
- Board Certified Emergency Physician (1981-2008) with 30 years of clinical experience (1978-2008)
- Medical Director, Emergency Departments (1982-1988; 2006-2008)
- Faculty, Director's Academy, American College of Emergency Physicians (ACEP)
- Introduced EMS defibrillation (1982) and EMS automated defibrillation (1985) into the field (Eastern US) in conjunction with Mickey Eisenberg, University of Washington, Seattle, PhysioControl, and Dartmouth Hitchcock Medical Center
- President of the Medical Staff, Memorial Hospital, North Conway, NH (2000-2004)
- Past President of the Medical Staff, Memorial Hospital, North Conway, NH (2004-2008)
- Board Member, Memorial Hospital, North Conway, NH (2000-2008)
- American Association for Physician Leadership (formerly American College of Physician Executives), Tampa, FL (Certified Physician Executive 2004 and Fellow of the American College of Physician Executives 2005-)
- Faculty, American Association for Physician Leadership (formerly American College of

Physician Executives) (2005-)

- University of Massachusetts Eisenberg School of Business, Amherst, MA (MBA 2008; graduated first in class and elected into Beta Gamma Sigma, international honor society for business schools)
- Senior Consultant and Director of Education, The Greeley Company, Danvers, MA (2004-2012): worked with over 700 healthcare organizations and medical staffs to perform the following functions- physician leadership training (top rated educator and speaker), bylaws redesign, credentialing/privileging redesign, peer review redesign, medical staff assessment and redesign, physician-hospital alignment strategies, physician-hospital contracting, alternative dispute resolution, expert witness for corporate negligence cases (credentialing/privileging, peer review, performance management, corrective action and fair/judicial hearings), coaching for physicians and management regarding performance management, behavioral, and health issues, OPPE/FPPE, accreditation compliance, legal/regulatory compliance, author or co-author of the following books: *The Complete Guide to FPPE (2012), Medical Staff Leadership Essentials (2011), Engage and Align the Medical Staff and Hospital Management: Expert Strategies and Field Tested Tools* (2010), *A Practical Guide to Managing Disruptive and Impaired Physicians* (2010), *The Top 40 Medical Staff Policies and Procedures,* Fourth Edition (2010), *Emergency Department On-Call Strategies: Solutions for Physician-Hospital Alignment* (2009), and *Peer Review Best Practices: Case Studies and Lessons Learned* (2008).
- Fellow of the American College of Healthcare Executives (2012-)
- Faculty of the American College of Healthcare Executives (2013-), faculty for twelve hour cluster program "Redesign the Medical Staff for Healthcare Reform", and winner of a national development grant (with David Nash, MD) to create a twelve hour cluster program entitled "Leading in a Changing Environment-Population Health" and of a development grant with John Byrnes, MD and Rich Priore, FACHE to create a twelve hour cluster program entitled "Physician Leadership Essentials-Management Skills", frequent national speaker at ACHE Congress, Chicago, Illinois. Produced with Rich Priore a new national program entitled "Integrating Finance and Quality in a Pay for Value Era"
- NAMSS Faculty with national programs on OPPE/FPPE, Managing Physician Impairments, Physician Re-Entry, The Impact of Pay for Value on Credentialing and Privileging, Introducing New Technology/Privileges, Best Practices in Physician Engagement and Alignment (2011-)
- President and CEO, The Burroughs Healthcare Consulting Network, Inc. (2012-): work with physicians and healthcare organizations throughout the nation and beyond on clinical, management, governance, and business solutions to optimize quality/service and minimize costs. Network includes: Kathleen Bartholomew, RN, MSN, Steve Berger, CPA, Joe Bujak, MD, FACPE, Steve Berger, CPA, FACHE, Chip Caldwell, FACHE, Michael

Callahan, JD, Nathan Kaufman, Ken Mack, FACHE, John Nance, JD, Peter Stille, and Alan Zuckerman, FACHE

- Cumulative work with over 1,500 healthcare organizations and systems in 50 states on: physician leadership academies, physician engagement/alignment strategies, physician performance strategies, medical staff redesign (credentialing/privileging, peer review, performance management, strategic medical staff development planning, medical staff structures/functions, medical staff and corporate bylaws), service line development, contracting strategies, population health, quality/safety/service/cost structure optimization, leadership (board, management, physician) retreats and facilitations, population health, clinical integration
- Author of monthly national healthcare blog on Hospital Impact, a Fierce Healthcare Publication, Washington, DC
- Frequent contributor to Board Room Press, a publication of The Governance Institute, San Diego, California
- Healthcare Legal Consulting with an emphasis in: negligent credentialing, negligent peer review, fair/judicial hearings, physician performance management, medical appropriateness.
- JD Candidate, Concord Law School, Los Angeles, California (2020-2024)
- Member of the American Health Lawyers Association (AHLA): presenter and contributor to association publications and American College of Legal Medicine (ACLM).

