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. 4 of 6

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

IN THE FOURTH JUDICIAL DISTRICT 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,

v.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD, 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; DOES

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

CERTIFICATE OF SERVICE

I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

CERTIFICATE OF SERVICE

I hereby certify that on the 1st day of October, 2021, I caused a true and correct copy of the foregoing **PLAINTIFF'S OPPOSITION TO PHC-ELKO, INC. DBA NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT** on the following person(s) by the following method(s) pursuant to NRCP 5(b):

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AFFIRMATION
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IN THE FOURTH JUDICIAL DISTRICT 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,

v.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD, 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; DOES I through X; ROE BUSINESS ENTITIE

Case No.: CV-C-17-439
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PLAINTIFF'S OPPOSITION TO PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT

XI through XX, inclusive,

Defendants.

Plaintiff hereby submits her Opposition to Defendant PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital's Motion for Partial Summary Judgment.

This Opposition is based upon the papers and pleadings on file, the Points and Authorities attached, and any arguments made by counsel at the hearing.

Dated this 29th day of September, 2021.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich
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CLAGGETT & SYKES LAW FIRM

I.

INTRODUCTION

This case arises out of the tragic and untimely death of Douglas Schwartz following Defendants' reckless attempt to improperly intubate him. On September 14, 2021, Defendant PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital (hereinafter "NNRH") filed a Motion for Partial Summary Judgment. Plaintiff opposes that Motion herein.

II.

STATEMENT OF THE FACTS

This case arises from medical negligence that led to the death of Douglas Schwartz. On or around June 22, 2016, Mr. Schwartz was struck by a car while he was walking. He had just finished eating dinner at a nearby restaurant with the Board of Directors at Elko Federal Credit Union, where he worked as their CEO. Mr. Schwartz was transported to Northeastern Nevada Regional Hospital by Elko County Ambulance on a "non-emergent" transport, arriving approximately a half an hour later.

Defendant David M. Garvey, M.D., performed a physical examination of Mr. Schwartz. *See* Dr. Womack Report, attached hereto as **Ex. "1."** Dr. Garvey's 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. *Id.* Mr. Schwartz had a normal heart rate and rhythm and did not display signs of respiratory distress. *Id.* Mr. Schwartz'

respirations were normal with clear breath sounds throughout. Mr. Schwartz' neurological status and abdominal evaluation were normal. *Id.*

Dr. Garvey elected to have the flight paramedic, Barry Bartlett, from Defendant REACH, perform the intubation. Rocuronium and Ketamine were administered by 12:18 a.m. by REACH flight nurse Ronnie Lyons. *See* Reach Air Records at **Ex. "2."** Mr. Schwartz' vital signs were stable up until that point. *See* Dr. Womack Report, attached hereto as **Ex. "1."** Barry Bartlett first attempted intubation at 12:20 a.m., unsuccessfully. *See* Reach Air Records, at **Ex. "2."** A large aspiration of gastric contents occurred after this initial intubation attempt and 13 minutes were spent suctioning his airway and re-oxygenating him with BVM. *Id.* Barry Bartlett attempted intubation again at 12:23 a.m. and 12:33 a.m. and was again unsuccessful. *Id.* Apparently, Barry Bartlett attempted both "tooled and digital intubations" during this time. *Id.* Dr. Garvey stepped in to attempt to intubate 3 separate times, all unsuccessfully. *Id.* Intubation attempts continued at 12:40 a.m., 12:44 a.m., 12:47 a.m., 12:52 a.m., and 12:53 a.m. *Id.* After another unsuccessful intubation attempt, a cric (surgical airway) was initiated by Dr. Garvey and Barry Bartlett. *Id.* Over the course of over 33 minutes, a total of 11 intubation attempts are documented by REACH's flight crew. *Id.* After multiple aspiration events and failed intubation attempts, Mr. Schwartz' vital signs and oxygenation indicated cardiopulmonary arrest, so CPR was administered. *Id.* CPR was unsuccessful, and Mr. Schwartz was pronounced dead at 1:33 a.m. *Id.* From the time the first drug was given for rapid sequence induction (RSI) until Dr. Garvey pronounced Mr. Schwartz deceased was 1 hour

and 15 minutes. *See* Dr. Womack Report, attached hereto as **Ex. "1."** During this time, neither Dr. Garvey nor Barry Bartlett were able to establish a definitive airway for Mr. Schwartz.

III.

LEGAL ARGUMENT

A. LEGAL STANDARD FOR SUMMARY JUDGMENT

Material factual disputes preclude summary judgment. Pursuant to NRCP 56(c), summary judgment is only appropriate if "there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." NRCP 56(c). "Summary judgment is appropriate under NRCP 56 when the pleadings, depositions, answers to interrogatories, admissions and affidavits, if any, that are properly before the court demonstrate that no genuine issue of material fact exists, and the moving party is entitled to judgment as a matter of law." *Wood v. Safeway*, 121 Nev. 724, 731, 121 P.3d 1026, 1031 (2005).

"A factual dispute is genuine when the evidence is such that a rational trier of fact could return a verdict for the nonmoving party." *Id*. In reviewing a request for summary judgment, the facts must be viewed in the "light most favorable to the non-moving party" and a Court must "give that party the benefit of all favorable inferences that may be drawn from the subsidiary facts." *O'Dell v. Martin*, 101 Nev. 142, 141 (1985) (citing *Lipshie v. Tracy Investment Co.,* 93 Nev. 370, 375, 566 P.2d 819, 822 (1977)).

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B. SUMMARY JUDGMENT IS IMPROPER AS THERE IS A GENUINE ISSUE OF MATERIAL FACT AS TO WHETHER MR. SCHWARTZ' INJURY MEETS THE DEFINTION OF A TRAUMATIC INJURY

Plaintiff concedes that Mr. Schwartz suffered a traumatic injury related to being hit by a car on June 22, 2016. However, the trauma statute found at NRS 41.503 does not apply in the instant case because Mr. Schwartz did not have a traumatic injury *as defined by that statute*. In order for the trauma cap to apply, ***all*** of the statutory elements must apply to the facts of the case, and ***none*** of the exceptions. That is not the case here. According to the statute:

> **NRS 41.503 Hospital care or assistance necessitated by traumatic injury; presumption regarding follow-up care.**
> 1. Except as otherwise provided in subsection 2 and NRS 41.504, 41.505 and 41.506:
> (a) A hospital which has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to NRS 450B.237 and which is a nonprofit organization;
> (b) A hospital other than a hospital described in paragraph (a);
> (c) An employee of a hospital described in paragraph (a) or (b) who renders care or assistance to patients;
> (d) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a) or (b), whether or not the care or assistance was rendered gratuitously or for a fee; and
> (e) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS:
> (1) Whose liability is not otherwise limited pursuant to NRS 41.032 to 41.0337, inclusive; and
> (2) Who renders care or assistance in a hospital of a governmental entity that has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to NRS 450B.237, whether or not the care or assistance was rendered gratuitously or for a fee,
> that **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**.

2. The limitation on liability provided pursuant to this section **does not apply** to any act or omission in rendering care or assistance:

(a) Which occurs **after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient**, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation on liability provided by subsection 1 applies to any act or omission in rendering care or assistance which occurs before the stabilization of the patient following the surgery; or

(b) **Unrelated to the original traumatic injury**.

3. If:

(a) A physician or dentist provides follow-up care to a patient to whom the physician or dentist rendered care or assistance pursuant to subsection 1;

(b) A medical condition arises during the course of the follow-up care that is **directly related to the original traumatic injury** for which care or assistance was rendered pursuant to subsection 1; and

(c) The patient files an action for malpractice based on the medical condition that arises during the course of the follow-up care,

there is a rebuttable presumption that the medical condition was the result of the original traumatic injury and that the limitation on liability provided by subsection 1 applies with respect to the medical condition that arises during the course of the follow-up care.

4. For the purposes of this section:

(a**) "Reckless, willful or wanton conduct,"** as it applies to a person to whom subsection 1 applies, shall be deemed to be that conduct which the person **knew or should have known** at the time the person rendered the care or assistance would be likely to result in injury so as to affect the life or health of another person, taking into consideration to the extent applicable:

(1) The extent or serious nature of the prevailing circumstances;

(2) The lack of time or ability to obtain appropriate consultation;

(3) The lack of a prior medical relationship with the patient;

(4) The inability to obtain an appropriate medical history of the patient; and

(5) The time constraints imposed by coexisting emergencies.

(b**) "Traumatic injury"** means any **acute injury** which, according to standardized criteria for triage in the field, involves a **significant risk of death or the precipitation of complications or disabilities**.

i. Douglas Schwartz did not sustain a "traumatic injury" as defined by NRS 41.503

NRS 41.503(4)(b), states that "traumatic injury" means any acute injury which, according to standardized criteria for triage in the field**, involves a significant risk of death or the precipitation of complications or disabilities**. Although Mr. Schwartz was hit by a motor vehicle and suffered injuries, he was **not** in significant risk of death or the precipitation of complications or disabilities. In fact, the medical records and evidence to date only prove conclusively that Mr. Schwartz' condition, while traumatic in nature, did not meet the statutory definition of a "traumatic injury…involving a significant risk of death or the precipitation of complications or disabilities." The Nevada Legislature specifically chose to give us the definition of "traumatic injury" that they wanted us to use and apply. Not all "trauma" poses a **"significant risk of death or the precipitation of complications or disabilities**." Sometimes "trauma" just means an injury but does not bring the injury within the scope of NRS 41.503. (See Section 6 below for a more in-depth discussion of Nevada legislative intent pertaining to NRS 41.503.)

For NRS 41.503 to apply in the first case, it requires a traumatic injury that involved a **significant risk of death or the precipitation of complications or disabilities.** Defendants have offered absolutely no evidence, or argument, that Mr. Schwartz' condition prior to the failed intubation attempts by Defendants' presented a "significant risk of death or the precipitation of complications or disabilities" or that his condition required "immediate" medical care. Certainly, Mr. Schwartz had serious injuries which required medical care in

order for them to improve and heal, however, he was not in an immediate or significant risk. A pneumothorax and/or rib fractures are not, in and of themselves, immediately life-threatening conditions. The ambulance that transported Mr. Schwartz to NNRH did so without its lights and sirens on and took over 30 minutes to arrive at NNRH. Furthermore, Dr. Garvey was seemingly not initially planning on intubating Mr. Schwartz until the receiving physician at the University of Utah suggested that he "possibly" intubate Mr. Schwartz. Notably, it was not until Mr. Schwartz' healthcare providers inappropriately decided to intubate him, and then completely botched that intubation, that his condition became life-threatening.

Dr. Seth Womack, Plaintiffs' emergency medicine expert, concluded:

> **Mr. Schwartz did not have injuries that were an immediate or imminent threat to life. Mr. Schwartz had rib fractures.** Mr. Schwartz' rib fractures were not an immediate or imminent 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.

See Dr. Womack Report, pp.15-16, attached hereto as **Ex. "1".**

ii. Even if Mr. Schwartz did sustain a "traumatic injury" the negligent acts and omissions alleged in the complaint were unrelated to the original traumatic injury

In order for the trauma statute to apply, the negligent acts and omissions at issue must be **directly related** to the ***original traumatic injury***. One of the main issues in dispute in this case between the Plaintiffs and Defendants is

whether or not Mr. Schwartz' condition was life threatening so as to require intubation. It is Plaintiffs' position, and the evidence will show, that Mr. Schwartz was not in any immediate or serious risk, yet Defendants herein inappropriately decided to intubate him anyway. Therefore, the decision to intubate, and the botched intubation attempts, were not "directly related" to the original traumatic injury as Defendants' claim. Instead, they were completely ***unrelated*** and were done for reasons that had nothing to do with Mr. Schwartz' clinical condition.

The evidence in this case suggests that Mr. Schwartz was intubated solely as a courtesy for air transfer, and not because his clinical condition warranted intubation. As such, the issue of whether Mr. Schwartz' intubation was necessary was due to a life-threatening traumatic injury, and whether or not his condition warranted intubation, is a question of fact for the jury in this case to decide.

Furthermore, NNRH allowed outsiders to come into its ER and render care to Mr. Schwartz. This act was negligent, as will be further explained in detail below, and was unrelated to the original traumatic event. The fact that NNRH lets outsiders who are not employees, not credentialed members of the medical staff, and are not working under a contractual agreement with the hospital, to come into its ER and render patient care, while not disclosing this fact to the actual patient, was not a negligent act directly related to the original traumatic injury. This was an ongoing negligent act by NNRH, not specific to just Mr.

Schwartz' care and treatment, and was done in conscious disregard of the rights of its patients, and was reckless, grossly negligent, and in bad faith.

iii. Douglas Schwartz was stabilized as far as any trauma was concerned and was capable of receiving treatment as a non-emergency patient at the time of the negligent acts and omissions

At the point that Mr. Schwartz' vital signs were stabilized, and his breathing was unlabored, he was "stable" as far as any alleged traumatic injury. NRS 41.503 ceases to apply once the patient is stable. However, NNRH and Dr. Garvey's negligence continues well after this point in their decision allow outsiders to intubate a patient with stable vital signs, who had just eaten a big meal, and who was speaking clearly and breathing on his own.

Both Dr. Womack and Dr. Jonathan Burroughs, Plaintiff's hospital administration expert, opine that Mr. Schwartz was a stable patient. See the expert report of Dr. Womack, attached hereto as **Ex "1".** Also see the expert reports of Dr. Burroughs, attached hereto as **Ex. "3".**

The NNRH medical records also note that Mr. Schwartz was not displaying signs of respiratory distress, his respirations were normal, his breath sounds were normal and clear throughout. *See NNRH Medical Records,* attached hereto as **Ex. "4."** Furthermore, Mr. Schwartz' airway was noted to be patent with good air movement and that he was breathing without difficulty. *Id.* This was evidenced by the testimony of the witnesses present at the hospital that night. Mr. Schwartz was laughing and joking. See Dr. Patton Dep., 15:9-11; 27:2-6; 30:3–23, attached hereto as **Ex. "5".**

After Mr. Schwartz was stabilized, then NRS 41.503 ceases to apply. Although Defendants take the contrary position, the evidence in this case demonstrates that Mr. Schwartz was stable and "non-emergent." Therefore, he was capable of receiving care as a non-emergency patient. Although Plaintiff believes that there is ample evidence in this case to prove that Mr. Schwartz was stabilized prior to the unnecessary failed intubation attempts by Defendants, the final determination of this issue of fact must be made by the trier of fact, the jury in this case. It is inappropriate for this Court to decide this issue as a matter of law in the particular care when Plaintiff's entire theory of the case is based upon the fact that Mr. Schwartz was stable and did not require intubation in the first place.

iv. Defendant NNRH's motion pertaining to the trauma statute presents genuine issues of material fact which can only be decided by the trier of fact, the jury

NNRH's position as to the applicability of the trauma statute contains issues of fact which will need to be decided upon by the jury. The applicability of the trauma statute is not a legal question, it is a factual one. As such, this Court must defer to the trier of fact to determine the ultimate answers to several important questions pertaining to the applicability of the trauma statute which may be included on the verdict form for this case if the Defendants are entitled to present this affirmative defense and meet their burden of proof.

v. The trauma statute does not apply because Defendants' conduct was not in good faith and was reckless, willful, and/or wanton

While "gross negligence" is not defined by the statute, "reckless, willful or wanton conduct" does have a statute specific definition:

(a) "**Reckless, willful or wanton conduct**," as it applies to a person to whom subsection 1 applies, shall be deemed to be that conduct which the person **knew or should have known** at the time the person rendered the care or assistance would be **likely to result in injury so as to affect the life or health of another person**, taking into consideration to the extent applicable:

(1) The extent or serious nature of the prevailing circumstances;
(2) The lack of time or ability to obtain appropriate consultation;
(3) The lack of a prior medical relationship with the patient;
(4) The inability to obtain an appropriate medical history of the patient; and
(5) The time constraints imposed by coexisting emergencies.

A myriad of specific, admissible, facts exist to demonstrate that the Defendants' conduct was not in good faith and was reckless, grossly negligent, willful, or wanton. In viewing the evidence in the light most favorable to the Plaintiffs, Defendants will not be able to avail themselves of the trauma statute because their actions were not in good faith.

NNRH seeks a ruling that NRS 41.503 applies to the entire instant action. However, if the Plaintiff can show that Defendants' conduct was not in good faith, or was grossly negligent, reckless, willful, or wanton, the cap does not apply. Notably, there is evidence in this case that Defendants were responsible for 11 or more unsuccessful intubation attempts before turning to a surgical airway. This is not only a breach of the standard of care, but is grossly negligent, reckless, willful and wanton in light of the fact that clinical evidence-based protocols indicate that no more than 3 intubation attempts should be made before a surgical airway is done. These evidence-based protocols exist because the risk of not following them is death. Something all Defendants should have known at the time of treating Mr. Schwartz.

Defendants "knew or should have known" that deviations from clinical evidence-based protocols in performing intubations can and would result in death.

To ignore these clinical evidence-based protocols, is to ignore the very real risk of death. This is not good faith. This is grossly negligent, reckless, willful and wanton conduct. Dr. Garvey, as the physician overseeing Mr. Schwartz' intubation attempts, knew or should have known of the risks of a failed intubation and the required clinical evidence-based protocols. He ignored both.

Defendants also knew or should have known that failure to ensure the crash cart inventory was properly stocked, so that all necessary lifesaving equipment was available at the patient's bedside during a code blue, could and would result in death. The evidence in this case shows that NNRH had an Occurrence Report completed by one of its staff, Nurse Donna Keavitt, following Mr. Schwartz' many failed intubation attempts, which noted that he was "stable and ready for transfer." *See Occurrence Report,* attached hereto as **Ex, "6".** Contributing factors to this incident occurring were noted to be: "Staff – use of Float Staff"; "Staffing issue"; "Task – training issue"; Work Envmt – Inadequate Equipment Availability." *Id.* In addition, the Occurrence Report notes that the "trauma cart" was "open" and "not fully stocked – Supplies had to be obtained from 2 other rooms and store room." *Id.*

The evidence in this case demonstrated that the NNRH Emergency Department was not properly staffed at the time Mr. Schwartz was a patient there. Both NNRH and Dr. Garvey, allowed outsiders (the Reach crew) to come into the ER and render care to a hospital patient. The Reach crew were not hospital employees, were not credentialed members of the medical staff, and were not working subject to a contractual agreement between Reach and NNRH. In

short, the Reach crew had *no authority* to touch an NNRH hospital patient, and Dr. Garvey had *no authority* to ask them to touch an NNRH hospital patient. In fact, the NNRH Bylaws state that "Except as otherwise specified herein, no person shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws." See NNRH Bylaws, attached hereto as **Ex. "7".** Yet, when confronted with the fact that the Reach crew improperly rendered care to an NNRH patient, Defendants only response is "it happens all the time." In fact, the NNRH NRCP 30(b)(6) witness, Rabecca Jones, testified that from the hospital's perspective, it was not improper for the Reach crew to assist in the intubation and intubation attempt and the code event and that it is common for EMS crews to assist with patient care in the ER. See excerpt from the deposition of Rabecca Jones, attached hereto as **Ex. "8".** This is a perfect example of reckless conduct that is in conscious, willful and wanton disregard of patient safety. It simply cannot be tolerated by this Court, or the community of Elko, that NNRH is recklessly and consciously putting patient lives at risk in this way. As such, the evidence in this case will show that the trauma cap does not apply as to NNRH, because it cannot demonstrate that the facts of this case meet the required elements of the trauma statutes and do not fall under any of the exceptions to the trauma statute. Based upon the supporting evidence, this Court cannot conclude that the trauma statute, and its $50,000 cap, apply to this case ***as a matter of law***.

iv. The legislative history is consistent with Plaintiffs' interpretation of the trauma statute

Legislative history notes for NRS 41.503 dictate that the **nature** of the injury dictates if a physician would qualify for the $50,000 cap. In legislative session, the statutory language of NRS 41.503 was being debated. Various witnesses of the bill noted that the language of the proposed statute was purposefully limited. Events one might typically assume to be "traumatic" and which are life and death, such as a heart attack, were considered by the authors of the bill to be non-traumatic. "Dr. Daubs echoed the testimony of Dr. McBride and stated **it was never the intent to include all medical cases, such as heart attacks**." *Legislative History,* attached hereto as **Ex. "9".** Certainly a heart attack is more traumatic and life-threatening than Mr. Schwartz' injury at issue herein. Yet, Defendants claim that that Mr. Schwartz' injury qualifies for statutory protection. Defendants have utterly failed to meet their burden of establishing that NRS 41.503 qualifies in the case at bar.

Additionally, whether a specific event, such as discharge by the treating physician, would trigger "stabilization" of the patient and end the protections of the cap was debated. *Id.* The legislature did not include a triggering event because the issue was a difficult one to be assessed on a ***case by case*** basis depending on the nature of the injury and course of treatment. Based upon the facts of this case, Mr. Schwartz was stabilized when Defendants charted that he had stable vital signs and was breathing on his own and talking with no signs of respiratory distress. This Court cannot ignore these facts or place undue weight

on the facts presented by the Defendants herein. The weighing of the available evidence is the job of the jury.

Dr. Garvey, the ostensible agent of NNRH, made the decision to intubate Mr. Schwartz, despite stable vital signs and no signs of respiratory distress. Dr. Garvey failed to inform Mr. Schwartz or his wife of the risks of undergoing an intubation. Dr. Garvey, elected to have a flight paramedic and flight nurse render care to Mr. Schwartz, in violation of the NNRH bylaws, and NNRH allowed him to do it. As such, NNRH is also responsible for the decision to intubate Mr. Schwartz, despite stable vital signs and no signs of respiratory distress, and the botched intubation attempt. The conduct of Defendants, including NNRH, presents genuine issues of material fact which can only be decided by a jury. Summary judgment is improper.

C. SUMMARY JUDGMENT IN NNRH's FAVOR IS IMPROPER AS TO PLAINTIFF'S CLAIMS FOR PROFESSIONAL NEGLIGENCE

Defendant NNRH has taken the position that Plaintiff has not referenced any allegations of active negligence by NNRH in the present matter. NNRH seemingly has overlooked the evidence in this case and the expert opinions of Dr. Jonathan Burroughs, both of which establish direct negligence by NNRH.

Dr. Burrough's has opined 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. See the

expert reports of Dr. Jonathan Burroughs, attached hereto as **Ex. "3".** NNRH failed to have evidence-based protocols in place for the management of trauma patients and for performing non-emergent elective intubations. Id.

Dr. Burroughs has also opined that NNRH was grossly negligent and showed a conscious disregard by allowing Barry Bartlett, an uncredentialed individual with no authorized clinical privileges to perform a high risk procedure on its premises in violation of federal law and its own bylaws which lead to the death of Mr. Schwartz. See the expert reports of Dr. Jonathan Burroughs, specifically the June 21, 2021 Supplemental Report, attached hereto as **Ex. "3".** As pointed out above, the NNRH Bylaws state that "Except as otherwise specified herein, no person shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws." See NNRH Bylaws, attached hereto as **Ex. "7".** Yet, when confronted with the fact that the Reach crew improperly rendered care to an NNRH patient, Defendants only response is "it happens all the time." The NNRH NRCP 30(b)(6) witness, Rabecca Jones, testified that from the hospital's perspective, it was not improper for the Reach crew to assist in the intubation and intubation attempt and the code event and that it is common for EMS crews to assist with patient care in the ER. See excerpt from the deposition of Rabecca Jones, attached hereto as **Ex. "8".**

If NNRH claims that they were not professionally negligent. Plaintiff maintains that its claims against NNRH sound in either ordinary negligence or professional negligence. Since there really is no issue of fact here, this Court

should grant summary judgment in Plaintiff's favor, not NNRH's, on this issue of ordinary negligence. It is not disputed that Barry Bartlett and Ronnie Lyons were not hospital employees, were not credentialed members of the medical staff, and were not providing care subject to a contractual agreement. As such, they had no right to touch Mr. Schwartz. Yet they did. Defendants concede that they did. NNRH's own Bylaw's forbid this, yet we are told by the hospital NRCP 30(b)(6) witness that the EMS providers render care frequently. Case closed. No issue of fact. This is ordinary negligence as a matter of law. There is no professional judgment being used and no expert testimony is required in order for the jury to understand the evidence. This isn't a case where the hospital negligently credentialed or hired a person they should not have. This is a case where they **didn't** hire or credential the Reach crew **at all**, yet they still provided care to an NNRH hospital patient without his knowledge or consent.

A cause of action can sound in ordinary negligence if it is capable of being understood by a lay jury relying on their own common knowledge and experience. In the present case, it is apparent that an expert is not needed to tell the jury that it isn't okay for a hospital to repeatedly allow random people to waltz in off the street and render patient care.

In *Estate of Mary Curtis v. South Las Vegas Medical Investors, LLC, d/b/a Life Care Center of South Las Vegas*, 136 Nev. Ad. Op. 39 (2020), the Plaintiff alleged 1) that a nurse had mistakenly administered 120 milligrams of Morphine to Curtis, which was not prescribed to her but, rather, was prescribed to another patient; and 2) that Life Care Center (LLC) failed to monitor Curtis

and sent her to the hospital timely. Curtis later died and her death certificate lists morphine intoxication as the cause of death. The issue in *Curtis* was whether or not the plaintiffs' claims fell within the "common knowledge" exception to the expert affidavit requirement in NRS 41A.071.

In *Curtis*, the Court performed an analysis of the difference between ordinary negligence and professional negligence. *Id*. The crux of this issue turns on whether the claim is one for professional negligence, and involves medical diagnosis, judgement or treatment, or is one based upon ordinary negligence and is based upon nonmedical services. *Id*. If the jury can only evaluate plaintiff's claim after presentation of the standard of care by a **medical** expert, then it is a professional negligence claim. *Id.* If, on the other hand, the reasonableness of the healthcare provider's actions can be evaluated by the jurors on the basis of their common knowledge and experience, then the claim is likely based in ordinary negligence. *Id.*

Plaintiffs herein have alleged non-medical factual claims against NNRH, which have caused and/or contributed to Mr. Schwartz' untimely death, which are not based upon medical diagnosis, judgment or treatment, and which do not require expert medical testimony in order to be understood by a jury. Even though a claim **appears to sound in professional negligence**, it may actually sound in ordinary negligence.

Defendants are incorrect when they claim Plaintiff does not reference allegations of "active" negligence by NNRH and that summary judgment is warranted as to the professional negligence claim. *Curtis* contemplates a

situation where there are *both* professional and ordinary negligence claims side by side in the same lawsuit. Nevada is a notice-pleading state, and Defendant NNRH has squarely been put on notice of the allegations against it. See NRCP 8. In fact, NNRH has retained several experts in this case defending the conduct of its administration, its nurses, Dr. Garvey, and even Reach. It is obvious that they are on actual notice of the claims against them.

The next fork in the road is to determine whether the underlying negligence sounds in ordinary negligence or professional negligence. *Curtis* mandates that if the "carelessness" of the defendant is readily apparent to anyone of average intelligence and ordinary experience, and the claim can be resolved without expert testimony, then it is one for ordinary negligence. Notably, in *Curtis*, the claim was for administering the wrong drug to the wrong patient. In the instant case, the claim is for allowing anyone to come in off of the streets and render patient care. In both claims, the carelessness of the defendant is readily apparent to anyone of average intelligence and ordinary experience and can be resolved without expert testimony. Both cases involve negligent decision-making with deadly consequences to the patient.

As of right now, Defendant NNRH is taking the position that it is completely fine for someone to come in from the street and render patient care like Defendant REACH did, it happens all the time, and it is no big deal. So, if that is Defendant NNRH's position, then summary judgment in Plaintiff's favor is warranted, not NNRH's, and Plaintiff will be filing its own Motion for Summary Judgment on this point.

However, if this Court feels that the issues do invoke medical judgment and do require expert testimony to be understood by a jury, then then claims are for professional negligence. Either way, the claims remain part of Plaintiff's case. If the Court feels that it cannot make this decision as a matter of law, then it becomes an issue of fact and must be submitted to the jury for final determination. Any way you look at it, NNRH is not entitled to summary judgment in its favor.

D. SUMMARY JUDGMENT IS IMPROPER AS TO PLAINTIFF'S CLAIMS FOR VICARIOUS LIABILITY, CORPORATE NEGLIGENCE, AND OSTENSIBLE AGENCY, AND NEGLIGENT HIRING, TRAINING, AND SUPERVISION

Defendant claims that summary judgment is warranted as to Plaintiff's claim for vicarious liability, corporate negligence, and ostensible agency because, among other things, there is no genuine issue of material fact that Dr. Garvey was neither an agent nor an ostensible agent of NNRH.

A principal may be bound to an agent's action if the principle expressed ostensible authority. *Myers v. Jones*, 99 Nev. 91, 93, 657 P.2d 1163, 1164. Ostensible agency applies when a patient goes to a medical provider and the medical provider selects the doctor to treat the patient, such that it is reasonable for the patient to assume the doctor is an agent of the medical provider. *Schlotfeldt v. Charter Hosp. Of Las Vegas*, 112 Nev.42, 48-49, 910 P.2d 271. Typical questions that arise in determining whether ostensible agency exists is whether the patient entrusted herself to the medical provider, whether the medical provider selected the doctor, whether the patient reasonably believed the

doctor was an agent of the medical provider and whether the patient had notice of the doctor's independent status. *Id.*

Here, Elko County EMS decided to take Mr. Schwartz to the NNRH emergency department. There is no evidence in the case to suggest that Mr. Schwartz wanted to go to NNRH specifically. Once he arrived at the NNRH ER, Mr. Schwartz was assigned Dr. Garvey as his physician. See NNRH medical records, attached hereto as **Ex. "4".** NNRH selected David Garvey to practice in its facility by virtue of contracting with Dr. Garvey's employer, Ruby Crest Emergency Medicine, to staff its ER. See the Exclusive Professional Services Agreement between NNRH and Ruby Crest, submitted to this Court as an exhibit under seal, as it is subject to a stipulated confidentiality agreement between the parties. Mr. Schwartz did not select Dr. Garvey, NNRH selected Ruby Crest and told Ruby Crest to staff the ER after all ER physicians were appropriately vetted by NNRH through the credentialing process and became members of the medical staff. Notably, Dr. Garvey was the only ER physician working in the NNRH emergency department on June 22, 2016, when Mr. Schwartz was brought in by ambulance. As such, Mr. Schwartz had absolutely no choice in who his physician was. However, NNRH made the choice to contract with Ruby Crest, to credential Dr. Garvey, and to have only 1 ER physician per shift. As such, NNRH is ostensibly liable for the actions of Dr. Garvey.

It is objectively reasonable that Mr. and Mrs. Schwartz believed that Dr. Garvey was an agent of NNRH. Finally, Mr. and Mrs. Schwartz did not have reasonable notice of Dr. Garvey's status. The NNRH consent to treatment form in

this case was *only* signed by Mrs. Schwartz, and *not* Mr. Schwartz, despite the fact that he was stable and conscious and fully capable of reading and signing hospital paperwork. Furthermore, the hospital consent form states that "most physicians and surgeons" providing care in the hospital are independent contractors. See Consent to Treatment form, at page NEN 000031 of the NNRH medical records, attached hereto as **Ex. "7".** Since the consent to treatment form does not indicate that all physicians are independent contractors, there is no way for a patient such as Mr. Schwartz to know who is, and who is not, an independent contractor. As such, it was objectively reasonable for Mr. Schwartz to believe that Dr. Garvey was an agent of the hospital.

A principal may be bound to an agent's action if the principle expressed apparent authority. *Myers v. Jones*, 99 Nev. 91, 93, 657 P.2d 1163, 1164. A person "who represents that another is his servant or other agent and thereby causes a third person to justifiably rely upon the care and skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such." *Montgomery Ward & Co., Inc. V. Stevens et al.,* 60 Nev. 358, 109 P.2d 895, 897-898; Myers at 92-93.

NNRH gave Plaintiff various forms and documents in furtherance of medical care and treatment of her husband, Mr. Schwartz. See generally NNRH Medical Records, NEN000001-83, attached hereto as **Ex. "7".** These forms suggest that Defendant David Garvey was an agent of NNRH. NNRH gave Plaintiff patient forms, consent for services, and other documents, all of which,

had the NNRH name and logo on the top of them. These forms did not have the name David Garvey, listed in the top, only NNRH and its logo. *Id.*

NNRH seemingly required Dr. Garvey to use the group name NNRH on almost all the documents and forms used to provide medical treatment and care for Mr. Schwartz. See Physician Documentation, NEN000003-7, attached hereto as **Ex. "7".** Dr. Garvey never represented himself as an independent physician nor ever mentioned he was independent. Therefore, virtually all forms and documents NNRH gave to Plaintiff in the care and treatment of her husband suggested that David Garvey was an agent, or an employee, of NNRH. There is no other reasonable way Plaintiff, or any other patient, could interpret the forms and documents.

Plaintiff reasonably relied on the care and skill of David Garvey as a physician who was an agent of NNRH. In deposition, Plaintiff made it obvious that she was under the impression that her husband was being taken to NNRH, a hospital that could help her husband, not to Dr. Garvey as an independent physician:

> Q. Then under that it says – correct me if I'm reading it wrong – the second sentence – "Most physicians and surgeons providing services to me, including radiologists, pathologists or emergency physicians, anesthesiologists, hospitalists and others are independent contractors and not employees or agents of the hospital." Did I read that correctly?
>
> A. Yes. It says "most," so it's hard to say which ones were and which ones weren't.

See Diane Schwartz Dep., 149:18-150:1, attached hereto as **Ex. "10".** Plaintiff reasonably believed that a physician working at a hospital like NNRH, would be

an agent of that hospital. Plaintiff had no way of knowing from the Consent for Services and Financial Responsibility document, that Dr. Garvey was an independent contractor. Further, it is absolutely absurd for NNRH to claim that Mr. Schwartz "did not entrust himself to NNRH" because it is quite obvious that a patient enters an establishment for medical care by that facility and its employees. In fact, the undisputed evidence in this case clearly shows that summary judgment on the issue of ostensible agency should be granted by this Court in Plaintiff's favor, not in NNRH's favor, because NNRH cannot demonstrate sufficient evidence for the court to determine as a matter of law that Dr. Garvey was not the hospital's ostensible agent.

Furthermore, Plaintiff's claims for corporate negligence, negligent hiring, training and supervision, and vicarious liability are also ordinary negligence claims as they include the hospital's actions in allowing outsiders to come into its ER and care for NNRH hospital patients. As such, summary judgment is not appropriate in NNRH's favor. Rather, summary judgment should be granted in Plaintiff's favor as the undisputed evidence in this case shows that outsiders were allowed to come into the NNRH ER and render care in clear violation of the NNRH Bylaws. In fact, no one at NNRH has identified one single document which allows outside individuals to render patient care without first going through the hospital hiring or credentialing process, or which allows Dr. Garvey to unilaterally decide to bring in additional staff to render patient care. In fact, the clear evidence in this case is that Dr. Garvey *did not* have a right to do this, as indicated in the Exclusive Professional Services Agreement between NNRH

and Ruby Crest. This Agreement provides that "Contractor agrees that it shall not use any Physician or Allied Health Professional to provide services under this Agreement to Hospital without first obtaining appropriate medical staff or other allied health privileges any other approvals required by such Hospital's Medical Staff Bylaws. Contractor agrees that all of Contractor's Representatives are subject to continuing approval of Hospital." See the Exclusive Professional Services Agreement between NNRH and Ruby Crest, submitted to this Court as an exhibit under seal, as it is subject to a stipulated confidentiality agreement between the parties, **Ex. "11".** Based upon the foregoing, NNRH is not entitled to summary judgment in its favor.

E. NOT ALL CLAIMS ARE SUBJECT TO NRS 41A

Defendant NNRH contends that it 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." However, not all of Plaintiff's claims against NNRH sound in "professional negligence" as NNRH claims. As shown above, if a cause of action is capable of being understood by a lay jury relying only on their common knowledge and experience, then an action may sound in ordinary negligence. Therefore, summary judgment in NNRH's favor should be denied. Plaintiff will be filing her own Motion for Summary Judgment pertaining to her claims for Ostensible Agency, Corporate Negligence and Vicarious Liability, and Negligent Hiring Training and Supervision.

IV.

CONCLUSION

Based on the foregoing, Plaintiff respectfully requests this Court **deny** Defendant PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital's Motion for Partial Summary Judgment.

Dated this 29th day of September, 2021

CLAGGETT & SYKES LAW FIRM

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

CERTIFICATE OF SERVICE

I hereby certify that on the 29th day of September, 2021, I caused a true and correct copy of the foregoing **PLAINTIFF'S OPPOSITION TO PHC-ELKO, INC. DBA NORTHEASTERN NEVADA REGIONAL HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT** on the following person(s) by the following method(s) pursuant to NRCP 5(b):

Via E-Mail Casey W. Tyler, Esq. James W. Fox, Esq. HALL PRANGE & SCHOOVELD, LLC 1140 N. Town Center Drive, Suite 350 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital*	***Via E-Mail*** Keith A. Weaver, Esq. LEWIS BRISBOIS BISGAARD & SMITH, LLP 6385 S. Rainbow Blvd., Suite 600 Las Vegas, NV 89118 *Attorneys for Defendant, David Garvey, M.D.*
Via E-Mail Todd L. Moody, Esq. Richard L. Wade, Esq. HUTCHISON & STEFFEN, PLLC. 10080 West Alta Drive, Suite 200 Las Vegas, NV 89145 James T. Burton, 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*	***Via E-Mail*** 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
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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.

****

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].

****

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.

REACH Air Medical Services | CAL-ORE Life Flight

Inc. Date: 06/23/2016
Run #: IFT
PCR #: 16-14083

REACH Air
Santa Rosa, CA 95403
DISPATCH
800-332-1292 ADMIN

Prehospital Care Report - Critical Care

Medical Record #: 000330967

Patient Information

Name: SCHWARTZ, DOUGLAS
Address: [redacted]
[redacted]
Country:

Age: 58 Years
Gender: Male
Weight: 90.718 KG / 200.00 LB
Phone: [redacted]
Pediatric Color: Not Applicable

D.O.B: 06/02/1958 (mm/dd/yyyy)
SSN [redacted]
Race:
Ethnicity:
Study: Not Applicable

Billing Information

Payment Method:
Work Related? No

Call Type and Location

Call Type: Interfacility Transfer (Unscheduled)
Vehicle Dispatch Location:
Dispatch Reason: Auto vs. Pedestrian
Resp. Mode: No Lights and Sirens
Service Level: Critical Care Transport
Unit Role: Non-Transport
Urgency: Immediate
Response: Interfacility Transfer (Unscheduled)
Location: Health Care Facility (clinic, hospital, nursing home)
Facility: Northeastern Nevada Regional Hospital
Address: 2001 Errecart Boulevard
Elko, Elko, NV 89801

Call Disposition

Disposition: Treated, Transported
Resp. Mode: No Lights or Sirens
Destination: University of Utah Healthcare, 50 Medical Drive, Salt Lake City, UT 84132
Dest. Determ.: Specialty Resource Center
Diverted From:
Dispatch Delay:
Turn Around Delays:

Response Times

Run #: IFT
Call Sign: REACH58
Vehicle #: N271SM
1st Resp. Arr.:
PSAP:
Disp. Notified: 23:36
Unit Disp.: 23:41
Standby Date/Time:
Enroute: 23:45
At Scene: 23:55
At Patient: 23:57
Depart: 01:39
Arrive Dest: 01:40
In Service: 01:41

Unit Personnel

Crew Member	Level of Certification	Role
Lyons, Ronnie (RL)		
Bartlett, Barry (BB)	EMT-Paramedic	

EMS Scene Information

Number of Patients: Single
Mass Casualty Incident: No
Level of Service Provided: Critical Care Transport
Referring EMS Agency:
Other EMS or Public Safety Agencies on Scene:

History of Present Illness

AUTO vs PEDESTRIAN ACCIDENT: At app. 2200 hours this date Mr. Schwartz and his family were enjoying an evening out and had finished dinner at a local restaurant. As they departed he was struck by an automobile and the driver fled the scene of the accident. Mr. Schwartz arrived at NNRH where he was evaluated by Dr. Garvey and REACH 58 was summoned at 2345 for transfer to the University of Utah hospital for trauma services.