B. Recent Publications:

1. Burroughs, Jon (editor and author), "Essential Operational Components for High Performing Healthcare Enterprises," Health Administration Press, September, 2018.
2. Burroughs, Jon., "Redesign the Medical Staff Model-A Collaborative Approach," Health Administration Press, November,2015(Winner of the 2016 James A. Hamilton Award for Outstanding Healthcare Management Book)
3. Burroughs, Jon, "Surviving and Thriving in the Post-COVID Era: Five Steps for Reinventing Rural Healthcare," The Governance Institute Rural Focus, September, 2020, pages 1-3.
4. Burroughs, Jon, "Key Operational Success Factors," Healthcare Executive, volume 34, number 6, pages 34-36, November-December, 2019.
5. Burroughs, Jon, "Creating a Primary Care Model for the 21st Century," Governance Institute System Focus, November, 2019.
6. Burroughs, Jon, "Aligning Physician Compensation in a Pay for Value Era," Governance Institute E-Briefings, Volume 16, No. 3, May, 2019, pages 1-3.
7. Burroughs, Jon, "Aligning Physician Compensation with Payer Contracts and your Organization's Strategic Objectives," Journal of Healthcare Compliance, May-June, 2019.
8. Burroughs, Jonathan H., "21st Century Skills for Accountable Boards," The Board Room Press, The Governance Institute, February 2019.
9. Burroughs, Jon, "How to Build a Population Health Program," Pediatric Focus, The Governance Institute, December, 2018.
10. Burroughs, Jon, "Rethinking Physician Documentation," Healthcare Executive, May-June, 2018, pages
11. Burroughs, Jon, Rural Focus: "Rural Healthcare: A Vision for 2018, The Governance Institute, March, 2018.
12. Burroughs, Jonathan H., Industry Voices: "The ACA is Flawed but a New Legal Threat could set the US Healthcare System back Decades," Fierce Healthcare, February 28, 2018.
13. Burroughs, Jonathan H., Hospital Impact: "Medicaid on the Chopping Block for 2018." Fierce Healthcare, February 6, 2018.
14. Burroughs, Jonathan H., Hospital Impact: "Why Funding of the Children's Health Insurance Program Matters," Fierce Healthcare, January 9, 2018.
15. Burroughs, Jonathan H., Hospital Impact: "Why Doctors should Oversee, Not Conduct Clinical Documentation, Fierce Healthcare, December 7, 2017.
16. Burroughs, Jonathan H. et al,"ACHE Roundtable: A focus on Physician Leadership," Healthcare Executive, volume 32, number 6, November/December, 2017, pp 20-26.
17. Burroughs, Jonathan H., Hospital Impact: "Medical Staff Services Professionals-A New Role for the 21st Century," Fierce Healthcare, August 31, 2017.
18. Burroughs, Jonathan H., Hospital Impact: "Death of the Skinny Repeal Bill and why Covered Lives Matter," Fierce Healthcare, August 3, 2017.
19. Burroughs, Jonathan H., Hospital Impact: "What's Next for the AHCA? Hopefully, pragmatic solutions to healthcare policy dilemmas," Fierce Healthcare, June 8, 2017.
20. Burroughs, Jonathan H., Hospital Impact: "The Meadows-MacArthur Amendment is Strike Two for the American Health Care Act", Fierce Healthcare, May 1, 2017.
21. Burroughs, Jonathan H., "What it takes to be a Top Performing Organization," NAMSS Synergy, May-June, 2017.
22. Burroughs, Jonathan H., "Hospital Impact-CBO Report Reveals Republican Healthcare Bill is Political Position," Fierce Healthcare, March 16, 2017.
23. Burroughs, Jonathan H., "Hospital Impact-A Closer Look at the GOP's 'Replace then Repeal' Proposal, Fierce Healthcare, February 22, 2017.
24. Burroughs, Jonathan H., "Hospital Impact-No Consensus in Sight for the Republican ACA Replacement," Fierce Healthcare, February 2, 2017.
25. Burroughs, Jonathan H., "Hospital Impact-The Implications of Donald Trump's ACA Executive Order," Fierce Healthcare, January 25, 2017.
26. Burroughs, Jon, "Regain Lost Luster with Modern Medicine Ideas," Physician Leadership Journal, Volume 4, Issue 1, January/February, 2017.
27. Burroughs, Jonathan H., "Hospital Impact-Drug Companies Win, Patient Safety Loses with the 21st Century Cures Act, Fierce Healthcare, December 15, 2016.
28. Burroughs, Jonathan H., "Hospital Impact-Why the GOP will not Repeal the Affordable Care Act in its Entirety," Fierce Healthcare, November 16, 2016.
29. Burroughs, Jonathan H., "Industry Voices: For President Candidates, Two very Different Views on Healthcare, Fierce Healthcare, November 7, 2016.
30. Burroughs, Jonathan H., "Three Keys to Giving Healthcare Consumers what they Want,"