REACH team arrives at 2357 to find Dr. Garvey speaking with the receiving physician by phone. Dr. Garvey reports Mr. Schwartz has an approximate 10% pneumothorax on the right side of his chest with a flail segment but is tolerating it well at this time. The receiving physician has recommended Mr. Schwartz be intubated with chest tube placement pre-flight. We arrive bedside to find Mr. Schwartz talking with his family as Dr. Garvey assembles his team and equipment. The procedure is explained to the pt. and family and the family is escorted from the room. Dr. Garvey has invited the REACH team to assist along with his staff in this process. The team includes a respiratory therapist, app. six ER nurses, one paramedic as well as both REACH attendants.

A procedural time out is completed, Dr. Garvey is sterile and ready for chest tube placement and Paramedic Bartlett is at the head of the bed for the initial attempt. The BVM, C-Mac, intubation gear and suction are at the ready and 180 mg's Ketamine and 90 mg's Rocuronium are both drawn up from REACH stock and verified by another nurse at the foot of the bed. The transport monitor is placed and 90% oxygen saturation will be the cut-off reading to stop and reoxygenate. Mr. Schwartz is pre-oxygenated to 99% and with staff in place around the bed the sedative and paralytic are pushed at 0018 hours with a 60 second pause for effect. Once the drugs take effect Paramedic Bartlett opens the airway at 0020 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 suctioned, which promptly plugs the suction tubing and yankauer tip. Over the course of the next 13 minutes Mr. Schwartz vomits several more times and numerous attempts are made at clearing / maintaining the airway and reoxygenating him with the BVM on high flow oxygen. ET tube placement is attempted again at 0023 and 0033, both unsuccessfully. 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. Cric pressure and POCPOM are provided several times with little to no benefit. Paramedic Bartlett attempts several tooled and digital intubations, all of which are unsuccessful.

Dr. Garvey steps in to attempt intubation three separate times and he too is unsuccessful due to the factors at hand. Mr. Schwarts loses pulses at 0035 and CPR is initiated for app. one minute and pulse is restored. The airway is again suctioned and a king airway placed from ER stock. BVM bagging remains very difficult and shortly afterward the king is removed after becoming plugged by emesis and food particles. A third suction unit is placed in play and vital signs at this time are 225/136, 119 and 47% on high flow oxygen. Intubation attempts continue with various size ET tubes, styletts and bougie introducers and airway adjuncts at 0040, 0044 and 0047 hours. The emesis is almost continuous and proving very difficult to keep cleared. At 0050 hours his oxygen saturation is ~50%. 0052 unsuccessful attempt, airway suctioned and oxygen sat is 55%. 0053 unsuccessful attempt and the airway suctioned, several operator changes. 0054 vital signs 221/148, 122, 42% with bagging and suctioning at every opportunity. A cricothyrotomy is discussed and the kit prepared.

Mr. Schwartz is becoming abdominally distended and a 16 french NG tube is attempted, once in each nare, and will not pass resulting in epistaxis. Facial seal remains a challenge due to the emesis and wet face. An oral OG placement attempt is also unsuccessful and abandoned. Staff in the room are watching his vital signs on the monitor and keeping the crew up to date on changes. At 0058 hours his 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 being prepared, however, the bagging pressure results in his trachea moving with each bag effort and will necessitate the need to stop bagging in order to make the attempt. 0102 vital signs are heart rate of 122 and oxygen saturation of 75%. After another unsuccessful intubation attempt the cric is initiated by Dr. Garvey and Paramedic Bartlett at 0106. The guidewire and dilators are placed however the ET tube is very difficult to advance into the trachea. As advancement is attempted it begins filling up with emesis, is pulled and replaced two additional times with the same results. Pulses are lost at 0117 and CPR resumes. Emesis continues and additional suction units and methods of airway clearance are discussed.

0120 the monitor is displaying asystole, CPR is ongoing with ER staff and at 0122 a pulse of 52 is noted on the monitor. CPR continues, gastric distension is increasing and cannot be evacuated. 0125 CPR ongoing by ER staff and at 0128 we note a oxygen saturation reading of 64% on the monitor. 0129 pleural decompression needles are placed in both the right and left upper chest cavities with no results and no air escape. 0133 hours CPR is stopped and Mr. Schwartz is pronounced deceased. The AOC on call for REACH, Mr. Jeff Cress, is updated on our outcome and the crew is released from the ER after assisting the ER crew in clean up duties.

Medication Administered

Time	Crew	Medication	Route	Site	Dose/Rate	Con.	Response	Progress Notes	PTA
00:18	RL	Ketamine	Intravenous		*180MG*			180 mg's Ketamine SIVP for sedation. Dose verified by ER nurse.	*No*

Crew Signature

Crew Member

I acknowledge that I have provided the above assessments/treatments for this patient.

I Agree I Disagree Not Applicable

Ambulance Crew Member Statement

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives were available or willing to sign on the patient's behalf.

I Agree I Disagree Not Applicable

Signature

Printed Name Ronnie Lyons Date

Reason Pt. Unable to Sign

Crew Signature

Crew Member

I acknowledge that I have provided the above assessments/treatments for this patient.

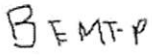
I Agree I Disagree Not Applicable

Ambulance Crew Member Statement

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives were available or willing to sign on the patient's behalf.

I Agree I Disagree Not Applicable

Signature



Printed Name Barry Bartlett Date

Reason Pt. Unable to Sign

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.
55. Burroughs, Jonathan H., "What Does the Hobby Lobby Ruling mean for Healthcare and the Separation of Church and State?" Hospital Impact, July 2, 2014.
56. Burroughs, Jonathan H., "Population Health is the Next Big Thing," Hospital Impact, June 5, 2014.
57. Burroughs, Jonathan H., and Bartholomew, Kathleen, "New Ways for Physicians and Nurses to Work Together, " Physician Executive Journal, Volume 40, Number 3, May-June, 2014.
58. Burroughs, Jonathan H., "Same Sex Marriage, Human Rights, and Affordable Healthcare," Hospital Impact, May 1, 2014.
59. Burroughs, Jonathan H., "Actuarial Management Key to Changing Industry," Hospital Impact, March 19, 2014.
60. Burroughs, Jonathan H., "Large Employers and the Drive for Healthcare Transformation," Hospital Impact, February 4, 2014.
61. Burroughs, Jonathan H., "The ACA and the Separation of Church and State," Hospital Impact, January 23, 2014.

62. Burroughs, Jonathan H., "More Unintended Consequences of Healthcare Reform," Hospital Impact, December 3, 2013.
63. Burroughs, Jonathan H., "Healthcare Leaders face Unintended Consequences of Reform," Hospital Impact, November 25, 2013.
64. Burroughs, Jonathan H., "The Origins of Healthcare-Aviation Comparisons," Hospital Impact, October 22, 2013.
65. Burroughs, Jonathan H., "Six Strategies Hospital Should Steal from the Airline Industry," Hospital Impact, September 17, 2013.
66. Burroughs, Jonathan H., "Informal Doc Leaders-A Help or Hindrance?" Hospital Impact, August 5, 2013.
67. Burroughs, Jonathan H., "Physician Engagement-Must Dos," Hospital Impact, July 10, 2013.
68. Burroughs, Jonathan H., "Physicians are not the only ones losing their Autonomy in Healthcare Reform," The Governance Institute's E-Briefings, Volume 10, Number 4, July, 2013.
69. Burroughs, Jonathan H., "Physician Engagement-What Not to Do," Hospital Impact, June 24, 2013.
70. Burroughs, Jonathan H., "Just what is Healthcare Reform Anyway?" Hospital Impact, May 20, 2013.
71. Burroughs, Jonathan H., "Is there Life after a Data Bank Report?", Physician Executive Journal, March-April, 2013.
72. Burroughs, Jonathan H., "How to Handle Medical Professional Conduct Violations," Hospital Impact, March 27, 2013.
73. Burroughs, Jonathan H., "How Healthcare Leaders can Prevent Doc Suspension," Hospital Impact, February 27, 2013.
74. Burroughs, Jonathan H., "Why it matters if States don't Expand Medicaid," Hospital Impact, January 23, 2013.
75. Burroughs, Jonathan H., "Is there Life for Docs after a Data Bank Report?" Hospital Impact, December 17, 2012.
76. Burroughs, Jonathan H., "Trends in Governance for New Care Delivery Models," Boardroom Press, December, 2012.
77. Burroughs, Jonathan H., "Revisiting the Key Components of the Affordable Care Act," Hospital Impact, November 24, 2012.
78. Burroughs, Jonathan H., "Dealing with the Aging Physician Advocacy or Betrayal," The Physician Executive," 38:6, November-December 2012.
79. Burroughs, Jonathan H., "What If? Two Post-Elections Scenarios for Healthcare," Hospital Impact, October 24, 2012.
80. Burroughs, Jonathan H., "Succession Planning-Luxury or Necessity?" Hospital Impact, October 10, 2012.
81. Burroughs, Jonathan H., "More ways to Reduce Hospital Readmissions," Hospital Impact, September 19, 2012.
82. Burroughs, Jonathan H., "Reducing Readmissions: It's Harder than it Looks," Hospital Impact, September 12, 2012.
83. Burroughs, Jonathan H., "New Models in Hospital-Physician Governance," Boardroom Press, August, 2012.
84. Burroughs, Jonathan H., "More of what Health Reform Doesn't Do," Hospital Impact, July 31, 2012.
85. Burroughs, Jonathan H., "What the Affordable Care Act Doesn't Do," Hospital Impact, July 26, 2012.
86. Burroughs, Jonathan H., "Improve Hospital-Doc Alignment with Job Expectations and Incentives," Hospital Impact, June 13, 2012.
87. Burroughs, Jonathan H., "Tips to Optimize Doc-Nurse Relationships," Hospital Impact, May 3, 2012.
88. Burroughs, Jonathan H., "Have Physician-Nurse Relationships Improved?" Hospital Impact, April 11, 2012.

C. Sources of Information 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

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)
62. Nevada Revised Statutes Pursuant to Case
63. Defendant Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine's Supplemental Responses to Plaintiff's First Set of Request for Production of Documents (5/11/20)
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
77. Reach Thoracostomy Tube Care Protocol
78. Reach Medical Direction Policy
79. Reach Medical Direction Standard of Care Protocol
80. Deposition of Katherine P. Raven, MD, Forensic Pathologist (10/21/20)
81. https://www.facs.org/quality-programs/trauma/education/rttdc
82. American Society of Anesthesiologists "Practice Guidelines for Management of the Difficult Airway," February, 2013.

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.

BURROUGHS

HEALTHCARE CONSULTING NETWORK

EXPERT SUPPLEMENTAL AND REBUTTAL 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

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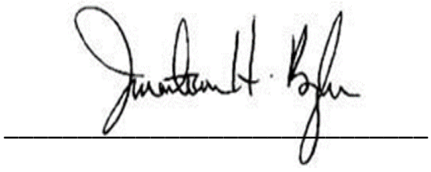
December 17, 2020



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 136 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.
55. Burroughs, Jonathan H., "What Does the Hobby Lobby Ruling mean for Healthcare and the Separation of Church and State?" Hospital Impact, July 2, 2014.
56. Burroughs, Jonathan H., "Population Health is the Next Big Thing," Hospital Impact, June 5, 2014.
57. Burroughs, Jonathan H., and Bartholomew, Kathleen, "New Ways for Physicians and Nurses to Work Together, " Physician Executive Journal, Volume 40, Number 3, May-June, 2014.
58. Burroughs, Jonathan H., "Same Sex Marriage, Human Rights, and Affordable Healthcare," Hospital Impact, May 1, 2014.
59. Burroughs, Jonathan H., "Actuarial Management Key to Changing Industry," Hospital Impact, March 19, 2014.
60. Burroughs, Jonathan H., "Large Employers and the Drive for Healthcare Transformation," Hospital Impact, February 4, 2014.
61. Burroughs, Jonathan H., "The ACA and the Separation of Church and State," Hospital Impact, January 23, 2014.

62. Burroughs, Jonathan H., "More Unintended Consequences of Healthcare Reform," Hospital Impact, December 3, 2013.
63. Burroughs, Jonathan H., "Healthcare Leaders face Unintended Consequences of Reform," Hospital Impact, November 25, 2013.
64. Burroughs, Jonathan H., "The Origins of Healthcare-Aviation Comparisons," Hospital Impact, October 22, 2013.
65. Burroughs, Jonathan H., "Six Strategies Hospital Should Steal from the Airline Industry," Hospital Impact, September 17, 2013.
66. Burroughs, Jonathan H., "Informal Doc Leaders-A Help or Hindrance?" Hospital Impact, August 5, 2013.
67. Burroughs, Jonathan H., "Physician Engagement-Must Dos," Hospital Impact, July 10, 2013.
68. Burroughs, Jonathan H., "Physicians are not the only ones losing their Autonomy in Healthcare Reform," The Governance Institute's E-Briefings, Volume 10, Number 4, July, 2013.
69. Burroughs, Jonathan H., "Physician Engagement-What Not to Do," Hospital Impact, June 24, 2013.
70. Burroughs, Jonathan H., "Just what is Healthcare Reform Anyway?" Hospital Impact, May 20, 2013.
71. Burroughs, Jonathan H., "Is there Life after a Data Bank Report?", Physician Executive Journal, March-April, 2013.
72. Burroughs, Jonathan H., "How to Handle Medical Professional Conduct Violations," Hospital Impact, March 27, 2013.
73. Burroughs, Jonathan H., "How Healthcare Leaders can Prevent Doc Suspension," Hospital Impact, February 27, 2013.
74. Burroughs, Jonathan H., "Why it matters if States don't Expand Medicaid," Hospital Impact, January 23, 2013.
75. Burroughs, Jonathan H., "Is there Life for Docs after a Data Bank Report?" Hospital Impact, December 17, 2012.
76. Burroughs, Jonathan H., "Trends in Governance for New Care Delivery Models," Boardroom Press, December, 2012.
77. Burroughs, Jonathan H., "Revisiting the Key Components of the Affordable Care Act," Hospital Impact, November 24, 2012.
78. Burroughs, Jonathan H., "Dealing with the Aging Physician Advocacy or Betrayal," The Physician Executive," 38:6, November-December 2012.
79. Burroughs, Jonathan H., "What If? Two Post-Elections Scenarios for Healthcare," Hospital Impact, October 24, 2012.
80. Burroughs, Jonathan H., "Succession Planning-Luxury or Necessity?" Hospital Impact, October 10, 2012.
81. Burroughs, Jonathan H., "More ways to Reduce Hospital Readmissions," Hospital Impact, September 19, 2012.
82. Burroughs, Jonathan H., "Reducing Readmissions: It's Harder than it Looks," Hospital Impact, September 12, 2012.
83. Burroughs, Jonathan H., "New Models in Hospital-Physician Governance," Boardroom Press, August, 2012.
84. Burroughs, Jonathan H., "More of what Health Reform Doesn't Do," Hospital Impact, July 31, 2012.
85. Burroughs, Jonathan H., "What the Affordable Care Act Doesn't Do," Hospital Impact, July 26, 2012.
86. Burroughs, Jonathan H., "Improve Hospital-Doc Alignment with Job Expectations and Incentives," Hospital Impact, June 13, 2012.
87. Burroughs, Jonathan H., "Tips to Optimize Doc-Nurse Relationships," Hospital Impact, May 3, 2012.
88. Burroughs, Jonathan H., "Have Physician-Nurse Relationships Improved?" Hospital Impact, April 11, 2012.

C. Sources of Information 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

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)
62. Nevada Revised Statutes Pursuant to Case
63. Defendant Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine's Supplemental Responses to Plaintiff's First Set of Request for Production of Documents (5/11/20)
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
77. Reach Thoracostomy Tube Care Protocol
78. Reach Medical Direction Policy
79. Reach Medical Direction Standard of Care Protocol
80. Deposition of Katherine P. Raven, MD, Forensic Pathologist (10/21/20)
81. https://www.facs.org/quality-programs/trauma/education/rttdc
82. American Society of Anesthesiologists "Practice Guidelines for Management of the Difficult Airway," February, 2013.
83. Expert Report of Myron J. Gomez, MD (11/3/20)
84. Expert Report of Peter Bastone, MPH (10/30/20)
85. Northeastern Nevada Regional Hospital Obtaining Informed Consent Policy/Procedure (1/16)
86. Northeastern Nevada Regional Hospital Crash Cart Documentation (1/16-6/16)
87. Northeastern Nevada Regional Hospital Ongoing and Focused Professional Practice Evaluations Policy/Procedure (5/16)
88. Exclusive Professional Services Agreement between Southeastern Emergency Physicians LLC and PHC-Elko d/b/a Northeastern Nevada Regional Hospital (2/10/15)
89. Deposition of Lauren Claerbout, Medical Staff Coordinator, NNRH (12/4/20)
90. Deposition of Rabecca Jones, RN, Director of Cardiopulmonary Services NNRH (12/4/20)

91. Deposition of Jennifer Tingle, RN, Director of Emergency Services NNRH (12/4/20)
92. Relevant Nevada Revised Statutes
93. Expert Rebuttal Report of Seth P. Womack, MD (12/17/20)

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. She has asked me to supplement my original expert opinions based upon recent discovery evidence and to rebut any expert opinions/reports with which I have disagreement.

E. Expert Supplemental 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 provide Douglas and Dianne Schwartz with informed consent for the elective intubation in violation of federal law, Nevada state law, the Joint Commission accreditation standards and the hospital's Obtaining Informed Consent Policy/Procedure.

II. Northeastern Nevada Regional Hospital failed to report Douglas Schwartz's unexpected and preventable death to the Nevada Division of Public and Behavioral Health of the Department of Health and Human Services in violation of Nevada state law

F. Foundations for Expert Supplemental Opinions

I. Northeastern Nevada Regional Hospital failed to provide Douglas and Dianne Schwartz with informed consent for the elective intubation in violation of federal law, Nevada state law, the Joint Commission accreditation standards and the hospital's Obtaining Informed Consent Policy/Procedure.

Introduction:

On December 7, 2020, I received the Northeastern Nevada Regional Hospital Obtaining Informed Consent Policy/Procedure (1/16) from retaining counsel in addition to multiple depositions and the rebuttal report of Seth P. Womack, MD. Although all hospitals must be in compliance with federal/state laws/regulation and accreditation standards with regards to informed consent, its hospital-based policy and procedure most clearly articulates its specific administrative standard of care consistent with federal and state law.

Foundation:

Northeastern Nevada Regional Hospital required the following informed consent process through its **January 2016: Northeastern Nevada Regional Hospital Obtaining Informed Consent Policy/Procedure**:

The patient, and when appropriate the family or the patient's delegated representative, is given a clear, concise explanation of (1) the nature of the proposed care, treatment, services, medications, interventions, or procedures; (**2) potential benefits, risks or side effects, including potential problems that might occur during recuperation; (3) the likelihood of achieving goals, (4) reasonable alternatives; (5) the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services;** and (6) when indicted, any limitations on the confidentiality of information learned from or about the patient.

A. Under Nevada Law, NRS 449.710 a patient has the right to receive information, in a manner in which they can understand, concerning the nature, risks, and costs associated with a given procedure or treatment plan. This information is to be provided by the treating and/or regular physician so that an informed decision can be made by the patient or other person legally designated to make decisions for the patient. NRS 41A.110 sites that a physician must have:

1. Explained to the patient in general terms a description of the procedure to be performed.

2. Explained to the patient any information on alternative methods of treatment, if any, and their general nature;

3. Explained to the patient that there may be risks, together with the general nature and extent of the risks involved;

4. Informed the patient when important surgical tasks may be performed by other doctors, assistant surgeons, providers, or residents under the supervision of the treating physician.