Hospital Impact, September 26, 2016.
31. Burroughs, Jonathan H., "Everything you need to know about the New CMS Cardiac Bundled Payment Program," Hospital Impact, August 17, 2016.
32. Burroughs, Jonathan H., "Healthcare Policy Implications of the Presidential Election," Hospital Impact, July 14, 2016.
33. Burroughs, Jonathan H., "MACRA is Now! A Roadmap to Compliance," Hospital Impact, June 15, 2016.
34. Burroughs, Jonathan H., "End Physician Burnout by Allowing Doctors to be Doctors Again," Hospital Impact, May 12, 2016.
35. Burroughs, Jonathan H., "Clinical Pharmacist-An Essential Member of the Healthcare Team," Hospital Impact, April 21, 2016.
36. Burroughs, Jonathan H., "When it comes to Patient Safety-Culture is Everything," Hospital Impact, March 17, 2016.
37. Burroughs, Jonathan H., "How MACRA is Hastening the Demise of Fee for Service," Hospital Impact, February 18, 2016.
38. Burroughs, Jonathan H., "The Ten Traits of a Great Healthcare Organization," Hospital Impact, January 21, 2016.
39. Burroughs, Jonathan H., "Five Steps to Staging and Integrating a Population Health Program," Hospital Impact, December 10, 2015.
40. Burroughs, Jonathan H., "The Supreme Court and the ACA Contraception Mandate-Deja Vu All over Again," Hospital Impact, November 12, 2015.
41. Burroughs, Jonathan H., "ICD-10: Collaborative Ways to Reduce Operating Costs," Hospital Impact, October 29, 2015.
42. Burroughs, Jonathan H., "Medical Overuse and why Fee for Service must Go," Hospital Impact, September 3, 2015.
43. Burroughs, Jonathan H., "Medicare's Potential Reimbursement for End of Life Discussion: A Big Step Forward," Hospital Impact, July 23, 2015.
44. Burroughs, Jonathan H., "Ken Cohn- In Tribute to a Colleague and a Friend," Hospital Impact, July 16, 2015.
45. Burroughs, Jonathan H., "Activity Base Costing Helps Providers Deliver High Quality Low Cost Care," Hospital Impact, May 20, 2015.
46. Burroughs, Jonathan H., "Strategies to Survive a Brave New Value Based World," Hospital Impact, April 1, 2015.
47. Burroughs, Jonathan H. and Nash, David, "Population Health and the Disruptive Innovative Business Models Necessary to Support It," Boardroom Press, April 2015
48. Burroughs, Jonathan H., "Are you ready for E-Health Invasion?" Hospital Impact, February 19, 2015.
49. Burroughs, Jonathan H., "How the Unraveling of the Affordable Care Act could Affect Providers," Hospital Impact, January 14, 2015.
50. Burroughs, Jonathan H., "Ebola-Fear not Facts Drive Frenzy," Hospital Impact, November 13, 2014.
51. Burroughs, Jonathan H., "St. Luke's Population Health Programs Promote Innovation," Hospital Impact, October 23, 2014.
52. Burroughs, Jonathan H., "Silence can Kill: Doctors, Nurses, and Staff must hold each other Accountable," Hospital Impact, September 4, 2014.
53. Burroughs, Jonathan H., "Disruptive Innovation in Healthcare: Are you ready?" The Governance Institute's E-Briefings, Volume 11, Number 7, September, 2014.
54. Burroughs, Jonathan H., "Involving Physicians in Strategic Planning," Hospital Impact, August 6, 2014.
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1. Complaint (Medical Malpractice and Wrongful Death) (6/22/17)
2. Affidavit of Kenneth N. Scissors, MD, General Internist (6/21/17)
3. Amended Complaint (Medical Malpractice and Wrongful Death) (10/20/17)
4. Second Amended Complaint (Medical Malpractice and Wrongful Death) (2/12/18)
5. Errata to Plaintiff's Compliant, Amended Complaint and Second Amended Complaint (9/10/18)
6. Deposition of Susan Olson, RN, House Supervisor NNRH (3/4/19)
7. Deposition of Donna Kevitt, RN, Emergency Department Nurse, NNRH (3/4/19)
8. Deposition of Carmen Gonzalez, Emergency Department Admitting and Discharge Clerk, NNRH (3/4/19)
9. Deposition of Diane Schwartz (1/23/19)
10. Elko Police Department Reports and Investigation re Accident between Daniel Vasu and Douglas Schwartz (6/22/16)
11. Elk County Ambulance Records re Douglas Schwartz (6/22/16)
12. NNRH Medical Records re Douglas Schwartz (6/22/16-6/23/16)
13. Reach Air Medical Records re Douglas Schwartz (6/22/16-6/23/16)
14. Confidential Investigation by Elite Investigations (9/29/16)
15. Paid Medical Bills on behalf of Douglas Schwartz (6/22/16-6/23/16)
16. Workman's Compensation Claim Results re Douglas Schwartz (5/22/17)
17. Death Certificate re Douglas Schwartz (10/25/16)
18. Police Report and Autopsy re Douglas Schwartz (6/24/16)
19. Elko Federal Credit Union Pay Stubs for Douglas Schwartz (2013-2016)
20. Itemization of Funeral Costs for Douglas Schwartz (7/7/16)
21. Employment Agreement between Elko Federal Credit Union and Douglas Schwartz (2/23/15)
22. IRS Tax Returns for Douglas and Diane Schwartz (2013-2017)
23. Tributes to Douglas Schwartz (2016)
24. Plaintiff's First Supplement to Early Case Conference List of Witnesses and Production of Documents Pursuant to NRCP 16.1 (7/19/18)
25. Plaintiff Diane Schwartz, as Special Administrator of the Estate of Douglas Schwartz' Answers to Defendant David Garvey's First Set of Interrogatories (8/1/18)
26. Plaintiff Diane Schwartz, as Special Administrator of the Estate of Douglas Schwartz' Responses to Defendant David Garvey's First Set of Requests for Production (8/1/18)
27. Vanderbilt University Medical Center Division of Trauma and Surgical Critical Care Guidelines for Rapid Sequence Intubation (4/12)
28. Plaintiff Diane Schwartz' responses to Defendant Reach Air Medical Services' First Set of Interrogatories, Requests for Production and Requests for Admission (11/13/18)
29. Defendant Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine's Answers to Plaintiff's First Set of Interrogatories (4/15/19)
30. Defendant Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine's Responses to Plaintiff's First Set of Request for Production of Documents (4/15/19)

31. Defendant Crum, Stefanko, & Jones LTC d/b/a Ruby Crest Emergency Medicine's First Supplemental Responses to Plaintiff's First Set of Request for Production of Documents (5/11/20)
32. Defendant Crum, Stefanko, & Jones LTC d/b/a Ruby Crest Emergency Medicine's First Supplemental Responses to Plaintiff's First Set of Request for Admissions (5/11/20)
33. Defendant Crum, Stefanko, & Jones LTC d/b/a Ruby Crest Emergency Medicine's First Supplemental Responses to Plaintiff's Second Set of Request for Production of Documents (5/11/20)
34. Defendant PHC-Elko, Inc. d/b/a Northeastern Nevada Regional Hospital's Motion that all Plaintiff's Claims against Northeastern Nevada Regional Hospital are Subject to the Requirements and Limitations of NRS 41.503 (The "Trauma" Statute)(2/12/18)
35. Defendant PHC-Elko, Inc. d/b/a Northeastern Nevada Regional Hospital's Motion that all Plaintiff's Claims against Northeastern Nevada Regional Hospital are Subject to the Requirements and Limitations of NRS 41.503 (The "Trauma" Statute) and all Joinders Thereto (7/14/20)
36. Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages (7/21/20)
37. Declaration of David Barcay, MD, FACEP, Emergency Physician
38. Deposition of Kathleen Jane Dunn, Senior Director of Clinical Operations, 30(b)(6) Designee of Reach Medical Services LLC (6/8/20)
39. Plaintiff's Second Amended Notice of Taking the Videotaped Deposition of PHC-Elko, Inc., d/b/a Northeastern Nevada Regional Hospital's N.R.C.P. 30(b)(6) Witnesses (6/30/20)
40. Deposition of Gary McCalla, MD, Medical Director, Reach Air Medical Services (6/8/20)
41. Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages and All Joinders Thereto (8/18/20)
42. Expert Report of Seth P. Womack, MD, Emergency Physician (8/17/20)
43. Plaintiff's Opposition to Defendant David Garvey, M.D.'s Motion to Strike the Declaration of Shirley Blazich Esq. and (2) Defendant David Garvey, M.D.'s Motion to Strike the Declaration of Seth Womack, MD, and any Joinders Thereto and Plaintiff's Countermotion for Leave to Amend the Complaint (9/9/20)
44. Third Amended Complaint (Proposed)
45. Provision of Care Event re Mr. Schwartz (6/24/16)
46. NNRH Code Blue Procedure and Crash Cart Maintenance Policy/Procedure (10/17)
47. NNRH Patient Safety Plan Policy/procedure (2/16)
48. Plaintiff's Third Amended Notice of Taking the Videotaped Deposition of Defendant PHC-Elko, Inc. d/b/a Northeastern Nevada Regional Hospital's N.R.C.P. 30(b)(6)Witness (9/17/20)
49. Defendant David Garvey, M.D.'s Response to Plaintiff's Improper Sur-reply to Partial Summary Judgment Motion and Request that the Court Disregards Plaintiff's Mislabeled and Untimely Motion for Reconsideration of this Court's October 16, 2019 Order Denying Leave to Amend with Prejudice (9/17/20)
50. Deposition of Ronnie Jay Lyons, RN, Reach Flight Nurse (8/19/20)
51. Defendant Crum, Stefanko, & Jones LTC d/b/a Ruby Crest Emergency Medicine's Answers to Plaintiff's Second Set of Interrogatories (5/11/20)
52. Deposition of Barry Bartlett, Paramedic, Reach Air (12/20/20)

53. NNRH Audit Trail for Douglas Schwartz (6/16-9/16)
54. NNRH EMTALA Policy/Procedure (2/16)
55. David Garvey, MD Credentialing File (2011-2017)
56. Deposition of David Garvey, MD, Emergency Physician (6/25/19)
57. NNRH Emergency Department Unassigned Call Schedule (6/7/16)
58. Response to Plaintiff's Third Set of Requests to Produce (9/24/20)
59. Northeastern Nevada Regional Hospital Medical Staff Bylaws (2/14)
60. NNRH Occurrence Report Policy/Procedure (4/16)
61. Privilege Log (6/16-7/16)
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64. Defendant David Garvey M.D.'s Reply in Support of Motion for Partial Summary Judgment to Statutorily Limit Damages (8/26/20)
65. Independent Contractor Agreement between Ruby Crest Emergency Medicine and David Garvey, MD (1/27/15)
66. Reach Medical Director Standard of Care Protocol (8/14)
67. Reach Pre-Hospital Care Report Douglas Schwartz (6/23/16)
68. Reach-Dr. Garvey Assistant Medical Director Agreement (5/28/15)
69. Reach Commercial General Liability Coverage Forms (2016-2017)
70. Reach Airway Algorithms
71. Reach C-Mac Video Laryngoscope Standard of Care Protocol
72. Reach Procedure, Endotracheal Intubation-Oral Protocol
73. Reach Procedure, Endotracheal Tube Introducer Protocol
74. Reach Procedure, LMA Supreme Insertion Protocol
75. Reach Rapid Sequence Intubation Procedure
76. Reach Standard Care for All Patients Protocol
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D. Introduction:

Ms. Blazich has asked me as a healthcare administrative expert to review the discovery materials for Dianne Schwartz, individual and as Special Administrator of the Estate of Douglas R. Schwartz, Deceased; v. PHC-Elko Inc. d/b/a/ Northeastern Nevada Regional Hospital, David Garvey, MD, Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine; Reach Air Medical Services LLC., Does I through X, Roe Business Entities XI through XX inclusive with regards to the corporate responsibilities of Northeastern Nevada Regional Hospital based upon a reasonable professional and administrative standard of care.