C. The medical staff is responsible for identifying those procedures which require informed consent.

3. Any procedure using sedation analgesia

D. During an emergency situation a physician is not required to provide full informed consent prior to rendering medical aid or performing a medical procedure when the physician has exercised reasonable efforts to locate the parents, legal guardian, or patient representative to obtain consent. The extent of services rendered should not extend beyond the immediate emergency. **Services rendered once the emergency has been abated would require informed consent of the patient or their authorized representative.**

As mentioned above, informed consent is also a federal, state, and Joint Commission mandated process.

The Centers for Medicare and Medicaid (CMS) Conditions of Participation require that:

§482.24(c)(2)(v) - Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.

Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative; (Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity. Hospitals are free to delegate to the responsible practitioner, who uses the available clinical evidence as informed by the practitioner's professional judgment, the determination of which material risks, benefits and alternatives will be discussed with the patient.)

This is confirmed by the Joint Commission Comprehensive Accreditation Manual (Hospital Standards) which confirm that:

RI.01.03.01 : The hospital honors the patient's right to give or withhold informed consent.

Rationale: Obtaining informed consent presents an opportunity to establish a mutual understanding between the patient and the licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps the patient to participate fully in decisions about his or her care, treatment, and services.

As emphasized above, the hospital's completion of a Federal/State/Hospital mandated informed consent form DOES NOT CONSTITUTE INFORMED CONSENT. The key is the understanding of the patient and her family as to what the realistic benefits and risks are so that they can make an 'informed consent' weighing all available information in words and concepts they can comprehend.

Note: A elements of performance indicate structural elements and C elements of performance indicate frequency elements.

A9: The informed consent process includes a discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.

A11: The informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment and services. The discussion encompasses risks, benefits, and side

effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.

C13: Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery.

Similarly, the State of Nevada through its revised statutes required that:

Nevada Revised Statute Ann. Section 41A.110

Consent of Patient: When conclusively established

A physician licensed to practice medicine under the provisions of chapter 630 or 633 NRS (Nevada Revised Statute), or a dentist licensed to practice dentistry under the provisions of chapter 631 of NRS has conclusively obtained the consent of a patient for a medical, surgical, or dental procedure as appropriate if the physician or dentist has done the following:

1. Explained to the patient in general terms without specific details the procedure to be undertaken

2. Explained to the patient alternative methods of treatment, if any and their general nature

3. Explained to the patient that there may be risks, together with the general nature and extent of the risks involved without enumerating such risks; and

4. Obtained the signature of the patient to a statement containing an explanation of the procedure, alternative methods of treatment and risks involved as provided in this section.

What were the specific issues pursuant to informed consent with regards to Mr. Schwartz's elective endotracheal intubation performed on June 22-23, 2016?

- Mr. Schwartz was determined to be stable prior to his procedure and thus per state law, The Joint Commission and hospital policy, the hospital was required to be provide an informed consent for the elective procedure following the general emergency informed consent signed by Ms. Schwartz earlier for emergency evaluation, management and stabilization.

As mentioned in my prior expert report, there is a significant misrepresentation in this case by the defense that Mr. Schwartz died of traumatic injuries as he died of massive aspiration secondary to multiple failed intubations. This is specifically addressed by Dr. Katherine Raven, Forensic Pathologist in her sworn testimony:

"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)

This is consistent with my own clinical background as I personally took care of dozens of patients like Mr. Schwartz in a community hospital setting, admitted them to a general surgeon for observation and monitoring, they did fine and were discharged home several days or a week later.

I would also like to remind the jury that this is also consistent with the testimony of the clinicians and risk management staff at the hospital who characterized his overall clinical condition prior to intubation as "stable."

"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"**

The hospital's January, 2016 "Obtaining Informed Consent Policy and Procedure" clearly states that:

"C. The medical staff is responsible for identifying those procedures which require informed consent.

3. Any procedure using sedation analgesia"

"D. During an emergency situation a physician is not required to provide full informed consent prior to rendering medical aid or performing a medical procedure when the physician has exercised reasonable efforts to locate the parents, legal guardian, or patient representative to obtain consent. The extent of services rendered should not extend beyond the immediate emergency. **Services rendered once the emergency has been abated would require informed consent of the patient or their authorized representative."**

This is consistent with every hospital I have worked with throughout the country. There is a general or emergency informed consent which is typically signed when a patient enters a hospital or emergency department. This covers general care in the hospital and emergency care in the emergency department while the patient is unstable. All hospitals then require a more specific informed consent for elective (as opposed to emergent) procedures both in the hospital and emergency department. This is why when you go to a hospital for a surgical procedure you must sign two informed consents. One for the admission and one for the procedure. If multiple elective procedures are performed, there is an

informed consent for each and every one and often anesthesia has its own informed consent form for the anesthesia portion of each and every case.

The hospital policy clearly states that "once the emergency has been abated" then informed consent of the patient or authorized representative is required and the policy further states that any procedures using sedation/analgesia requires informed consent.

Why informed consent for an elective endotracheal intubation prior to transfer? Contrary to several opinions, Mr. Schwartz had stable vital signs and stable oxygen saturation (92%-90%) which could easily be maintained through a face mask. Performing an elective endotracheal intubation under rapid sequence moderate sedation is potentially dangerous for several reasons:

- The medication administered paralyzes the skeletal muscles of the chest making it impossible for the patient to breathe on his own. Thus the patient is completely dependent upon emergency clinical personnel securing the airway 100% of the time. There is no margin for error.

- Since the patient did not require endotracheal intubation to support his life at that time, this is an elective and not an emergent procedure that may place the patient's life at risk and each and every patient has the right to make the determination as to whether to take that risk.

Thus, Mr. and Ms. Schwartz had the legal right of informed consent prior to this elective procedure which led directly to his untimely and preventable death.

- A majority of reasonable physicians and clinical experts would not have intubated Mr. Schwartz based upon his clinical and respiratory findings nor transferred him to a level one trauma center and thus Dr. Garvey was obligated to provide Mr. and Ms. Schwartz with reasonable management alternatives to the endotracheal intubation and transfer to a level one trauma center.

As mentioned above, I personally cared for many patients of equivalent acuity as Mr. Schwartz over a 30-year clinical career as an emergency physician and never sent any of them to a tertiary care center. We had a well-staffed monitoring unit in a critical access hospital with well trained nurses and qualified general surgeons and nurse anesthetists who could easily handle such patients 24/7 without the use of trauma surgeons or a level one trauma center and surgical ICU.

Dr. Seth Womack, board certified emergency physician and expert agrees:

"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… 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."

Obviously, it will be for the jury to decide as to whether the procedure was necessary or not as defense experts will likely testify to the contrary. However, the point is that a significant number of reasonable physicians will agree that the elective endotracheal intubation was not medically necessary contrary to what Dr. Garvey informed Mr. and Ms. Schwartz. The key is that it was the legal right of Mr. and Mrs. Schwartz to ultimately make the decision as to whether to consent to a procedure which many physicians would agree was not indicated and unnecessary.

This is verified in the CMS Conditions of Participation, Nevada Revised Statutes and the Joint Commission accreditation standards above. Northeastern Nevada Regional Hospital specifically states in its "Obtaining Informed Consent Policy and Procedure":

"The patient, and when appropriate the family or the patient's delegated representative, is given a clear, concise explanation of (1) the nature of the proposed care, treatment, services, medications, interventions, or procedures; **(2) potential benefits, risks or side effects, including potential problems that might occur during recuperation; (3) the likelihood of achieving goals, (4) reasonable alternatives; (5) the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services;"**

Dr. Garvey did not have the legal right to perform an elective endotracheal intubation on a stable patient under moderate sedation utilizing paralytic agents without offering Mr. and Ms. Schwartz the opportunity to decide for themselves as to whether they would consent to such a procedure given the risks of performing the procedure in an awake stable patient with a full stomach. Again, they were denied the legal right to consent to a procedure that directly led to the untimely and preventable death of Mr. Schwartz.

- Mr. and Mrs. Schwartz had the legal right to know that another practitioner (Barry Bartlett, RN, Paramedic) was going to perform the endotracheal intubation so that they could make the decision as to whether or not they would consent to such treatment by a paramedic.

As I mentioned in my previous report, this was a high-risk elective endotracheal intubation for several reasons:

- The patient more likely than not had a full stomach and was at significant risk of aspiration
- The patient was stable and required moderate sedation techniques that would paralyze the chest muscles, eliminate many protected airway reflexes, and make it necessary for clinical personnel to successfully secure the airway and protect it from aspiration
- Neither Dr. Garvey nor Mr. Bartlett were qualified to place a true surgical airway (tracheostomy) or perform advanced airway techniques and thus, there was no safety net if they failed to secure the airway in a timely way.
- Both practitioners declined to call the general surgeon on call or nurse anesthetist who could have performed a surgical airway and utilized advanced airway techniques which placed Mr. Schwartz under even greater risk.

Under the hospital's "Providing Informed Consent" policy, Mr. and Ms. Schwartz had a legal right to know what clinical personnel were available to perform or assist in this procedure and who would perform it:

"A. Under Nevada Law, NRS 449.710 a patient has the right to receive information, in a manner in which they can understand, concerning the nature, risks, and costs associated with a given procedure or treatment plan. This information is to be provided by the treating and/or regular physician so that an informed decision can be made by the patient or other person legally designated to make decisions for the patient. NRS 41A.110 sites that a physician must have:

4. Informed the patient when important surgical tasks may be performed by other doctors, assistant surgeons, providers, or residents under the supervision of the treating physician."

In my clinical administrative career, I encountered many patients who did not wish to allow paramedics, advanced practice nurses, or physician assistants to perform procedures that could also be performed by highly skilled physicians and/or nurse anesthetists. It is the patient's legal right to know who is performing elective procedures and what are the reasonable staffing alternatives. Both Mr. and Mrs. Schwartz were denied the right to provide informed consent as to not only who would perform this procedure but whether there were more skilled personnel available on call who could perform the procedure more safely than an emergency physician and paramedic.

Thus, neither Mr. or Ms. Schwartz were ever provided their legal right to consent (or not) to an elective procedure which a majority of physicians would agree was medically unnecessary and which ultimately led to Mr. Schwartz's untimely and avoidable death through massive aspiration secondary to failure to intubate properly.

Their failure to receive legally mandated informed consent led directly to the failed intubation attempt that caused Mr. Schwartz's massive aspiration and untimely preventable death.

II. Northeastern Nevada Regional Hospital failed to report Douglas Schwartz's unexpected and preventable death to the Nevada Division of Public and Behavioral Health of the Department of Health and Human Services in violation of Nevada state law

Introduction:

On December 8, 2020, I received the following pieces of discovery evidence:

- Deposition of Lauren Claerbout, Medical Staff Coordinator, NNRH (12/4/20)
- Deposition of Rabecca Jones, RN, Director of Cardiopulmonary Services NNRH (12/4/20)
- Deposition of Jennifer Tingle, RN, Director of Emergency Services NNRH (12/4/20)
- Northeastern Nevada Regional Hospital Ongoing and Focused Professional Practice Evaluations Policy/Procedure (5/16)

On December 17, 2020, I received the rebuttal report of Seth P. Womack, MD.

What I was looking for upon review was the hospital's approach to addressing events such as what happened to Mr. Schwartz in a systemic way in order to avoid similar incidents from recurring in the future. This is an important indicator as to whether a hospital is willing to do what reasonable hospitals are obligated to do which is to investigate unexpected adverse outcomes in order to analyze and diagnose systemic failures that more likely than not led to this incident. The presence (or absence) of such investigations is indicative of how seriously a hospital takes such incidents, whether or not they are willing to openly acknowledge systemic failures (through public reporting and disclosure to families) and whether or not they are committed to preventing similar episodes from happening in the future.

For instance, as articulated in my original expert report (11/5/20), one of the obvious systemic failures in this case was not having fundamental policies and procedures such as "Managing Advanced Airways" and "Rapid Sequence Intubation" and "Trauma Team Activation" which would have enabled the clinical team to handle Mr. Schwartz's case very differently. Another systemic failure was not creating administrative expectations to involve the on call general surgeon and nurse anesthetist in both clinical decision-making and in co-managing Mr. Schwartz's trauma care within the context of an elective endotracheal intubation that was both optional and extremely high risk due to Mr. Schwartz's full stomach, alert sensorium, and more than adequate oxygenation.

Thus, I was looking in the above listed documents for evidence that a comprehensive systemic evaluation was completed and appropriately reported to both the State of Nevada and The Joint Commission to enable the hospital to both rectify systemic failures within this case and to prevent its recurrence in other cases. In addition, many of my points regarding the intubation of Mr. Schwartz by Dr. Garvey and Mr. Bartlett from a healthcare administrative perspective were confirmed in both the report and rebuttal report of Seth P. Womack, MD, the plaintiff's clinical expert.

Finally, the presence or absence of a comprehensive investigation is indicative as to whether the hospital has a culture of facing its systemic failures or defending and denying them in order to avoid legal liability and to create the illusion of patient safety when in fact, patients and the public may be placed at risk. Thus, the presence or absence of such a comprehensive investigation is indicative more likely than not as to whether the hospital engaged in similarly necessary investigations in the past which would have more likely than not prevented the Schwartz case from occurring.

Hence the following supplemental opinion is based upon the newly received discovery evidence listed above:

Foundation:

The State of Nevada has specific requirements for the reporting of unexpected deaths that occur in healthcare facilities throughout the state:

NRS 439.835 Mandatory reporting of sentinel events.

1. Except as otherwise provided in subsection 2:

(a) A person who is employed by a health facility shall, within 24 hours after becoming aware of a sentinel event that occurred at the health facility, notify the patient safety officer of the facility of the sentinel event; and

(b) The patient safety officer shall, within 13 days after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to:

(1) The Division; and

(2) The representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer.

2. If the patient safety officer of a health facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the health facility, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:

(a) The Division; and

(b) The representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer.

NRS 439.837 Mandatory investigation of sentinel event by health facility; exceptions.

1. Except as otherwise provided in subsections 2 and 3, **a health facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation or cause an investigation to be conducted concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.**

2. A health facility is not required to take the actions described in subsection 1 concerning a death confirmed to have resulted from natural causes.

NRS 439.855 Notification of patients involved in sentinel events.

1. Each health facility that is located within this state shall designate a representative for the notification of patients who have been involved in sentinel events at that health facility.

2. A representative designated pursuant to subsection 1 shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at the health facility, provide notice of that fact to each patient who was involved in that sentinel event.

3. The provision of notice to a patient pursuant to subsection 2 must not, in any action or proceeding, be considered an acknowledgment or admission of liability.

4. A representative designated pursuant to subsection 1 may or may not be the same person who serves as the facility's patient safety officer.

A sentinel event is defined by The Joint Commission as follows:

"A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events."

A sentinel event is so named because it signals the need for immediate investigation and response. The Joint Commission requires that all sentinel events undergo immediate investigation by the hospital and are subject to review by The Joint Commission.

The Joint Commission further requires that the following steps take place for all identified sentinel events:

- A formalized team response that stabilizes the patient, discloses the event to the patient and family, and provides support for the family as well as staff involved in the event
- Notification of hospital leadership
- Immediate investigation
- Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
- Strong corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement overtime
- Timeline for implementation of corrective actions
- Systemic improvement

Northeastern Nevada Regional Hospital also has a policy requirement to investigate "unexpected deaths" through its May, 2016 "Ongoing and Focused Professional Practice Evaluations Policy/Procedure" where it describes the triggers of an 'ongoing professional practice evaluation by service:

"Ongoing Professional Practice Triggers by Service:

A. All Service Lines:

1. Unexpected mortality

2. Unanticipated death

4. Patient/Family complaint

11. Informed consent not obtained

14. Respiratory Depression following IV conscious sedation

The reason for the emphasis by the State of Nevada and Joint Commission on sentinel event reporting is that such events indicated systemic failures that must be addressed to prevent similar injuries or deaths in the future. This is essential for the health and safety of the people of Nevada which is why the state has such a statute to enforce this necessary reporting and investigatory activity.

I have not received any evidence of such a report to the State of Nevada and my understanding is that there are consequences for non-compliance:

2. If a health facility commits a violation of any provision of NRS 439.800 to 439.890, inclusive, and does not, of its own volition, report the violation to the Administrator, the Division may, in accordance with the provisions of subsection 3, impose an administrative sanction:

(a) For failure to report a sentinel event, in an amount not to exceed $100 per day for each day after the date on which the sentinel event was required to be reported pursuant to NRS 439.835;

(b) For failure to adopt and implement a patient safety plan pursuant to NRS 439.865, in an amount not to exceed $1,000 for each month in which a patient safety plan was not in effect; and

(c) For failure to establish a patient safety committee or failure of such a committee to meet pursuant to the requirements of NRS 439.875, in an amount not to exceed $2,000 for each violation of that section.

Although the failure to report Mr. Schwartz's untimely and preventable death did not lead directly to his death as it occurred after the fact, it is evidence of the hospital's more likely than not failure to perform similar comprehensive investigations in prior similarly situated cases which would have directly led to the prevention of the case involving Mr. Schwartz. It also demonstrated the hospital's "utter indifference and conscious disregard" for the safety of its patients and may provide the court with evidence for punitive damages.

Hospitals that fail to take systemic failures seriously are destined to repeat them and it is appropriate for the State of Nevada to actively enforce its requirement for mandatory reporting

in order to acknowledge of the importance of a comprehensive and detailed analysis in order to prevent similar events from occurring in the future.

G. Rebuttal Opinions:

Introduction: I had the opportunity to review the expert reports of the following individuals:

- Expert Report of Myron J. Gomez, MD (11/3/20)
- Expert Report of Peter Bastone, MPH (10/30/20)

and was asked by retaining counsel to respond to some of their expert opinions.

Expert Report of Myron J. Gomez, MD (11/3/20):

Assertion: "Mr. Schwartz sustained multiple traumatic life-threatening injuries when he was struck by a drunk driver. Due to his pneumothorax, compromised respiratory status and multiple rib fractures, Mr. Schwartz needed to be evaluated and treated by a trauma surgeon. It was therefore appropriate to transfer Mr. Schwartz to a trauma center."

Rebuttal: As noted above in both of my reports, according to forensic pathology testimony, there was nothing in the original traumatic injuries that directly led to Mr. Schwartz's untimely and preventable death. The cause of his death according to his forensic pathology report was "massive aspiration" which was caused by a failure to properly intubate him by Dr. Garvey and Mr. Bartlett. In my experience as medical director of three emergency departments, most reasonable emergency physicians would not refer such a patient as Mr. Schwartz to a trauma center as general surgeons and qualified nursing staffs are more than adequate to manage such minor to moderate trauma that requires symptomatic monitoring and no significant surgical intervention. The treatment of multiple rib fractures with pulmonary contusions is well within the scope of service of community hospitals that are staffed with qualified personnel. Dr. Garvey never considered the option of keeping the patient at Northeastern Nevada Regional Hospital and the necessity of Mr. Schwartz's transfer is not consistent with what many reasonable clinicians and healthcare administrators would do based upon the hospital's scope of practice.

Northeastern Nevada Regional Hospital's Website contains the following information concerning its surgical services:

"Surgery Department

The staff of the Northeastern Nevada Regional Hospital Department of Surgery is credited with over 200 years of combined surgical experience. In addition to two nationally certified

staff personnel, all Same Day Surgery (SDSU) and Recovery (PACU) nurses have Pediatric Advanced Life Support (PALS) and Advance Cardiac Life Support (ACLS) certifications.

The services include same-day surgery, operating and endoscopic procedure rooms, post-anesthesia care, recovery and discharge units, as well as services provided for longer-stay inpatients. Each specialty provides services from minor to major surgical procedures.