E. Expert Opinions:

Douglas R. Schwartz's death was the direct result of Northeastern Nevada Regional Hospital systems failures that included the following components:

I. **Northeastern Nevada Regional Hospital failed to participate in the American College of Surgeons Trauma program as a designated level III or level IV trauma center or have an organized trauma team to provide coordinated care for trauma patients which placed trauma patients such as Douglas Schwartz at significant and mortal risk**

II. **Northeastern Nevada Regional Hospital failed to have policies and procedures to guide clinicians in the appropriate method for elective non-emergent intubations which placed trauma patients such as Douglas Schwartz at significant and mortal risk**

III. **Northeastern Nevada Regional Hospital negligently supervised its organized medical staff members and nursing staff to ensure that they complied with nationally recognized evidence-based standards regarding the treatment of trauma patients and the performance of elective non-emergent intubations which placed trauma patients such as Douglas Schwartz at significant and mortal risk**

F. Foundations for Expert Opinions

Foundational Background:

Northeastern Nevada Regional Hospital is a 59-bed community hospital located in Elko, Nevada. It has a full complement of clinical services for a rural community hospital such as medicine, general surgery, anesthesia (staffed by nurse anesthetists), a full-service emergency

department, and an intensive care unit. It is well managed financially and has an approximately 9% margin on revenues of approximately $215 million. Unfortunately, its quality scores do not match and it has a two-star Medicare rating (out of five stars), a Leapfrog Safety Grade of "C" (average) (spring, 2020) with very low ratings in critical care, average "healthgrade" ratings with below average patient satisfaction, and an average complication rate for surgical procedures per propublica.com.

I. **Northeastern Nevada Regional Hospital failed to participate in the American College of Surgeons Trauma program as a designated level III or level IV trauma center or have an organized trauma team to provide coordinated care for trauma patients which placed trauma patients such as Douglas Schwartz at significant and mortal risk**

Foundation for Opinion:

Northeastern Nevada Regional Hospital has not chosen to participate in the American College of Surgeons Trauma or American Trauma Society trauma programs as either a level III or level IV trauma center. These programs have been in existence since the early 1980s and provide a framework for the safe and effective provision of trauma services no matter the size or scope of a healthcare facility. For instance, I have personally served as an emergency physician in several small rural facilities that sought and received level III trauma designations. Participation in these programs enables healthcare organizations to do the following:

A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.

Elements of Level III Trauma Centers include:

- 24-hour immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists.
- Incorporates a comprehensive quality assessment program.
- Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
- Provides back-up care for rural and community hospitals.
- Offers continued education of the nursing and allied health personnel or the trauma team.
- Involved with prevention efforts and must have an active outreach program for its referring communities

Northeastern Nevada Regional Hospital certainly has the resources and expertise to perform at this level with a 24-hour emergency department, general surgeon on call, nurse anesthetist on call, and an inpatient intensive care unit.

Even smaller healthcare facilities may become a Level IV Trauma Center which include:

- Basic emergency department facilities to implement ATLS protocols and 24-hour laboratory coverage. Available trauma nurse(s) and physicians available upon patient arrival.
- May provide surgery and critical-care services if available.
- Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
- Incorporates a comprehensive quality assessment program.
- Involved with prevention efforts and must have an active outreach program for its referring communities.

What makes these programs essential and important to provide a minimum administrative standard of care?

A. Trauma management is a "team" and not an "individual" discipline. As someone who practiced emergency medicine for over 30 years, I relied on members of a trauma team to both assist and, in many cases, take over aspects of care. The cliché is that the most qualified individual available to should handle that aspect of care. Emergency medicine has long progressed past the specialty of the "rugged individual" where one professional was expected to handle care when there are other and, in some cases, more skilled resources available.

In this case, there was a general surgeon available on call. Contrary to testimony by Dr. Garvey, a general surgeon (as opposed to a trauma surgeon typically found in larger medical and trauma centers) is vastly more experienced in the management of trauma than an emergency physician. I say this having taken care of tens of thousands of trauma patients over a 34-year period and working with hundreds of trauma and general surgeons. Emergency physicians have expertise in the initial evaluation and stabilization of trauma injuries; however, we have limited experience in the longitudinal care of trauma victims across the continuum of care and this is something that general surgeons excel at. They see trauma patients initially, take them to surgery to stabilize or repair injuries, admit them to the ICU or regular medical/surgical floor and then follow up with them post-discharge. This is a range of experience that emergency physicians (no matter how experienced) simply do not have. Therefore, it is imperative that general surgeons in an organization such as Northeastern Nevada Regional Hospital participate in trauma management of patients who may require transfer to a more sophisticated facility. Why was this so important in this case?

Mr. Schwartz arrived at NE Nevada Regional Hospital on June 22, 2016 with the following injuries as a result of a hit and run automobile accident:

- Abrasions of the right forehead
- Injury to right lateral chest wall with
- Abrasions to right elbow, biceps and knee
- Fractures of right 4^{th}-7^{th} ribs (with 4^{th} and 6^{th} ribs broken in two places)
- Bibasilar and perihilar opacities indicative of pulmonary contusions
- < 10% right pneumothorax
- Deformities of T10 and T11 pedicles (? Fractures)
- Two areas of focal subgaleal hemorrhage
- Normal vital signs
- Oxygen saturations > 90%
- Patient alert and oriented X 3

Having taken care of hundreds of patients like this, the majority of general surgeons would observe such a patient in a community hospital ICU and a minority of general surgeons would transfer such a patient to a higher level of care. It is necessary for a general surgical service to be available 24/7 to manage such a patient as the majority of patients with multiple rib fractures and pulmonary contusions do fine with conservative management and a small percentage get worse and must be intubated and transferred to a higher level of care.

The point of this discussion is not to render a "clinical expert opinion" but rather to point out from a healthcare administrative perspective that a qualified general surgeon is the one who should make the determination as to who should be transferred and who should stay based upon his/her commitment and willingness to manage such a patient locally. That is part of the point of a trauma team that involves all relevant clinical personnel. This is a team (and not individual) based decision that requires expertise and experience beyond the emergency physician's acumen.

Secondly, there was a nurse anesthetist available that evening on call. Again, contrary to Dr. Garvey's testimony, the average nurse anesthetist manages thousands of airways annually both in training and beyond and advanced airway management is the stock and trade of nurse anesthetists, particularly those in relatively rural areas like Elko, Nevada where they must manage the airway of everyone they see without the immediate availability of an anesthesiologist.

Dr. Garvey was complete unaware of the scope of practice and expertise of nurse anesthetists:

"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 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. Q Have you ever called in an anesthesiologist, the anesthesiologist or a nurse anesthetist to perform a high-risk intubation in the ER? A Never." (Deposition of Dr. Garvey, pages 128-129, page 133)

I personally practiced in rural-based emergency departments for 20 years and worked along side nurse anesthetists clinically, in an administrative capacity when I was President of the Medical Staff and Medical Director of three emergency departments and since 2004 as a national healthcare administrative consultant. I am personally familiar with credentialing and privileging criteria for nurse anesthetists, their scope of practice, the range of their skills and their specific abilities to the management of airways, both basic and advanced. And again, their basic skills go far beyond any emergency physician who may manage several airways per month, whereas a nurse anesthetist will manage hundreds and thousands of airways a year and has advanced training to utilize endoscopic laryngoscopes and other equipment utilized to manage problematic airways.

Unfortunately, the culture at Northeastern Nevada Regional Hospital was NOT to utilize these important clinical resources as indicated by Nurse Olson, the House Supervisor's testimony:

"There's the CRNAs, and they're a group so they take rotation. You know, they -- different ones are on call. Q And were they available all hours of the night for those calls? A Yes. Q Would they also be called in for emergency intubation procedures? A That would be up to the doctor's discretion. Q Have you ever heard of a nurse anesthetist providing anesthesia and doing an intubation in the emergency department? A No." (Deposition of Susan Olson, RN, pages 24-25, pages 27-28)

As will be seen in the next section of this report, there were basic and fundamental errors made in the intubation attempts of Mr. Schwartz that would have been avoided with a trauma team policy/procedure (designating roles and responsibilities), the involvement of nurse anesthetists in both the decision to intubate and in the intubation process itself, the immediate availability of a general surgeon to perform a tracheostomy (as opposed to a cricothyroidotomy) in the event of an airway failure during intubation and the organizational expectation that teams (and not individuals) manage moderate to complex trauma patients and not individual emergency physicians.

It is my healthcare administrative opinion that Mr. Schwartz's untimely death was the direct result of a lack of coordinated organization around the diagnosis, treatment, and management of trauma patients at Northeastern Nevada Regional Hospital, the lack of a trauma team, the lack of any involvement of an on-call general surgeon, and the lack of any involvement of an on-call nurse anesthetist.

II. **Northeastern Nevada Regional Hospital failed to have policies and procedures to guide clinicians in the appropriate method for elective non-emergent intubations which placed trauma patients such as Douglas Schwartz at significant and mortal risk**

Foundation of Opinion:

One of the major misrepresentations of this case is that Mr. Schwartz would more likely than not have died from his traumatic injuries and that he arrived at Northeastern Nevada Regional Hospital with immediately life-threatening injuries that placed him in critical condition and significant risk of death. The fact is that both causation experts and defendant testimony all testified and confirmed that Mr. Schwartz's cause of death was his significant aspiration of gastrointestinal contents as a direct result of the intubation attempts and not his original traumatic injuries per se:

"Q. From your experience as a medical examiner and as a physician, there is a high mortality rate associated with massive aspiration that involves occlusion of an airway, correct? A. Extremely high morbidity and mortality, yes." (Deposition of Katherine Raven, MD, Forensic Pathologist, pages 101)

"Q. **As you sit here today, if Mr. Schwartz had not experienced a massive aspiration, if we took that component out of your autopsy, do you have an opinion one way or the other as to whether Mr. Schwartz would have survived these other injuries? A. So if I took the aspiration out, I have no other fatal mechanism from the injury or the traffic accident."** (Deposition of Katherine Raven, MD, Forensic Pathologist, pages 137-138)

"Q And did you have an understanding that 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." (Deposition of Dr. Garvey, pages 107-108)

"It is my professional opinion that Dr. David James Garvey breached the applicable standard of care for Mr. Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital. Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz. **Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him.** Mr. Schwartz could protect his own airway. Mr. Schwartz was not in respiratory distress." (Expert report of Seth P. Womack, MD, Emergency Physician)

"A He was on a nonrebreather, **I remember his saturations were in the 96, 97th percentage, his blood pressure and his pulse were stable, as was his level of consciousness. It's normal.** Q And he was able to talk to you. Correct? A He was." (Deposition of Barry Bartlett, Paramedic, Reach Air, pages 55-56)

June 24, 2016: Provision of Care Event Report re Mr. Schwartz per Northeastern Nevada Regional Hospital: **"NOTE: "PATIENT WAS STABLE AND READY FOR TRANSFER"**

I should mention that all of this sworn testimony and direct evidence is consistent with my 30 + years of clinical experience as a board certified emergency physician, medical director of three emergency departments, president of the medical staff and past-president of the medical staff for eight years, a faculty of the American College of Emergency Physicians (ACEP), and sixteen years of healthcare administrative management consulting where I work directly with clients to fashion clinical-administration policies and procedures pursuant to evidenced-based clinical care.