Surgical Services: Ears, Nose & Throat, Gastroenterology/Endoscopy, **General Surgery,** Gynecology , Obstetrical Surgery (C-Sections) , Ophthalmology , Orthopedic Surgery, Pain Management (RF Ablations, Epideral Steroid Injections), Podiatry, Urology , Spinal Procedures, Interventional Cardiology Procedures"

Under Anesthesia, Mr. Michael Hunt and Mr. James Cooper are listed as certified registered nurse anesthetists (CRNAs) on staff.

Thus, Northeastern Nevada Regional Hospital had a robust surgical department and all of the necessary resources to manage a patient such as Mr. Schwartz.

Assertion: "Mr. Bartlett's and Dr. Garvey's management of a difficult airway followed fundamental principles. This included preoxygenation, rapid sequence intubation, repositioning of the air way, log rolling the patient, use of video assisted and standard blades, removal of occluded endotracheal tubes, use of a bougie and finally cricothyrotomy. Difficult airway management by Mr. Bartlett and Dr. Garvey met the standard of care."

Rebuttal: I am frankly embarrassed to respond to this absurd statement. According to the Forensic Pathologist Dr. Katherine Raven, the direct cause of Mr. Schwartz's death was massive aspiration secondary to a failed elective intubation attempt. An elective procedure that directly causes the unexpected, untimely, and preventable cause of death cannot be considered the standard of care unless reasonable physicians and healthcare administrators would believe that a 58-year-old male with essential hypertension and the injuries described should be expected to die of an elective endotracheal intubation. Attempting an intubation nine times and directly causing massive aspiration comes nowhere near a reasonable standard of care from a healthcare administrative perspective. A reasonable hospital would have provided its clinicians with specific guidance in the management of high-risk elective intubations and require consultation with its on call general surgical and anesthesia staff to ensure that such procedures are conducted safely each and every time. I personally believe that a jury will be offended and angered by Dr. Gomez's assertion.

Expert Report of Peter Bastone, MPH (10/30/20):

Assertion: "NNRH is a fully accredited JCAH hospital that met and exceeded those policies and procedures driven by the standards and rationale .NNRH does have an informed consent policy. There is no Informed Consent requirement for intubation on chest tube placement when in a trauma or ER emergency situation."

Rebuttal: Obviously, my rebuttal for this assertion is found on pages 12-19 of this report. I will simply add that The Joint Commission has not been called JCAH in over a decade and both my original and supplemental reports go into detail on the policies and procedures that Northeastern Nevada Regional Hospital should have had (e.g. Trauma Team and Management of High-Risk Airways etc.) in order to avoid Mr. Schwartz's untimely and avoidable death secondary to massive aspiration and failed intubation attempts. Ultimately, the primary responsibility of any hospital is patient safety and there were structural, procedural, and outcomes driven interventions that NNRH could have done that would have protected patients like Mr. Schwartz and its failure to implement and enforce reasonable policies and procedures and provide reasonable supervision to members of its medical and nursing staff directly contributed to Mr. Schwartz's death at age 58.

H. Conclusion:

Having served in the healthcare industry as an emergency physician, medical director, president of a medical staff, member of a governing body, national healthcare administrative consultant and expert, healthcare administrative author, this case is disturbing for several reasons:

1. Mr. Schwartz had routine minor to moderate traumatic injuries that any reasonable community hospital with qualified nurses, monitored beds, general surgeons, and nurse anesthetists should be able to handle. As mentioned above, I cared for dozens of patients with the equivalent injuries of Mr. Schwartz and considered such patients routine general surgical admissions. This is the first case in over 43 years that I have encountered where an individual with such injuries died of a poorly performed elective procedure such as an intubation.

2. Northeastern Nevada Regional Hospital had qualified general surgeons and nurse anesthetists who could have successfully managed Mr. Schwartz conservatively without the necessity for endotracheal intubation or air transfer to a level one trauma center. It makes no sense to advertise for such services on a web site and then fail to utilize them for routine care well within the hospital's scope of service.

3. As someone who taught endotracheal intubation in my role as medical director of three emergency departments over a thirty-year period. Both Dr.

Garvey and Mr. Bartlett made elemental errors which are both covered in my original expert report based upon reasonable hospital policies and by the expert clinical testimony of others. These errors led directly to the massive aspiration of gastric contents and the failure to rescue Mr. Schwartz's airway in time to save his life with a bona fide surgical airway (tracheostomy) that neither practitioner was qualified to perform.

4. A reasonable hospital would utilize a sentinel event policy and procedure to perform an in-depth root cause analysis and involve all relevant practitioners and administrative staff, inform the family of its findings and report both its analysis and findings to The Joint Commission and the State of Nevada Division of Public and Behavioral Health in order to ensure that such events never recurred. Attempting to "defend and deny" such liability only serves to place the public on notice that the hospital places its financial interests over its fiduciary responsibility to its patients and community to provide safe services and protect each and every person from harm. The VA Hospital in Lexington, Kentucky demonstrated decades ago that the early disclosure of medical errors and early settlement with patients and their families in conjunction with a robust investigatory analysis of unexpected serious injuries and deaths resulted in a significant decrease in risk management costs. Thus, it is neither self-serving nor productive for hospitals or their carriers to deny medical errors when they occur secondary to systemic failures for it only perpetuates the problem, increases risk management costs, and sends a damaging message to the public who rely on its services for care and entrust a hospital with their lives.

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.

BURROUGHS

HEALTHCARE CONSULTING NETWORK

SECOND EXPERT SUPPLEMENTAL REPORT

In the matter of

Dianne Schwartz, individual and as Special Administrator of the Estate of Douglas R. Schwartz, Deceased;

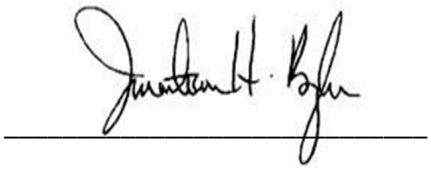
v.

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

June 21, 2021



Jonathan H. Burroughs, MD, MBA, FACHE, FAAPL
President and CEO, The Burroughs Healthcare Consulting Network, Inc.

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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**
- **17-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 153 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 (2020-2021)
- JD Candidate, University of New Hampshire Franklin Pierce School of Law, Concord, New Hampshire (2021-2024)
- CALI Excellence for the Future Award for excellence and highest performance in the study of Introduction to Legal Analysis I (March, 2021)
- CALI Excellence for the Future Award for excellence and highest performance in the study of Torts I (March, 2021)
- 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 and Smith, Ron, "Data-Driven Population Health Shapes a New Model of Primary Care," Journal of Healthcare Management, Volume 66, Number 1, January-February, 2021, pages 9-13.
4. 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.
5. Burroughs, Jon, "Key Operational Success Factors," Healthcare Executive, volume 34, number 6, pages 34-36, November-December, 2019.
6. Burroughs, Jon, "Creating a Primary Care Model for the 21st Century," Governance Institute System Focus, November, 2019.
7. Burroughs, Jon, "Aligning Physician Compensation in a Pay for Value Era," Governance Institute E-Briefings, Volume 16, No. 3, May, 2019, pages 1-3.
8. Burroughs, Jon, "Aligning Physician Compensation with Payer Contracts and your Organization's Strategic Objectives," Journal of Healthcare Compliance, May-June, 2019.
9. Burroughs, Jonathan H., "21st Century Skills for Accountable Boards," The Board Room Press, The Governance Institute, February 2019.
10. Burroughs, Jon, "How to Build a Population Health Program," Pediatric Focus, The Governance Institute, December, 2018.
11. Burroughs, Jon, "Rethinking Physician Documentation," Healthcare Executive, May-June, 2018, pages
12. Burroughs, Jon, Rural Focus: "Rural Healthcare: A Vision for 2018, The Governance Institute, March, 2018.
13. 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.
14. Burroughs, Jonathan H., Hospital Impact: "Medicaid on the Chopping Block for 2018." Fierce Healthcare, February 6, 2018.
15. Burroughs, Jonathan H., Hospital Impact: "Why Funding of the Children's Health Insurance Program Matters," Fierce Healthcare, January 9, 2018.
16. Burroughs, Jonathan H., Hospital Impact: "Why Doctors should Oversee, Not Conduct Clinical Documentation, Fierce Healthcare, December 7, 2017.
17. Burroughs, Jonathan H. et al,"ACHE Roundtable: A focus on Physician Leadership," Healthcare Executive, volume 32, number 6, November/December, 2017, pp 20-26.
18. Burroughs, Jonathan H., Hospital Impact: "Medical Staff Services Professionals-A New Role for the 21st Century," Fierce Healthcare, August 31, 2017.
19. Burroughs, Jonathan H., Hospital Impact: "Death of the Skinny Repeal Bill and why Covered Lives Matter," Fierce Healthcare, August 3, 2017.
20. Burroughs, Jonathan H., Hospital Impact: "What's Next for the AHCA? Hopefully, pragmatic solutions to healthcare policy dilemmas," Fierce Healthcare, June 8, 2017.
21. Burroughs, Jonathan H., Hospital Impact: "The Meadows-MacArthur Amendment is Strike Two for the American Health Care Act", Fierce Healthcare, May 1, 2017.
22. Burroughs, Jonathan H., "What it takes to be a Top Performing Organization," NAMSS Synergy, May-June, 2017.
23. Burroughs, Jonathan H., "Hospital Impact-CBO Report Reveals Republican Healthcare Bill is Political Position," Fierce Healthcare, March 16, 2017.
24. Burroughs, Jonathan H., "Hospital Impact-A Closer Look at the GOP's 'Replace then Repeal' Proposal, Fierce Healthcare, February 22, 2017.
25. Burroughs, Jonathan H., "Hospital Impact-No Consensus in Sight for the Republican ACA Replacement," Fierce Healthcare, February 2, 2017.
26. Burroughs, Jonathan H., "Hospital Impact-The Implications of Donald Trump's ACA Executive Order," Fierce Healthcare, January 25, 2017.
27. Burroughs, Jon, "Regain Lost Luster with Modern Medicine Ideas," Physician Leadership Journal, Volume 4, Issue 1, January/February, 2017.
28. Burroughs, Jonathan H., "Hospital Impact-Drug Companies Win, Patient Safety Loses with the 21st Century Cures Act, Fierce Healthcare, December 15, 2016.
29. Burroughs, Jonathan H., "Hospital Impact-Why the GOP will not Repeal the Affordable Care Act in its Entirety," Fierce Healthcare, November 16, 2016.

30. Burroughs, Jonathan H., ”Industry Voices: For President Candidates, Two very Different Views on Healthcare, Fierce Healthcare, November 7, 2016.
31. Burroughs, Jonathan H., "Three Keys to Giving Healthcare Consumers what they Want," Hospital Impact, September 26, 2016.
32. Burroughs, Jonathan H., “Everything you need to know about the New CMS Cardiac Bundled Payment Program,” Hospital Impact, August 17, 2016.
33. Burroughs, Jonathan H., “Healthcare Policy Implications of the Presidential Election,” Hospital Impact, July 14, 2016.
34. Burroughs, Jonathan H., “MACRA is Now! A Roadmap to Compliance,” Hospital Impact, June 15, 2016.
35. Burroughs, Jonathan H., “End Physician Burnout by Allowing Doctors to be Doctors Again,” Hospital Impact, May 12, 2016.
36. Burroughs, Jonathan H., “Clinical Pharmacist-An Essential Member of the Healthcare Team,” Hospital Impact, April 21, 2016.
37. Burroughs, Jonathan H., “When it comes to Patient Safety-Culture is Everything,” Hospital Impact, March 17, 2016.
38. Burroughs, Jonathan H., “How MACRA is Hastening the Demise of Fee for Service,” Hospital Impact, February 18, 2016.
39. Burroughs, Jonathan H., “The Ten Traits of a Great Healthcare Organization,” Hospital Impact, January 21, 2016.
40. Burroughs, Jonathan H., “Five Steps to Staging and Integrating a Population Health Program,” Hospital Impact, December 10, 2015.
41. Burroughs, Jonathan H., “The Supreme Court and the ACA Contraception Mandate-Deja Vu All over Again,” Hospital Impact, November 12, 2015.
42. Burroughs, Jonathan H., “ICD-10: Collaborative Ways to Reduce Operating Costs,” Hospital Impact, October 29, 2015.
43. Burroughs, Jonathan H., “Medical Overuse and why Fee for Service must Go,” Hospital Impact, September 3, 2015.
44. Burroughs, Jonathan H., “Medicare’s Potential Reimbursement for End of Life Discussion: A Big Step Forward,” Hospital Impact, July 23, 2015.
45. Burroughs, Jonathan H., “Ken Cohn- In Tribute to a Colleague and a Friend,” Hospital Impact, July 16, 2015.
46. Burroughs, Jonathan H., “Activity Base Costing Helps Providers Deliver High Quality Low Cost Care,” Hospital Impact, May 20, 2015.
47. Burroughs, Jonathan H., “Strategies to Survive a Brave New Value Based World,” Hospital Impact, April 1, 2015.
48. Burroughs, Jonathan H. and Nash, David, “Population Health and the Disruptive Innovative Business Models Necessary to Support It,” Boardroom Press, April 2015
49. Burroughs, Jonathan H., “Are you ready for E-Health Invasion?” Hospital Impact, February 19, 2015.
50. Burroughs, Jonathan H., “How the Unraveling of the Affordable Care Act could Affect Providers,” Hospital Impact, January 14, 2015.
51. Burroughs, Jonathan H., “Ebola-Fear not Facts Drive Frenzy,” Hospital Impact, November 13, 2014.
52. Burroughs, Jonathan H., “St. Luke’s Population Health Programs Promote Innovation,” Hospital Impact, October 23, 2014.
53. Burroughs, Jonathan H., “Silence can Kill: Doctors, Nurses, and Staff must hold each other Accountable,” Hospital Impact, September 4, 2014.
54. Burroughs, Jonathan H., “Disruptive Innovation in Healthcare: Are you ready?” The Governance Institute’s E-Briefings, Volume 11, Number 7, September, 2014.
55. Burroughs, Jonathan H., “Involving Physicians in Strategic Planning,” Hospital Impact, August 6, 2014.
56. Burroughs, Jonathan H., “What Does the Hobby Lobby Ruling mean for Healthcare and the Separation of Church and State?” Hospital Impact, July 2, 2014.
57. Burroughs, Jonathan H., “Population Health is the Next Big Thing,” Hospital Impact, June 5, 2014.
58. Burroughs, Jonathan H., and Bartholomew, Kathleen, “New Ways for Physicians and Nurses to Work Together, “ Physician Executive Journal, Volume 40, Number 3, May-June, 2014.
59. Burroughs, Jonathan H., “Same Sex Marriage, Human Rights, and Affordable Healthcare,” Hospital Impact, May 1, 2014.
60. Burroughs, Jonathan H., “Actuarial Management Key to Changing Industry,” Hospital Impact, March 19, 2014.
61. Burroughs, Jonathan H., “Large Employers and the Drive for Healthcare

Transformation," Hospital Impact, February 4, 2014.

62. Burroughs, Jonathan H., "The ACA and the Separation of Church and State," Hospital Impact, January 23, 2014.
63. Burroughs, Jonathan H., "More Unintended Consequences of Healthcare Reform," Hospital Impact, December 3, 2013.
64. Burroughs, Jonathan H., "Healthcare Leaders face Unintended Consequences of Reform," Hospital Impact, November 25, 2013.
65. Burroughs, Jonathan H., "The Origins of Healthcare-Aviation Comparisons," Hospital Impact, October 22, 2013.
66. Burroughs, Jonathan H., "Six Strategies Hospital Should Steal from the Airline Industry," Hospital Impact, September 17, 2013.
67. Burroughs, Jonathan H., "Informal Doc Leaders-A Help or Hindrance?" Hospital Impact, August 5, 2013.
68. Burroughs, Jonathan H., "Physician Engagement-Must Dos," Hospital Impact, July 10, 2013.
69. Burroughs, Jonathan H., "Physicians are not the only ones losing their Autonomy in Healthcare Reform," The Governance Institute's E-Briefings, Volume 10, Number 4, July, 2013.
70. Burroughs, Jonathan H., "Physician Engagement-What Not to Do," Hospital Impact, June 24, 2013.
71. Burroughs, Jonathan H., "Just what is Healthcare Reform Anyway?" Hospital Impact, May 20, 2013.
72. Burroughs, Jonathan H., "Is there Life after a Data Bank Report?", Physician Executive Journal, March-April, 2013.
73. Burroughs, Jonathan H., "How to Handle Medical Professional Conduct Violations," Hospital Impact, March 27, 2013.
74. Burroughs, Jonathan H., "How Healthcare Leaders can Prevent Doc Suspension," Hospital Impact, February 27, 2013.
75. Burroughs, Jonathan H., "Why it matters if States don't Expand Medicaid," Hospital Impact, January 23, 2013.
76. Burroughs, Jonathan H., "Is there Life for Docs after a Data Bank Report?" Hospital Impact, December 17, 2012.
77. Burroughs, Jonathan H., "Trends in Governance for New Care Delivery Models," Boardroom Press, December, 2012.
78. Burroughs, Jonathan H., "Revisiting the Key Components of the Affordable Care Act," Hospital Impact, November 24, 2012.
79. Burroughs, Jonathan H., "Dealing with the Aging Physician Advocacy or Betrayal," The Physician Executive," 38:6, November-December 2012.
80. Burroughs, Jonathan H., "What If? Two Post-Elections Scenarios for Healthcare," Hospital Impact, October 24, 2012.
81. Burroughs, Jonathan H., "Succession Planning-Luxury or Necessity?" Hospital Impact, October 10, 2012.
82. Burroughs, Jonathan H., "More ways to Reduce Hospital Readmissions," Hospital Impact, September 19, 2012.
83. Burroughs, Jonathan H., "Reducing Readmissions: It's Harder than it Looks," Hospital Impact, September 12, 2012.
84. Burroughs, Jonathan H., "New Models in Hospital-Physician Governance," Boardroom Press, August, 2012.
85. Burroughs, Jonathan H., "More of what Health Reform Doesn't Do," Hospital Impact, July 31, 2012.
86. Burroughs, Jonathan H., "What the Affordable Care Act Doesn't Do," Hospital Impact, July 26, 2012.
87. Burroughs, Jonathan H., "Improve Hospital-Doc Alignment with Job Expectations and Incentives," Hospital Impact, June 13, 2012.
88. Burroughs, Jonathan H., "Tips to Optimize Doc-Nurse Relationships," Hospital Impact, May 3, 2012.
89. Burroughs, Jonathan H., "Have Physician-Nurse Relationships Improved?" Hospital Impact, April 11, 2012.

C. Sources of Information 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

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)
62. Nevada Revised Statutes Pursuant to Case
63. Defendant Crum, Stefanko & Jones Ltd. d/b/a Ruby Crest Emergency Medicine's Supplemental Responses to Plaintiff's First Set of Request for Production of Documents (5/11/20)
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
77. Reach Thoracostomy Tube Care Protocol
78. Reach Medical Direction Policy
79. Reach Medical Direction Standard of Care Protocol
80. Deposition of Katherine P. Raven, MD, Forensic Pathologist (10/21/20)
81. https://www.facs.org/quality-programs/trauma/education/rttdc
82. American Society of Anesthesiologists "Practice Guidelines for Management of the Difficult Airway," February, 2013.
83. Expert Report of Myron J. Gomez, MD (11/3/20)
84. Expert Report of Peter Bastone, MPH (10/30/20)
85. Northeastern Nevada Regional Hospital Obtaining Informed Consent Policy/Procedure (1/16)
86. Northeastern Nevada Regional Hospital Crash Cart Documentation (1/16-6/16)
87. Northeastern Nevada Regional Hospital Ongoing and Focused Professional Practice Evaluations Policy/Procedure (5/16)

88. Exclusive Professional Services Agreement between Southeastern Emergency Physicians LLC and PHC-Elko d/b/a Northeastern Nevada Regional Hospital (2/10/15)
89. Deposition of Lauren Claerbout, Medical Staff Coordinator, NNRH (12/4/20)
90. Deposition of Rabecca Jones, RN, Director of Cardiopulmonary Services NNRH (12/4/20)
91. Deposition of Jennifer Tingle, RN, Director of Emergency Services NNRH (12/4/20)
92. Relevant Nevada Revised Statutes
93. Expert Rebuttal Report of Seth P. Womack, MD (12/17/20)

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. She has asked me to supplement my original expert opinions based upon discovery evidence and motions approved by the Court.