Thus, it is clear from the evidence that the primary and direct cause of Mr. Schwartz's untimely and unexpected death was the failed intubation attempts and resultant massive aspiration and not the blunt trauma injuries that set this fatal chain of events into motion.

Thus, from a healthcare administrative vantage, the key question is: "What was the hospital's independent duty and responsibility in protecting Mr. Schwartz from failed intubation attempts and resultant massive aspiration and subsequent death?"

Standardized practices based upon scientific information and professional consensus is called "evidence-based practices." Several decades ago, a physician was entitled to utilize "professional judgment" and courts generally deferred to the "medical judgment rule" whereby if a physician at a point in time considered a course of action to be appropriate, then it was considered a safe harbor for which the courts would defer. Today, both medical practice and the law has come to realize that non-value-added clinical variation is the third greatest cause of death and injury behind only heart disease and cancer and that scientifically based guidelines honed by peer review and acceptance now guide clinicians and hold them accountable to clinical decisions. Examples of such standardized practices include the treatment of: sepsis, congestive heart failure, acute myocardial infarction (heart attacks), community acquired pneumonia, and in this specific case, elective intubations.

What makes an intubation so high risk? In conscious and stable patients, drugs are administered to patients that serve to sedate and then paralyze the skeletal muscles of the chest to enable clinicians to place a laryngoscope in the back of the throat (where normally a gag reflex would make this maneuver nearly impossible), elevate the glottis (surrounding membranes around the entrance to the vocal cords and trachea), and then insert a tube into the upper trachea. The danger of this procedure is that once you paralyze an individual, the clinician is 100% obligated to at the very least, secure a reasonable airway because the patient can no longer breathe on their own or support the protective reflexes that keep food and secretions out of the airway.

To ensure that this procedure is done properly, clinical-administrative guidelines have been developed to standardize intubation practices throughout the country to minimize risk and

optimize patient safety. It is no longer considered within the realm of "professional judgment" to significantly deviate from these standards unless a good rationale exists that can be defended before peers. Thus, these standardized approaches have become the modern "minimum standard of care" which both clinicians and healthcare administrators develop together and which is a hospital responsibility to create and enforce and a clinical responsibility to read and comply.

Mr. Schwartz presented to Northeastern Nevada Regional Hospital as a high-risk intubation candidate for several reasons.

- He was awake and conscious and therefore required medications to sedate and paralyze him.
- He had chest wall, rib, and lung injuries which would make it more difficult to ventilate him once intubated
- He was on a backboard with a cervical collar which nearly always obscures any visualization of the anatomic landmarks of the airway
- Because of his position, his neck was flexed which obscures visualization of anatomic landmarks even more
- He had just eaten a large meal and had a full stomach
- After the first intubation attempt, both Barry Bartlett and Dr. Garvey realized that Mr. Schwartz's airway was "tilted" downward so that it was virtually impossible to visualize

For reference, I will refer to the American Society of Anesthesiologists "Practice Guidelines for Management of the Difficult Airway," February, 2013 as well as my own decades of work developing such policies and procedures for healthcare administrative clients throughout the United States.

The first clinical-administrative rule when making the decision as to whether to intubate a "stable" patient or not is that the most experienced individual in airway management available should make the decision. In this case, this would be the nurse anesthetist and general surgeon on call. Both would confer and collaborate with the emergency physician as to whether an intubation should be attempted at all (based upon input from the general surgeon with regards to the other blunt trauma injuries). Many clinicians would opine (including plaintiff's clinical expert) that the patient merely required supplemental oxygen administered VIA venti-mask and not an intubation at all. Intubation policies and procedures require mandatory consultation for potentially high-risk intubations in otherwise stable patients to determine the necessity (and risk) of such procedures at all.

If the decision is made to intubate the otherwise stable patient several additional steps must be taken:

- ✓ The patient's stomach should be emptied (every third-year medical student learns this). Nobody ever gets intubated with a full stomach unless it is an immediately life-threatening situation.

- ✓ The patient's neck should be cleared of injury (which it was in this case) so that the patient can be properly positioned to optimize visualization of anatomic landmarks. The ideal position is with the neck elevated (often on a pillow) and hyperextended to open the back of the airway to the greatest extent possible. Even routine intubations may be impossible to do with the patient on a backboard with a rigid cervical collar.

- ✓ Two precautions need to be taken in case of a failure to secure an airway. First, advanced airway instruments need to be brought to the bedside. These may include: fiberoptic guided endotracheal tubes, rigid fiberscopes, lighted stylets/wands etc. Second, a failed intubation and loss of airway should be anticipated with a general surgeon at the bedside prepared to perform a surgical airway if necessary. A cricothyroidotomy which an emergency physician is trained to do is considered a preliminary surgical airway and provides oxygen through a narrow catheter inserted through a cricothyroid membrane whereas a tracheostomy performed by a general surgeon allows the insertion of a full-size endotracheal tube directly into the trachea through the anterior neck in order to properly ventilate a person, particularly with underlying lung and rib injuries. Therefore, throughout my clinical career and as a medical director, I insisted that if a high risk difficult intubation was identified, an emergency physician have a cricothyroidotomy set up immediately available and, if required, a general surgeon (with a tracheostomy set up) and a nurse anesthetist (with high risk airway equipment) must be at the bedside as backup, ready to go once the medications to paralyze the patient were administered and it was discovered that a standard intubation would not be possible or that an airway was technically difficult to obtain.

These are the types of issues discussed in a "Management of the Difficult Airway Policy/Procedure" which is a hospital responsibility to create, disseminate and enforce with input and support from the clinical staff.

I will leave it to the clinical experts to inform the jury as to whether an intubation should have been performed at all on Mr. Schwartz. However, I can state unequivocally as a healthcare administrative expert that Northeastern Nevada Regional Hospital was negligent in not creating, disseminating and enforcing such a policy and procedure to its clinical staff in the emergency department so that evidence-based care would be provided to its high-risk patients such as Mr. Schwartz each and every time. The hospital's failure to do so led directly to the failed intubation, lost airway and subsequent massive aspiration which led directly to Mr. Schwartz's untimely and preventable death.

III. Northeastern Nevada Regional Hospital negligently supervised its organized medical staff members and nursing staff to ensure that they complied with nationally recognized evidence-based standards regarding the treatment of trauma patients and the performance of elective non-emergent intubations which placed trauma patients such as Douglas Schwartz at significant and mortal risk

Foundation of Opinion:

Another major misrepresentation in this case is that Dr. Garvey and Dr. Garvey alone had accountability for the care rendered to Mr. Schwartz since he was an independent contractor with both Ruby Crest Emergency Medicine and Northeastern Nevada Regional Hospital.

The Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (the minimum federal requirements necessary to be eligible to receive Medicare and Medicaid payments) clearly state that:

§482.12(a)(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;

Interpretive Guidelines §482.12(a)(5)

The governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients. **The governing body is responsible for the conduct of the hospital and this conduct includes the quality of care provided to patients.**

Thus, the hospital is ultimately responsible through its governing body for the quality of care provided to patients and this duty is in addition to the physician's duty to a patient through his professional license.

The Joint Commission (which is the hospital's accreditor) has similar leadership standards consistent with the conditions of participation and state:

LD.01.03.01: The governing body is ultimately accountable for the safety and quality of care, treatment and services.

Rationale for LD.01.03.01: The governing body's ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for hospital performance.

The medical staff standards go on to explain in the introduction to Standard MS.01.01.01.:

"While the governing body is ultimately responsible for the quality and safety of care at the hospital, the governing body, medical staff, and administration collaborate to provide safe, quality care."

A5: The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

Thus, the hospital has an independent duty through its governing body to oversee the quality of care provided by members of its medical, nursing, and ancillary staff and the management team creates policies and procedures (with input and collaboration from the medical staff) to ensure the quality and safety of its practices.

Therefore, the traditional "hands-off" approach whereby physicians manage patients and managers manage operations and finance no longer applies.

The organized medical staff, through its medical executive committee (MEC), clinical departments (e.g. emergency department) is responsible for overseeing the day to day clinical practice in collaboration with management that oversees nursing, ancillary, technology, and clerical staff.

At its core, this case is about a normal victim of blunt trauma who did not receive the benefit of a normal trauma team activation and team-based approach and did not have access to the general surgeon and nurse anesthetist on call who would have added additional and necessary clinical expertise, knowledge, experience, and perspective to guide Dr. Garvey's management of Mr. Schwartz. This was Northeastern Nevada Regional Hospital's responsibility. Management of the organization must provide at least as much oversight to clinical administrative management as it does to financial performance. The mismatch between the hospital's above average financial performance and average to below-average quality performance is indicative.

Dr. Garvey is a well trained and qualified emergency physician who got caught (along with Barry Bartlett and Reach Air) in a case that they could not manage and which was over their heads. Neither an emergency physician nor a paramedic has the training or expertise to manage advanced airway techniques and perform a tracheostomy in emergent situations and it was the hospital's responsibility to supervise their clinical activity to ensure that the requisite consultations and organized care was a requirement of their duties and that each and every clinician, nurse, clerk, and technologist functioned in a manner consistent with nationally promulgated guidelines by such organizations as the American College of Surgeons, the American Trauma Society, and the National Quality Forum.

As healthcare experts agree, the system of care has a far greater impact on individual patient outcomes than any of the individuals within the system and thus the system must be redesigned and held accountable to provide the necessary guard rails within which clinicians can practice safely.

Mr. Schwartz's untimely and preventable death was the direct result of a routine case handled below the minimum healthcare administrative standard of care and which resulted in a multiple intubation attempt that caused Mr. Schwartz's massive aspiration and subsequent death

G. Conclusion:

By reasonable probability, the above actions or omissions of Northeastern Nevada Regional Hospital were deviations from the administrative and professional standards of care and were contributing causes to the untimely and preventable death of Douglas Schwartz.

The conduct of Northeastern Nevada Regional Hospital employees, taken as a whole, showed utter indifference and conscious disregard for the safety of Douglas Schwartz through their failure to implement nationally recognized trauma and intubation practices as recommended by nationally approved clinical administrative guidelines and thus provide him with a minimum standard of care led directly to his unnecessary and preventable death.

All of these opinions are stated to a degree of reasonable administrative and professional probability.

I further reserve the right to modify or add additional opinions as additional information becomes available, including remaining expert witness depositions and any further discovery.