E. Expert Supplemental Opinion:

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 was grossly negligent and demonstrated utter indifference and conscious disregard by allowing Barry Bartlett, an uncredentialed individual with NO authorized clinical privileges to perform a high-risk procedure which he was unqualified to perform on its premises in violation of federal law and its Medical Staff Bylaws which directly and proximately led to the death of its patient Douglas R. Schwartz at the age of 56.

F. Foundations for Expert Supplemental Opinion

Federal law is clear as to the responsibility and authority of a hospital or healthcare system to grant membership and clinical privileges to physicians, physician assistants, advanced practice nurses and other clinical personnel. Clinically trained individuals have no vested rights to care for patients within a healthcare facility without explicit authorization by the healthcare organization to do so. The Centers for Medicare and Medicaid Services (CMS) explicitly states in its conditions of participation:

§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.

All hospital patients must be under the care of a practitioner who meets the criteria of 42 CFR 482.12(c)(1) and who has been granted medical staff privileges, or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner who has been granted privileges in accordance with the criteria established by the governing body, and who is working within the scope of those granted privileges.

All practitioners under the "supervision of a member of the medical staff" must be either credentialed through the Human Resources Department (e.g. nurses, clinical aides, technologists, clerks) through a job description or under the organized medical staff's credentialing and privileging process through its medical staff bylaws:

"CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a medical staff member, allied health professional or specified professional personnel to render specific patient services." (Medical Staff Bylaws, page 6)

"Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws." (Medical Staff Bylaws, page 8)

"…no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws." (Medical Staff Bylaws, page 18)

As discussed in my Expert Supplemental and Rebuttal Report (12/17/20), informed consent requires that Mr. Schwartz and his wife be given the right to make an "informed" choice of what would happen to him and by whom. Furthermore, Northeast Nevada Regional Hospital's

consent form only permits members of its medical staff to provide and immediately direct healthcare services and that "trainees may observe, examine, treat, and participate with supervision in my care as part of medical education programs." Also, as discussed in my previous expert reports, neither Dr. Garvey nor Mr. Bartlett were trained or qualified to place a definitive surgical airway in Mr. Schwartz and neither practitioner had advanced airway skills necessary to successfully intubate Mr. Schwartz.

Dr. Garvey made the unilateral decision to allow Barry Bartlett, an individual who was never credentialed or privileged by the organized medical staff nor credentialed with a job description through the Hospital's Human Resources Department to perform a high-risk procedure which he did not have the training, background or experience to perform. Dr. Garvey will probably claim that it is a common custom for emergency physicians to allow paramedics and emergency medical technicians (EMTs) to perform tasks under physician supervision and so I will address this in kind.

As someone who practiced emergency medicine for thirty years and who was medical director of three emergency departments in largely rural areas, I agree that paramedics and EMTs are commonly permitted to perform routine tasks under supervision such as:

- Transporting patients
- Oxygenating patients
- Placing IVs and administering fluids
- Placing uncomplicated foley catheters for urinary drainage
- Resuscitating patients under physician direction

What these personnel are not qualified to do is to perform high-risk or complex procedures that many emergency physicians are unqualified to do. As mentioned in my original report, 98% of intubations are routine and can be done by any qualified emergency physician. 1%-2% are not routine and require advanced techniques which the majority of emergency physicians and all paramedics and EMTs are unqualified to do. Both Dr. Garvey and Mr. Bartlett realized after the patient's first intubation attempt that this was a high-risk, technically difficult intubation due to an anteriorly placed glottis which made direct visualization of the airway landmarks virtually impossible in a patient with a full stomach and a high likelihood of vomiting and aspiration once sedated and paralyzed. Neither Dr. Garvey nor Mr. Bartlett had any training, background, or experience to place a definitive surgical airway (tracheostomy) and neither had any training, background, or experience to utilize advanced airway techniques such as an endoscopic intubation which anesthesiologists and nurse anesthetists are trained to utilize in difficult situations. Thus, Dr. Garvey made the unilateral decision to utilize an unqualified individual to perform a complex high-risk procedure that neither Dr. Garvey nor Mr. Bartlett was qualified to do without the Hospital's authorization or supervision.

It is a hospital responsibility to ensure that everyone within the hospital practices within their authorized scope of practice within either their job description (HR) or their delineated clinical privileges (the organized medical staff). It is a truism that physicians cannot supervise clinical activities for which they are themselves unqualified to perform and Dr. Garvey does not under any circumstances have the legal right to authorize clinical privileges to anyone on behalf of the hospital without the governing board's approval and consent.

In the multiple emergency departments in which I served, if physicians and nurses wanted paramedics transporting patients to be able to assist them in routine tasks, we created policies and procedures approved by both the management team and governing board to do so. This can provide standing authorization by the Hospital for EMTs, paramedics and other ambulance personnel to perform routine, low-risk tasks under physician and/or nursing supervision.

Under NO circumstances does the hospital authorize anyone to perform non-authorized procedures or tasks without permission of the governing body.

In many states, if an uncredentialed and unprivileged healthcare provider performs an unauthorized procedure that causes harm to a patient (such as injury or death), this is neither covered under the hospital's director's and officer's indemnification policy nor under the "supervising physician's" liability coverage. Also, in many states, unauthorized procedures may constitute a battery or aggravated battery and false imprisonment under criminal (as well as tort) law that can result in significant penalties up to and including imprisonment. It will be up to the Court to determine what potential penalties apply in the State of Nevada for a wrongful death based upon an unauthorized procedure performed by an unqualified and uncredentialed/unprivileged healthcare provider.

It should also be noted that Dr. Garvey was an independent contract with Ruby Crest Emergency Medicine Inc. when this incident occurred. Following Mr. Schwartz's death, Dr. Garvey's notified Ruby Crest of this event and, according to the audit trail, Ruby Crest accessed the electronic medical record of Mr. Schwartz several times immediately following Dr. Garvey's notification. It will be for the Court to decide as to whether Ruby Crest Inc. had legal authorization to access protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) and to what purpose Ruby Crest accessed the confidential information if it was under the belief that it had no supervisory responsibility, accountability, or potential liability in this case.

As mentioned previously, the tragedy of this case is that Northeastern Nevada Regional Hospital had a qualified general surgeon and a qualified nurse anesthetist on call for just such situations and could have performed this intubation (if clinical experts deem that it was even necessary) safely and efficiently without risking Mr. Schwartz's life. In many situations as a board-certified emergency physician over a thirty-year period, did I clinically defer to more qualified clinical personnel such as a general surgeon/nurse anesthetist when I realized that the intubation was beyond my skills. It is the sign of experience when a practitioner understands

what he can and cannot do safely and acts as a fiduciary to his patient to ensure that his patient receives safe care rendered by qualified personnel who are legally authorized to perform the procedure.

Dr. Garvey had no legal standing to unilaterally authorize Mr. Bartlett to perform such a high-risk procedure and the hospital was grossly negligent in permitting him to do so as a member of its medical staff.

G. Conclusion:

The public has a right when it enters a hospital or any healthcare system to entrust that the system will only allow qualified clinical personnel who are carefully vetted by the hospital to perform clinical activities and procedures on them. The public is completely dependent on the Hospital's willingness to comply with federal, state, bylaws, and human resources requirements in order to serve as a fiduciary to the public and to ensure that only qualified and authorized individuals provide any clinical services.

There is no way that Mr. and Mrs. Schwartz could know that the physician they provided consent for treatment would unilaterally authorize an uncredentialed and unprivileged individual to perform a high-risk procedure on Mr. Schwartz or that the hospital would allow such an occurrence to happen without its authorization.

Credentialing and privileging, both at the medical staff and human resources level is not merely "paper-work" to complete; it is the safety net to the public at large that assures that only qualified trained personnel can practice at its facilities and that the hospital has performed due diligence in vetting the qualifications and training of such personnel.

The failure of Northeastern Nevada Regional Hospital to perform these fundamental oversight procedures represents a failure to exercise its most basic purpose which is to protect the public from unnecessary and preventable harm. The hospital violated the public's trust in not doing so and must be held accountable as a deterrent to other hospitals within the State of Nevada to do the same.

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 properly supervise its medical and nursing staff to ensure that unqualified uncredentialed and unauthorized clinical personnel such as Barry Bartlett would not be permitted to perform high-risk procedures under the supervision of a physician who was

unqualified to perform a definitive surgical airway or utilize advanced airway techniques such as endoscopy and thus provide Mr. Schwartz 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.

NORTHEASTERN NEVADA REGIONAL HOSPITAL
PHYSICIAN ATTESTATION

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

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

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

NORTHEASTERN NEVADA REGIONAL HOSPITAL

Facesheet

MEDICAL RECORD NUMBER	MRSA	VRE	PATIENT ACCOUNT NUMBER
000330967			6139781

PATIENT (Name, Address, Phone)

SCHWARTZ DOUGLAS R
[redacted]

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

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

ADMIT DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM / BED NO.
06/22/16 21:10	06/23/16 06:05	ED	/

PATIENT EMPLOYER (Name, Address, Phone, Occ.)

ELKO FEDERAL CREDIT
MOUNTAIN CITY HWY
ELKO NV 898010000

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

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

SCHWARTZ DIANE
[redacted]

REFERRAL SOURCE / AGENCY / TEAM MEMBER

PHONE:
CONTACT NAME:

GUARANTOR (Name, Address, Phone)

SCHWARTZ DOUGLAS R
[redacted]

GUARANTOR EMPLOYER (Name, Address, Phone)

ELKO FEDERAL CREDIT
MOUNTAIN CITY HWY
ELKO NV 898010000

PHONE: (775)738-4083

FINANCIAL CLASS

94 LIABILITY (TPL)

ATTENDING PHYSICIAN

GARVEY DAVID J MD 2818

ADMISSION STATUS	DISCHARGE STATUS
	20

PRIMARY INSURANCE

MRA AUTO LIABILITY
6840 CAROTHERS PKWY STE 1

FRANKLIN TN 37067

PHONE: (877)324-2722

POLICY# 518864393

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

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

SECONDARY INSURANCE

BCBS PREFIX YF
PO BOX 5747

DENVER CO 802175747

PHONE: (877)833-5742

POLICY# YFO841M50938

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

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

TERTIARY INSURANCE

PHONE:

POLICY#

GROUP #:
GRP NAME:
AUTH#:

DOB: SEX:
REL:

CHIEF COMPLAINT

ENCOUNTER FOR EXAM AND OBS FOLLOWING TRANSPORT ACC Z041

COMMENTS:

2242 ALL PAPERWORK SIGNED COPY OF INS CARD AND ID CONSENTS SCANNED PT WAS HI

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

Name: Douglas Schwartz
Age: 58 yrs **Sex:** Male **DOB:** 06/02/1958
Arrival Date: 06/22/2016 **Time:** 20:51
Bed 16
ED Physician Garvey, David
MRN: 330967
Account#: 6139781
Private MD:

HPI:

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

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

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

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

ROS:

21:18 djg/jkp

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

Exam:

21:20 djg/jkp

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

Physician Documentation Con't.

Chest/axilla: Inspection: normal, Palpation: tenderness, that is moderate, of the right lateral posterior chest.
Cardiovascular: Rate: normal, Rhythm: regular.
Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, Breath sounds: are normal, clear throughout.
Abdomen/GI: Inspection: abdomen appears normal, Bowel sounds: normal, active, all quadrants, Palpation: abdomen is soft and non-tender, in all quadrants.
Back: pain, that is moderate, of the left scapular area and left subscapular area.
Musculoskeletal/extremity: Extremities: grossly normal except: noted in the right knee and right elbow and right bicep: abrasion, ROM: intact in all extremities, Circulation is intact in all extremities. Sensation intact.
Skin: Appearance: normal except for affected area.
Neuro: Orientation: is normal, to person, place & time. Memory: immediate memory is intact, remote memory is intact. recent memory is impaired.
Psych: Behavior/mood is pleasant, cooperative.

Vital Signs:

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

Physician Documentation Con't.

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

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

Glasgow Coma Score:

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

Procedures:

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

MDM:

06/22 20:52 MSE Initiated by Provider. djg

06/23 djg

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

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

05:21 djg

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

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

Physician Documentation Con't.

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

Dispensed Medications:

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

Disposition:

Physician Documentation Con't.

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

Disposition:

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

Critical care time excluding procedures:

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

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

Signatures:

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

Name: Douglas Schwartz
Age: 58 yrs **Sex:** Male **DOB:** 06/02/1958 **MRN:** 330967
Arrival Date: 06/22/2016 **Time:** 20:51 **Account#:** 6139781
Bed 16 **Private MD:**
Diagnosis: Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum; Cardiac arrest - Due to Asphyxiation

Presentation:

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

20:53 Acuity: Emergent (2). dk

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

20:53 Compressions began at 00:35. dk

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

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

Screening:

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

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

Assessment:

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

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

Nurse's Notes Con't

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

21:02 Method Of Arrival: EMS: Elko EMS. dk

21:13 **Neuro:** Level of Consciousness is awake, alert, unknown LOC at time of injury. A/O at this time. . Oriented to person, place, time, Grips are equal bilaterally Moves all extremities. Speech is normal, Facial symmetry appears normal. dk

21:21 **Derm:** Abrasions noted to Right scalp area, outer right arm, right elbow and right knee. **Injury Description:** Abrasion Auto vs. Ped. Vehicle traveling approx 35-40 on impact. Pt hit right drivers door and was thrown up over vehicle. Unknown LOC at scene. EMS reported pt A/O on their arrival. Pt is alert and oriented at time of arrival to NNRH. dk

21:31 visited this patient and evaluated for pain, information needs and comfort. dk

23:17 visited this patient and evaluated for pain, information needs and comfort. dk

23:27 visited this patient and evaluated for pain, information needs and comfort. dk

23:31 visited this patient and evaluated for pain, information needs and comfort. dk

23:36 **Injury Description:** dk

06/23 00:35 **CPR assessment:** unresponsive, no respiratory effort, mechanical ventilation, Ambu ventilation, cyanotic, pulses absent w/ compressions. dk

00:35 Cardiac rhythm is asystole. dk

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

Vital Signs:

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

Nurse's Notes Con't

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

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

Glasgow Coma Score:

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

ED Course:

06/22 20:51 Patient arrived in ED. dk

20:51 Patient moved to Waiting. dk

20:51 Patient moved to 12. dk

20:52 Garvey, David, MD is Attending Physician. djg

20:58 Triage completed. dk

21:08 Kevitt, Donna is Primary Nurse. dk

21:20 Maintain field IV. Dressing intact. Good blood return noted. Site clean & dry. Gauge & site: 20g left wrist. Oxygen administration via nasal cannula @ 4L/min. dk

21:20 Cardiac monitor on. Pulse ox on. NIBP on. Warm blanket given. dk

21:25 Patient has correct armband on for positive identification. Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Adult w/ patient. dk

21:29 Awaiting Per MD- hold medication administration at this time due to meds given by EMS. OK to wait on urine at this time until after CT completed. dk

21:32 Inserted peripheral IV: 20 gauge left hand blood drawn and sent to lab per order. dk

21:33 Patient moved to CT. hr

21:33 Patient moved to CT Scan. hr

21:33 Lipase Sent. dk

21:33 Amylase Sent. dk

21:33 CMP Sent. dk

21:33 Cbc W/ Auto Diff Sent. dk

21:40 Patient moved to CT. dk

23:00 Patient moved back from CT. hr

23:00 Patient moved to 12. hr

23:37 Pt placed on 40% Venti mask per respiratory. Pt sats: 92-93%. dk

23:51 Oxygen administration via non-rebreather mask @ 15L/min. dk

06/23 01:45 Wife notified of patient's death by Dr. Garvey. Dr. John Patton, friend of family at wife's side. Wife moved to Triage room. Assisted Dr. Patton in calling family members. Sons DJ, Taylor, and Mitchell notified. Called dk

Nurse's Notes Con't

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

02:14 Patient moved to 16. so

02:30 Garvey, David, MD is Pronouncing Provider. djg

02:40 Wife escorted to room 16 via wheelchair. Friend John Patton at side. dk

03:06 Patient moved to D1. na

03:06 Patient moved to 16. na

04:10 Awaiting Call to donor line. Case #: 10402647. dk

04:13 Awaiting Elizabeth Gill with Donor line called. Release to coroner. dk

04:25 Gastric tube NGT removed. dk

05:46 Custody of body released to Elko Co. Sheriff Officer Coroner. Transported by Burn's Funeral home. dk

05:50 Assist provider with intubation Unsuccessful attempts. See Code sheet. dk

Administered Medications:

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

Intake:

01:33 1000 plus ml from suctioning during event. Copius amounts of vomitus from posterier pharynx using 2 suctions simutaneously. dk

Output:

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

01:33 1000 plus ml from suctioning during event. Copius amounts of vomitus from posterier pharynx using 2 suctions simutaneously. dk

Outcome:

05:00 Outcome Patient expired. dk
Patient expired: Time of death 01:33 Pronounced by David Garvey MD Body released to ME Organ Donation no.

05:00 dk
Condition: expired

05:00 dk
Discharge Assessment: Patient Pt expired @ 0133.

06:05 Patient left the ED. dk

Signatures:

Name: Douglas Schwartz

Nurse's Notes Con't

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

Lab Results Summary

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

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

Order name	Last Status	Reason	Time	By	For
Cbc W/ Auto Diff	**Reviewed**		**06/22/16 21:02**	**djg**	**djg**
Order Method: Electronic					
Details:					
Notes:					
Interpretation:					

Test	Value	Range	Abnormal	Units	Status	Updated
WBC	**13.0**	**4.8-10.8**	**Above high normal**	**X 10(3)**	**F**	**06/22 21:42**
NEUTS	64.3	41.7-82.3		%	F	06/22 21:42
LYMPHS	27.2	15.0-51.1		%	F	06/22 21:42
MONOS	6.0	0.0-11.7		%	F	06/22 21:42
EOSINS	1.7	0.0-5.5		%	F	06/22 21:42
BASOS	0.2	0.0-3.0		%	F	06/22 21:42
NE#	8.4	2.5-9.0		X 10(3)	F	06/22 21:42
LY#	3.5	0.9-4.8		X 10(3)	F	06/22 21:42
MO#	0.8	0.1-0.9		X 10(3)	F	06/22 21:42
EO#	0.2	0.0-0.7		X 10(3)	F	06/22 21:42
BA#	0.0	0.0-0.2		X 10(3)	F	06/22 21:42
RBC	4.89	4.7-6.1		X 10(6)	F	06/22 21:42
HEMOGLOBIN	15.5	14.0-18.0		GM/DL	F	06/22 21:42
HEMATOCRIT	42.8	42.0-54.0		%	F	06/22 21:42
MCV	87.5	80.0-99.0		FL	F	06/22 21:42
MCH	31.7	27.0-34.0		PG	F	06/22 21:42
MCHC	**36.2**	**31.0-36.0**	**Above high normal**	**G/%**	**F**	**06/22 21:42**
RDW	12.1	11.5-15.2		%	F	06/22 21:42
PLATELET	234	140-440		X 10(3)	F	06/22 21:42
MPV	10.1	6.5-12.0		FL	F	06/22 21:42

CMP	Reviewed		06/22/16 21:02	djg	djg
Order Method: Electronic					
Details:					
Notes:					
Interpretation:					

Test	Value	Range	Abnormal	Units	Status	Updated
SODIUM	**134**	**136-148**	**Below low normal**	**mmol/L**	**F**	**06/22 21:56**
K	**3.4**	**3.5-5.2**	**Below low normal**	**mmol/L**	**F**	**06/22 21:56**
CHLORIDE	100	98-108		mmol/L	F	06/22 21:56
BICARB	25.1	21-32		mmol/L	F	06/22 21:56
ANIONGAP	8.9	6-18			F	06/22 21:56
GLUCOSE	**127**	**70-100**	**Above high normal**	**mg/dl**	**F**	**06/22 21:56**
BUN	15	7-24		mg/dl	F	06/22 21:56
CREAT	1.3	0.6-1.3		mg/dl	F	06/22 21:56
BUN/CREATININE RATIO	**11.5**	**12.0-20.0**	**Below low normal**	**ratio**	**F**	**06/22 21:56**
EGFR	**60**	**70-**	**Below low normal**	**mL/min/1.73m**	**F**	**06/22 21:56**
CA	**8.3**	**8.8-10.5**	**Below low normal**	**mg/dl**	**F**	**06/22 21:56**
SGOT-AST	**301**	**9-35**	**Above high normal**	**U/L**	**F**	**06/22 21:56**
ALBUMIN	4.1	3.4-5.0		g/dl	F	06/22 21:56
PROTEIN	7.4	6.4-8.2		g/dl	F	06/22 21:56
GLOBULIN	3.3	2.3-3.5			F	06/22 21:56
A/GRATIO	1.2	1.1-1.9			F	06/22 21:56
T BIL A	0.4	0.0-1.0		mg/dl	F	06/22 21:56
ALK PHOS	55	46-116		U/L	F	06/22 21:56

SGPT-ALT	226	23-65	Above high normal	U/L	F	06/22 21:56

Amylase	**Reviewed**		**06/22/16 21:02**	**djg**	**djg**
Order Method: Electronic					
Details:					
Notes:					
Interpretation:					

Test	Value	Range	Abnormal	Units	Status	Updated
AMYLASE	87	25-115		U/L	F	06/22 21:56

Lipase	**Reviewed**		**06/22/16 21:02**	**djg**	**djg**
Order Method: Electronic					
Details:					
Notes:					
Interpretation:					

Test	Value	Range	Abnormal	Units	Status	Updated
LIPASE	397	73-393	Above high normal	U/L	F	06/22 21:57

Urinalysis	**Reviewed**		**06/22/16 21:02**	**djg**	**djg**
Order Method: Electronic					
Details:					
Notes:					
Interpretation:					

Test	Value	Range	Abnormal	Units	Status	Updated
COLOR	YELLOW				F	06/22 23:30
CLARITY	CLEAR				F	06/22 23:30
URINE SG	1.010	1.005-1.030			F	06/22 23:30
UR GLUC	NEGATIVE	-NEG			F	06/22 23:30
UR BILI	NEGATIVE	-NEG			F	06/22 23:30
UR KETON	NEGATIVE	-NEG			F	06/22 23:30
UR PH	5.5	5.0-8.0			F	06/22 23:30
UR PROT	TRACE	-NEG			F	06/22 23:30
UROBILIN	0.2	NORM			F	06/22 23:30
NITRITE	NEGATIVE	-NEG			F	06/22 23:30
BLOODHGB	3+	NEG			F	06/22 23:30
LEUK EST	NEGATIVE	-NEG			F	06/22 23:30
URINE DIP ONLY	NO	-------			F	06/22 23:30
UR WBC	0-2			PER HPF	F	06/22 23:30
UR RBC	20-30			PER HPF	F	06/22 23:30
MUCUS	TRACE			PER HPF	F	06/22 23:30

Medication Orders Summary

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

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

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

Douglas Schwartz
MRN: 330967
ACCT: 6139781

Northeastern Nevada Regional Hospital

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

06/23/2016 02:33

Discharge Instructions for: **Schwartz, Douglas R**

Arrival Date: **Wednesday, June 22, 2016**

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

Care provided by: Garvey, David, MD

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

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

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

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

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

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

TESTS AND PROCEDURES

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

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

Procedures
Labs drawn, Intubation, CPR, CPR

Other
Urine, Obtain, NS saline lock

Patient Copy

Encounter Summary

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

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

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

Arrival: 06/22/2016 20:51

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

Responsible Dept: Trauma

Special Handling:
Family Waiting: No
Bed 16

Assigned staff & roles

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

Outcome: Expired
Time of death: 06/23/16 01:33
Location:
Condition:
Chief Complaint: Auto vs Pedestrian
Diagnosis: - Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum, Cardiac arrest - Due to Asphyxiation
Prescriptions:
Follow up:
Special Notes:
Attending Physician: Garvey
Mid Level Provider:
Orders: Cbc W/ Auto Diff, CMP, Amylase, Lipase, Urinalysis, Urine, Obtain, NS saline lock, NS saline lock, Ct Brain Head Wo, CT C Spine Wo, CT T Spine W/O, Ct Chest W, CT Abd/Pelvis IV Only, Dilaudid, Ondansetron, Ondansetron, Ativan
Discharge Instruction:

Event Log

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

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

Encounter Events

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

Event Log

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

Event Log

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

Event Log

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

Event Log

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

Event Log

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

Event Log

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

Order Events

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

Event Log

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

Event Log

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

Event Log

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

Chart Events

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

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

Staff Events

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

NORTHEASTERN NEVADA REGIONAL HOSPITAL

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

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

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer's or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. **OTHER ACKNOWLEDGEMENTS:**

a. **Personal Valuables:** I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables and that the hospital shall not be liable for the loss of such valuables unless deposited with the hospital for safekeeping. The liability of the hospital for loss of personal property that is deposited for safekeeping is limited to $5000 or the maximum required by law. I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, IPads/Pods and all other such devices.

b. **Smoke Free Facility Policy:** The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

c. **Weapons / Explosives / Drugs:** I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

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

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

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

ESIG DESC=Signature of Patient Diane 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 CG 6/22/16

Signature of Witness — Date / Time

Dias

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 #: 000330967 PT #: 6139781

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

CARDIAC ARREST RECORD

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

PATIENT NAME: Douglas R. Schwartz   PAGE ____ OF ____

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

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

TEAM MEMBERS (Name and Title)
1) David Garvey, MD   2) Donna Kevitt, RN   3) Sue Olson, RN   4) Cyndy Fox RN
5) Nancy Abrahamsen Tech   6) Bonnie, RN - REACH Air   8) Barry RN - REACH   7) Tom R.T.   Paul EMS Board

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

INITIAL ASSESSMENT
RESPIRATIONS: ☐ PRESENT ☐ ABSENT ☐ AGONAL
CAROTID PULSE: ☐ PRESENT ☐ ABSENT

INTUBATION
SIZE: ________ FIO2 ________
TIME: ________
BY WHOM: ________
BILAT BS: ☐ PRESENT ☐ ABSENT

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

TIME	RESPIRATION / PULSE / RHYTHM / BP / JOULES / EXTERNAL PACING / SINGLE DOSES (EPI IV or ETT, ATROPINE IV or ETT, LIDOCAINE) / DRIP MEDS (DOPAMINE) / ABG (PH, PO2, PCO2) / COMMENTS/LAB
0018	Ketamine 180 mg IVP. Rocuronium by Reach Air nurse Ronnie RN
0020	ET tube attempted / unsuccessful started bagging 7.5 tube by Barry RN
0033	" " " / unsuccessful " " 7.5 tube / 9 tube by Barry RN
0035	CPR in progress HR 36 O_2 sat 37% while bagging Brady
0036	King airway placed 225/136 O_2 sat to 79% King placed by Barry RN
0040	HR 120 O_2 sat 82% 249/140
0044	ET tube attempted by Dr Garvey / unsuccessful / started bagging
0047	" " " " " " / " " / started bagging
0050	O_2 sat 65% CPR continues asystole
0052	ET tube insertion attempted by Barry (Reach) unsuccessful 55-60% O_2 sat / bagging
0053	O_2 sat 50% unsuccessful c ET tube insertion CPR continue
0054	HR 147 42% O_2 while bagging 221/148
0057	NPA placed by Dr. Garvey
0058	O_2 sat 69% c NPA CPR continues asystole
0102	75% O_2 sat HR 122
0104	65% O_2 sat 202/143 121 HR
0108	Crik attempted by Dr. Garvey
0113	O_2 sat 60% asystole continuing CPR

OUTCOME
DISPOSITION: ☐ SUCCESSFUL ☒ UNSUCCESSFUL   Code Terminated At: 0133 (time)   BY WHOM: [signature] MD

SIGNATURE OF RECORDER X: Silvia Wines EMT
SIGNATURE OF NURSE X: Donna Kevitt RN
SIGNATURE OF MD IN CHARGE X: [signature]

CHWARTZ DOUGLAS R   HSV: ED
DB: 06/02/1958 AGE: 58 SEX: M
DMIT: 06/22/16 RM/BED: /
TT: GARVEY DAVID J MD #: 2818
R #: 000330967 PT #: 6139781

Suctioning throughout the code

PA. 826

NEN000033

SUMMARY OF CQI/RM MONITORING AND EVALUATION

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

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

CONFIDENTIAL: NOT PART OF MEDICAL RECORDS

DEPARTMENT _____ DATE _____ REVIEWER _____

NEN000034

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

CARDIAC ARREST RECORD

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

PATIENT NAME Douglas R. Schwartz PAGE ____ OF ____

DATE 06-23-16 TIME OF ARREST: ____ CPR INITIATED BY: ____ LOCATION OF ARREST: ____ DIAGNOSIS: ____

ED ARRIVAL TIME: ____ ATTD PHYS NOTIFIED TIME ____ BY ____ FAMILY NOTIFIED TIME ____ BY ____

TEAM MEMBERS (Name and Title)

1) ____ 2) ____ 3) ____ 4) ____

5) ____ 6) ____ 8) ____) ____

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

INITIAL ASSESSMENT
RESPIRATIONS
☐ PRESENT ☐ ABSENT ☐ AGONAL
CAROTID PULSE
☐ PRESENT ☐ ABSENT

INTUBATION
SIZE: ____ FIO_2 ____
TIME: ____
BY WHOM: ____
BILAT BS: ☐ PRESENT ☐ ABSENT

☐ IV PRESENT - Site ____
☐ IV STARTED - Site ____
NEEDLE SIZE: ____
SOLUTION: ____
BY WHOM: ____

TIME	RESPIRATION	PULSE	RHYTHM	BP	JOULES	EXTERNAL PACING	EPI IV or ETT	ATROPINE IV or ETT	LIDOCAINE			DOPAMINE (mg/min)			PH	PO_2	PCO_2		COMMENTS/LAB
0116	O2 sat 37% HR 81 BP 126/95																		
0117	CPR started. No pulse O2 41% HR 33																		
0119	O2 sat 36%																		
0120	Asystole. No O2 cyanotic																		
0122	52% O2 sat. CPR still in progress.																		
0124	61% O2 sat. CPR still in progress. Gastric extension.																		
0125	49% O2 sat. CPR continues																		
0128	64% O2 sat. CPR continues																		
0129	Needle decompression - Right																		
0131	Needle decompression - Left/Right chest																		
0133	Stop compressions. Time of death 0133																		
During procedure - suctioning performed. Copious amounts of vomitus from posterior pharynx.																			

OUTCOME

☐ SUCCESSFUL DISPOSITION

☒ UNSUCCESSFUL Code Terminated At 0133 (time)

PHYSICIAN [signature] MD

SIGNATURE OF RECORDER X Silvia Wines, EMT

SIGNATURE OF NURSE X [signature], RN

SIGNATURE OF MD IN CHARGE X [signature]

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

PA. 828

NEN000035

SUMMARY OF CQI/RM MONITORING AND EVALUATION

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

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

CONFIDENTIAL: NOT PART OF MEDICAL RECORDS

DEPARTMENT _____ DATE _____ REVIEWER _____

NEN000036

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

TREND SUMMARY REPORT
Name:
ID: Patient 0206
Patient Mode: Adult
Start Time:
06/23/2016 12:06:14AM
Total Trend Events: 27
Dept:
Unit:
S/N: AI11K001505
SW: 02.01.27.00

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:45	???	???	OFF	???	???	???
01:40	???	???	OFF	???	???	???
01:35	???	???	OFF	???	???	???
01:32	134	49	149/55(88)	---	0	0
01:30	---	60	OFF	---	0	0
01:25	---	64	OFF	---	0	0
01:20	36	39	OFF	---	0	0
01:15	119	46	126/95(106)	---	0	0
01:15	123	41	OFF	---	0	0
01:14	124	60	202/125(150)	---	0	0
01:10	126	52	OFF	---	0	0
01:05	120	71	OFF	---	0	0
01:00	121	62	207/143(165)	---	0	0
01:00	124	69	OFF	---	0	0
00:55	128	43	OFF	46	OFF	OFF
00:50	126	62	OFF	57	OFF	OFF
00:45	118	73	221/148(173)	23	OFF	OFF
00:45	119	75	OFF	30	OFF	OFF
00:41	125	81	249/140(178)	31		
00:40	111	77	OFF	34		
00:35	36	37	OFF	35		
00:30	124	76	225/136(166)	57		
00:30	127	76	OFF	57		
00:25	108	92	OFF	27		
00:20	97	83	OFF	22		
00:15	73	99	OFF	19		
00:10	66	97	OFF	17		

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

NEN000037

TREND SUMMARY REPORT

Name:
ID: Patient 0206
Patient Mode: Adult
Start Time:
06/23/2016 12:06:14AM
Total Trend Events: 27
Dept:
Unit:
S/N: AI11K001505
SW: 02.01.27.00

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:45	???	???	OFF	???	???	???
01:40	???	???	OFF	???	???	???
01:35	???	???	OFF	???	???	???
01:32	134	49	149/55(88)	---	0	0
01:30	---	60	OFF	---	0	0
01:25	---	64	OFF	---	0	0
01:20	36	39	OFF	---	0	0
01:15	119	46	126/95(106)	---	0	0
01:15	123	41	OFF	---	0	0
01:14	124	60	202/125(150)	---	0	0
01:10	126	52	OFF	---	0	0
01:05	120	71	OFF	---	0	0
01:00	121	62	207/143(165)	---	0	0
01:00	124	69	OFF	---	0	0
00:55	128	43	OFF	46	OFF	OFF
00:50	126	62	OFF	57	OFF	OFF
00:45	118	73	221/148(173)	23	OFF	OFF
00:45	119	75	OFF	30	OFF	OFF
00:41	125	81	249/140(178)	31		
00:40	111	77	OFF	34		
00:35	36	37	OFF	35		
00:30	124	76	225/136(166)	57		
00:30	127	76	OFF	57		
00:25	108	92	OFF	27		
00:20	97	83	OFF	22		
00:15	73	99	OFF	19		
00:10	66	97	OFF	17		

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

NEN000038

Organ and Tissue Notification:

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

Spoke with : Elizabeth Hill
Time: 0324 – returned call at 0335
Date: 3-26-16

Contacted by: [signature] (Staff Signature)

IORS rules medically eligible: ____ **YES** ✓ **NO**

Explain: Pt not eligible. Ready to close. Sent for investigation

The option of Organ and Tissue Donation has been presented:

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

N/A **Family declines option of donation**

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

Completed by: [signature] **(Staff signature)**

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

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

NEN000039

NENRH
NORTHEASTERN NEVADA REGIONAL HOSPITAL

PATIENT TRANSFER

Name: SCHWARTZ DOUGLAS R Patient Number: 6139781

Age: 58 Date of Birth: 06/02/1958 Sex: M MR No.: 000330967

Date: 6·22.16

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

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

Transported Via: ☐ ALS ☐ BLS ☐ POV Against Medical Advice
☒ Air Evacuation ☐ POV Reach Air

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

N/A N/A
Patient / Responsible Party's Signature Relationship Date

Summary of Risks and Benefits:

Risk of Transfer:

☒ Worsening of medical condition including risk to unborn/ newborn in the case of pregnancy. Disease specific risks: Death

☒ Transportation Risks plane crash

☐ Other:

Benefits of Transfer:

☒ Immediate access to specialized practitioner / equipment / monitoring, specifically: Trauma

☐ Bed capacity that is not currently available at this facility.

☒ Continuity of care

☐ Other:

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

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

Section II: Patient Refusal for Transfer

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

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

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

SUMMIT AIR AMBULANCE

Flight # 16-14083 (16-14060)

Transport Info

Sending Facility _____

Unit _____ Bed _____

Physician _____

Receiving Facility _____

Bed _____

Physician _____

Patient _____

Weight 92 CODE STATUS _____

Chief complaint _____

Called back with "GO" _____

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

Arrive bedside 1157

Called for ambulance _____

Ambulance arrives _____

Walk out of referring _____

Loaded and leaving referring _____

Arrive airport _____

Lift off from airport _____

Destination airport _____

Loaded and leaving dest. airport _____

Arrived receiving _____

Arrive bedside / handoff _____

Depart receiving _____

Past Medical History _____

Allergies: _____

Time	Drug / Fluids	Dose
	Dilaudid	

Time	Drug / Fluids	Dose

Time	HR	B/P	Sat	Pain

10% NRB 97%

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

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

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

Epi 1mg
Keta
Roc

Keta Roc
0018 0018

Tube 0020 - No
0023 unsuccessful
0033 unsuccessful 7.5
0033 unsuccessful 9.
0035 CPR
0036 king 1065? 225/136 47% 79% (Paul).
Resp O2
0040 1207 82 O_2 Resp25 249/140
0044 unsuccessful
0047 unsuccessful
0050 O_2 65%
0052 unsuccessful ~ 55% , 60%
0053 50% O_2 unsuccessful
0054 127? 42 O_2 221/148
NPA 0057 (69% 0058)

0102 ♡172
75%

0104 suctions 65 O_2 207/143 121♡
0108 Crik in prog.
0113 O_2 60 (gone up)

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

0116 $37O_2$ 81♡ 126/95

0117 CPR started no pulse
$44 O_2$ 33♡

0119 360_2

0120 asystoly - no O_2 cyanotic

0122 52 CPR still in progress

0124 610_2 CPR still gastric extention

0125 490_2 CPR

0128 640_2

0129 needle right no output

0131 decompression L & R ← little air

0133 stop compressions

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

SUMMIT AIR AMBULANCE

Flight # 16-14083 (16-14060)

Transport Info

Sending Facility _____

Unit _____ Bed _____

Physician _____

Receiving Facility _____

Bed _____

Physician _____

Patient _____

Weight 92 CODE STATUS _____

Chief complaint _____

Time	Drug / Fluids	Dose
	Dilaudid	

Time	Drug / Fluids	Dose

Called back with "GO" _____

Depart /arrive sending ~~1152~~ 1145-1155

Arrive bedside 1157

Called for ambulance _____

Ambulance arrives _____

Walk out of referring _____

Loaded and leaving referring _____

Arrive airport _____

Lift off from airport _____

Destination airport _____

Loaded and leaving dest. airport _____

Arrived receiving _____

Arrive bedside / handoff _____

Depart receiving _____

Past Medical History _____

Allergies: _____

Time	HR	B/P	Sat	Pain

10% Prevmo = 97%

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

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

180mg
KETA ROC
0018 0018

Tube 0020 - No
0023 unsucessful
0033 unsucessful 7.5
0033 unsucessful 9.
0035 CPR
0036 King 106 57 225/136 47% 79% (Paul)
Rsp O2
0040 120 87 82 O2 Rsp25 249/140

0044 unsucessful

0047 unsucessful
0050 O2 65%

0052 unsucessful ~ 55% , 60%

0053 50% O2 unsucessful

0054 127 R 42 O2 221/148

NPA 0057 (69% 0058)

0102 R122
75%

0104 suctions 65 O2 207/143 121 R

0108 Crik in prog.

0113 O2 60 (going up)

Epi 1mg
Keta
RoC

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

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

As the medical professional involved in the air ambulance transport provided by _____ (Air ambulance supplier)

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

Patient Data

Please Complete Each Sec

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

Call # _____ Patient Name _____

Date of Service _____ Date of Birth _____

Diagnosis or Potential Diagnosis of Patient _____

Requesting Source

Requested By (full name and title) DR David Garvey

Requesting Entity (name and contact) NNRtt

Accepting-Receiving Hospital University of Utah

Requesting Air Transport General Criteria

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

☐ Patient requires higher level of care ☐ Facility on Divert

☐ Weather / road conditions prohibit ground transport

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

Specify care:

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

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

Mechanism of Injury

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

☐ Vehicle rollover / ejection / high speed collision
☑ Vehicle striking pedestrian > 10 mph
☐ Falls from > 15 feet
☐ Motorcycle victim ejected at > 20 mph
☐ Near drowning injuries
☐ Major crush injuries
☐ AMI / Chest pain
☐ Other (specify) _____

☐ Symptomatic hypotension
☐ High-risk obstetrical conditions
☐ Penetrating trauma
☐ Spinal Cord / spinal column injury
☐ Partial or total amputation
☐ 2 or more long bone fx. Pelvic fx.
☐ Altered level of consciousness

☐ Patient experiencing neurological impairment (CVA, Stroke, Seizures)
☐ Symptomatic hypertension
☐ Major burns of the body surface area; burns involving the face, hands, feet, perineum; burns with significant respiratory involvement; major electrical or chemical burn
☐ Same vehicle fatality

Specialty Care Required

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

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

I order/certify that this patient's condition requires Air Ambulance Transportation due to the time or geographical factors. Such certification is to the best of my professional ability. By so certifying, I am NOT assuming any financial responsibility for the transportation services provided by: _____ (Air ambulance supplier)
The ambulance supplier agrees that it will bill only the patient or any applicable third party payor for any transportation cost.

Signature/Date _____ Name (print) Donna Gevitt RN

☐ EMT ☐ Paramedic ☐ Trained First Responder ☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☑ R.N. per VO/TO of Dr _____

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

Revision Date 1/1/2013

NEN000046

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

ervices Signature form

Patient Nam

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

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

SECTION I - PATIENT SIGNATURE

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

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

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

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

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

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

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

Patient unable to sign multi trauma

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

Authorized representatives include **only** the following individuals:

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

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

Printed Address of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

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

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

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

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

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

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

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

Elko County Ambulance Physician Certification for Transport

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139761

SECTION I – GENERAL INFORMATION

Patient's Date of Birth: _____ Medicare #: _____

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

Origin: University of Utah

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: Multi System

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

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

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

Multi System TRAUMA

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

3) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☑ Moderate/severe pain on movement
☐ Danger to self/others ☑ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints
☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer
☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport
☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

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

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

_____

Signature of Physician* or Healthcare Professional

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

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

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

☐ Physician Assistant ☐ Clinical Nurse Specialist ☑ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

Attestation Statement – Authorized PCS Signers

Name of Patient: _____ Patient ID Number: _____

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

Signed

Donna Kevitt

Printed Name

10-22-16

Date

statrad®
Leading Teleradiology

Northeastern Nevada Regional Hospital

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

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

Final Report

EXAM: CT head without contrast.

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

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

COMPARISON: None.

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

IMPRESSION:

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

2. No midline shift or depressed calvarial fracture.

3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Radiologist: Max Pollock, M.D Phone: 858-626-8106

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

Critical Value Communications

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

statrad®
Leading Teleradiology

Northeastern Nevada Regional Hospital

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

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

Final Report

EXAM: CT thoracic spine

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

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

COMPARISON: None.

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

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

IMPRESSION:

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

2. Mild thoracic spondylosis without significant spinal canal stenosis.

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

4. Please see CT chest report for further detail.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

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

Critical Value Communications

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

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Leading Teleradiology

Northeastern Nevada Regional Hospital

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

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

Final Report

EXAM: CT abdomen and pelvis with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

The liver is enlarged with the right hepatic lobe measuring 19.9 cm. No hypoenhancement is present to suggest hepatic contusion or laceration. A small amount of hyperdense free fluid is seen adjacent to the inferior portion of the right hepatic lobe. The gallbladder is nondistended and the common bile duct is normal in caliber. The pancreas enhances uniformly without evidence for laceration. Small calcifications are seen within the spleen and there is no definite splenic laceration allowing for limitations of streak artifact related to arms down scanning technique. The bilateral adrenal glands are normal. The bilateral kidneys enhance uniformly without evidence for contusion or laceration and there is no hydroureteronephrosis. The small bowel loops are nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes.

Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right. No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

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

IMPRESSION:

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

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.

3. No free air to suggest visceral perforation.

4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture, dedicated lumbar spine CT could enter evaluate.

5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.

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

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

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

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:07	Verify Receipt	Verified receipt with Cheryl in the ER for Dr. Garvey on 06/2 23:07 (-07:00)

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Northeastern Nevada Regional Hospital

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

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

Final Report

EXAM: CT chest with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

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

IMPRESSION:

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

recommended.

2. Prominent right pleural fat without definite pleural effusion.

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

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

5. Mild atherosclerosis without evidence for traumatic aortic injury.

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

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

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

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

Critical Value Communications

Clear Time	Type	Notes
	Verify Receipt	

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Northeastern Nevada Regional Hospital

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

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

Final Report

EXAM: CT cervical spine.

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

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

COMPARISON: None.

FINDINGS:

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

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

Please see CT chest for further detail regarding intrathoracic findings.

IMPRESSION:

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

2. Very mild cervical and upper thoracic spondylosis as described above.

3. Please see CT chest report for further detail.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT cervical spine.

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

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

COMPARISON: None.

FINDINGS:

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

There is no prevertebral soft tissue thickening.

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

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Please see CT chest for further detail regarding intrathoracic findings.

IMPRESSION:

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

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT head without contrast.

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

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

COMPARISON: None.

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

IMPRESSION:

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

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2. No midline shift or depressed calvarial fracture.

3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Critical Value Communications

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT head without contrast.

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

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

COMPARISON: None.

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

IMPRESSION:

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

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

2. No midline shift or depressed calvarial fracture.

3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Critical Value Communications

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

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Critical Value Communications

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

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT thoracic spine

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

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

COMPARISON: None.

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

IMPRESSION:

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

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

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

2. Mild thoracic spondylosis without significant spinal canal stenosis.

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

4. Please see CT chest report for further detail.

Critical Value Communications

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT thoracic spine

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

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

COMPARISON: None.

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

IMPRESSION:

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

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

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

2. Mild thoracic spondylosis without significant spinal canal stenosis.

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

4. Please see CT chest report for further detail.

Critical Value Communications

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

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Critical Value Communications

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

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT chest with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

IMPRESSION:

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

Critical Value Communications

Verify Receipt

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT chest with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

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

IMPRESSION:

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

Critical Value Communications

Verify Receipt

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

CR

Critical Value Communications

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

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT abdomen and pelvis with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

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nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes. Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right. No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

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

IMPRESSION:

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

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

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.

3. No free air to suggest visceral perforation.

4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture, dedicated lumbar spine CT could enter evaluate.

5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.

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

Critical Value Communications

Verify Receipt

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT abdomen and pelvis with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

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

nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes. Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right. No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

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

IMPRESSION:

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

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

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.

3. No free air to suggest visceral perforation.

4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture, dedicated lumbar spine CT could enter evaluate.

5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.

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

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

CR

Critical Value Communications

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

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT chest with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

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

IMPRESSION:

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

Critical Value Communications

Verify Receipt

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

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

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

Radiology Report

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

StatRad Final Report

EXAM: CT chest with contrast.

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

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

COMPARISON: None.

FINDINGS:

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

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

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

IMPRESSION:

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

Critical Value Communications

Verify Receipt

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

CR

Critical Value Communications

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

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

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

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 Special 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 AIR MEDICAL SERVICES, L.L.C., DOE BARRY, R.N., DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

_____/

DEPOSITION
OF
DR. JOHN PATRICK PATTON

Taken in Elko, Nevada on May 31, 2019, at 9:13 a.m.
Reported by LISA M. MANLEY, CCR No. 271

A P P E A R A N C E S

For the Plaintiff: (Via conference call)
JENNIFER MORALES, ESQ.
CLAGGETT & SYKES LAW FIRM
4101 Meadows Lane, Ste 100
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Tel: 702-655-2346

For the Defendant: (Reach Air Medical)
JAMES T. BURTON, ESQ.
KIRTON MCCONKIE
36 S. State Street
Suite 1900
Salt Lake City, UT 84111
Tel: 801-328-3600

For the Defendant: (Ruby Crest)
CHELSEA R. HUETH, ESQ.
CARROLL, KELLY, TROTTER, FANZEN, McKENNA & PEABODY
8329 W. Sunset Road
Suite 260
Las Vegas, NV 89113
Tel: 702-792-5855

For the Defendant: (David Garvey, M.D.)
ALISSA BESTICK, ESQ.
LEWIS BRISBOIS BISGAARD & SMITH, LLP
6385 S. Rainbow Boulevard
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Las Vegas, NV 89118
Tel: 702-893-3789

For the Defendant: (NNRH) (Via Zoom video)
JENNIFER RIES-BUNTAIN, ESQ.
HALL PRANGLE SCHOONVELD,LLC
200 South Wacker Drive
Suite 3300
Chicago, IL 60606
Tel: 312-345-9608

ALSO PRESENT:
BILL STEPHENS, Videographer

INDEX

EXHIBITS MARKED: PAGE
None

BE IT REMEMBERED that on Friday, May 31, 2019, at the hour of 9:13 a.m. of said day, at the Ledgestone Hotel, 2585 E. Jennings Way, Elko, Nevada, 89801, before me, LISA M. MANLEY, a notary public and certified court reporter, personally appeared DR. JOHN PATTON, who was by me first duly sworn and was examined as a witness in said cause.

P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning. We are now on the record.

The time is 9:13 a.m.

The date is May 31, 2019.

This is the deposition of John Patton. The caption of the case is Diane Schwartz, et al., versus David Garvey, M.D., et al. Case Number CV-C-17-439 in the Fourth Judicial District Court of the State of Nevada in and for the County of Elko.

This deposition is being taken on behalf of the defendants.

Would all attorneys in the room please state your party and introduce yourself.

MR. BURTON: Good morning. This is James Burton from Kirton McConkie. I represent Reach Air Medical Services.

MS. HUETH: Chelsea Hueth on behalf of Ruby Crest.
MS. BESTICK: Alissa Bestick on behalf of Dr. Garvey.
THE VIDEOGRAPHER: And on the phone, please.
MS. MORALES: Jennifer Morales on behalf of Diane Schwartz and the estate.
MS. RIES-BUNTAIN: Jennifer Ries-Buntain on behalf of Northeast Regional Nevada Hospital.
THE VIDEOGRAPHER: Is that all?
MR. BURTON: That's it.
THE VIDEOGRAPHER: Okay. Thank you. We are located at Ledgestone Hotel in Elko, Nevada. My name is Bill Stephens, certified legal videographer, representing Bill Stephens Productions, Incorporated, at 10580 North McCarran Boulevard, Number 115, Suite 319, Reno, Nevada, 89503.
I am not related to the parties involved and have no -- no interest in the financial outcome of this deposition.
The court reporter is Lisa Manley.
Lisa, would you please swear in the deponent.
(witness sworn)
THE VIDEOGRAPHER: Please proceed.
/
/

DR. JOHN PATRICK PATTON
called as a witness in said case, having been first duly sworn, testified as follows:

EXAMINATION

BY MR. BURTON:

Q. Good morning, Mr. Patton. We met before we started. Could you please state your full name for the record?
A. John Patrick Patton.
Q. And could you spell your last name?
A. P-a-t-t-o-n.
Q. What is your home address?
A. 718 Bluegrass Drive, Spring Creek, Nevada.
Q. Does it have a zip code?
A. 8980 -- 89815.
Q. Do you have an office address as well?
A. 1775 Browning Way, Suite 101, Elko, Nevada 89801.
Q. Have you ever had your deposition taken before?
A. For this case?
Q. No, just ever.
A. Yes.
Q. How recently?
A. Probably 15 years.

Q. And how many times in total have you had your deposition taken?
A. Just once.
Q. Because it's been awhile I just want to repeat some or set out some ground rules so that you know what to expect today.
The first is, the court reporter is transcribing what you and I say. I tend to be a fast talker and I think you might also talk quickly.
To make it easy for her, if you could speak slowly, and also if we could make an effort not to speak over one another so that it makes her job a lot easier.
The second issue is you have been placed under oath just as if we were in trial in front of a judge, and you have the obligation to tell the truth with the penalty of perjury being applicable.
Do you understand?
A. Um-hmm.
Q. Is that a yes?
A. Yes.
Q. The third thing I was going to say is, is it's normal in our conversation to give "um-hmms" and "uh-uhs." They are very hard to transcribe. So if you could say yes and no, give audible answers, it will make for a cleaner record.

If at any time you don't understand a question, please let me know. If you answer a question I will assume that you understood it.
Do you understand?
A. Yes.
Q. There may be a time when you need to take a break. As long as there is not a question pending, I'm happy to accommodate a break.
There also may be a time when various attorneys make an objection.
You are not represented by an attorney today, correct?
A. No.
Q. And so the objections will be simply for the record, then I will instruct you to answer after the objections are made. If that comes up, you will see how that works.
A. All right.
Q. Are you under the influence of any medication, drugs, alcohol, anything else that would inhibit your ability to testify truthfully?
A. No.
Q. I want to do -- get a little background. Can you tell me briefly -- I know that you are a doctor. Could you give us your education background?

A. Yeah. I'm a podiatrist. I do -- I'm a foot and ankle specialist. I did my undergraduate studies at Brigham Young University in Provo. Went to the Pennsylvania College of Podiatric Medicine in Philadelphia for four years. Did a three-year surgical residency at the Veteran's Hospital and the University of Utah in Salt Lake City.

I practiced here in Elko for 24 -- in August it'll be 24 years.

Q. Does your practice have a clinical and a surgical component today?

A. Yes.

Q. Any other education or training?

A. I have continuing education that I do on a yearly basis. Require 50 hours of continuing education every two years for my state board and national board certifications and requirements.

Q. And are you a board certified?

A. I am, with the American Board of Podiatric Surgery. I'm a fellow of the American College of Podiatric Surgeons.

Q. Thank you. We're here today in the matter of -- in a case that was filed by Diane Schwartz.

Are you familiar with her?

A. Yes.

Q. How do you know her?

A. I know her as a friend.

Q. How long has Mrs. Schwartz been your friend?

A. This happened three years ago. Probably for around three years previous to this.

Q. And what -- how did you become friends with Mrs. Schwartz?

A. We attend church together. Doug was an avid sports enthusiast. My son is -- my children are -- were -- at the time that Doug was here, my son was a varsity athlete in our local high school. He came and enjoyed games with us, basketball games.

We had a common interest of BYU football. We had many common interests in church. And that friendship, you know, evolved around neighbors, church, sports, community events, service projects, things of that nature.

Q. Were you in the same ward?

A. Yes.

Q. In the ward capacity, did you and Mr. Schwartz serve together?

A. No.

Q. Did you and Mr. Schwartz socialize together, go out to dinner, things of that nature?

A. Yes.

Q. I want to focus -- I'm going to try to be quick here. I want to get right to the point and try to be efficient with your time.

You are aware there was an accident in June of 2016?

A. Yes.

Q. Were you with Mr. Schwartz when that accident occurred?

A. No.

Q. How did you become aware that there had been an accident?

A. We had a phone call from his wife, Diane. And that was maybe 20 minutes to an hour after the injury. That was when he was in the -- when he was in the E.R.

And she called in the capacity to ask me -- Doug had asked her to call me to come and give him a blessing.

Q. And did you go to the hospital to give him a blessing?

A. I did.

Q. Did you -- did somebody go with you to assist in the blessing?

A. Yes.

Q. Who was that?

A. His name is Perry Wilson.

(court reporter interjects)

Q. Is Perry Wilson a member of your ward?

A. Yes.

Q. Did he travel with you to the hospital?

A. He traveled with me to the hospital and brought Doug's truck home from the hospital.

Q. So Ms. Schwartz -- Mrs. Schwartz called you on the phone. What did she say to you?

A. That Doug had been in an accident and he was in the emergency room and that he had asked her to call me to give him a blessing.

Q. And were you at your home?

A. Yes.

Q. In Spring Creek?

A. Yes.

Q. How long is the drive from Spring Creek to the hospital?

A. About 23 minutes.

Q. When you arrived at the hospital, what happened then?

A. Now, please understand, this is three years ago, okay, minus about three weeks. But I called Perry Wilson, asked him to go with me, to accompany me, and he rode in with me.

When we got to the hospital -- just a little drink here -- when we got to the hospital, we were able to

go in. We met Diane. We were able to go into the emergency room room where he was.

And he was just on his way -- just near on his way to go down to the CT scanner. And he was -- you know, we talked with him, I visited with him. There were nurses in and out of the room.

He was -- he was in a position where we -- we talked and conversed. It was only a few minutes, I think, that we were there, maybe five or ten minutes, and then he was taken down for CT scan.

So he was down at the CT scan where Diane went with him. Perry Wilson and I were there that -- we gave him a blessing. It was right in the -- in the CT room.

And he was -- so we visited with him in the E.R. suite, visited with him and went with him to the CT scan. Then he -- you know, the CT scan doesn't take a long time.

He was back in his room. Then we visited again back in his room. Perry Wilson at that point was -- had -- Diane had asked if he could go and get Doug's truck from the location of where the accident occurred, and then Perry went on home.

And because Doug was doing -- was stable and was doing fine, and so we talked a little bit about, you know, what did she think was -- is he going to get

transferred, is he going to stay.

And I said -- of course, you know, I'm -- that's not my specialty, it's not my thing generally.

So we went back in the -- the process was that the air ambulance crew was being -- had been called and at this point were there and were making preparations to transport him to Salt Lake.

And so just before -- I don't know how much time transpired here, but maybe -- maybe 45 minutes or so from the CT scanner to the time that we left him. Then that was -- that was the last time that we had seen him.

Our conversation with Doug was -- was an interesting situation in that he was in a lot of pain. He had been hurt and he was -- he was in a lot of pain.

But he had a -- he was just a fun guy, just a fun personality. People loved him and we loved him. He was a fun guy.

So he was always -- you know, the first thing he asked about was, it just so happened to be that very day -- that very day we had taken our son, whom he had come to watch basketballs games with and things, we had taken him to the MTC to -- for -- he was going to serve an LDS mission in France.

So we had been to Salt Lake -- or been to Provo that day and got back. And so his first questions

were, "How'd Logan do?" That's my son. "How" -- "How did Logan do?" How was -- "How did it go at the MTC?"

And so he was, you know, talking, making some -- you know, just joking about his French he don't know yet and things of that nature.

And so he -- he -- you know, we asked him about how you feeling, how you doing, you know, how you doing here.

And naturally he was -- he was in some discomfort and -- and -- but he was speaking, talking, joking, laughing. It was uncomfortable for him to laugh.

And then that's how -- that's how we left. And so we were -- we were each invited to leave. And we at that point went out into the waiting room into the E.R.

Q. Why were you invited to leave, if you know?

A. I don't.

Q. Let me follow up on a couple things that you said. Do you have surgical privileges at the hospital?

A. Yes.

Q. And how often do you perform surgery -- and when we say the hospital, what's the -- for the record, what's the name of the hospital?

A. Northeast Nevada Regional Hospital.

Q. How often do you perform surgeries at the hospital?

A. It varies. I have block time the first and third Tuesdays of each month. I take cases out of the E.R. that -- fractures, diabetic wounds, ulcers, and things like that that -- that are taken when they come.

Q. Are there any other facilities where you perform surgery besides the hospital?

A. Not currently. We used to have another outpatient surgical center that has been closed for about four years.

Q. You mentioned that -- I'm going to bounce around a little bit because I took some notes while you were -- while you were testifying.

When you went into the emergency room for the first time, into the room where Doug was -- Mr. Schwartz was actually being treated, who all was in the room, if you recall?

Let me -- before you answer, let me say, we all recognize this was three years ago.

A. Um-hmm.

Q. And so we're looking for your best recollection. We don't want you to guess, but just your best recollection.

A. Then I don't know.

Q. Okay. When -- when Doug -- after the blessing, after the CT scan, and Doug was back, was he in

an individual room within the emergency department?

A. The suite that he was in has a -- it's a double room with a curtain in the middle of it, which he was the only one in that suite.

Q. Meaning there was nobody else on the other side of the curtain?

A. I don't know.

Q. Is there a door that closes off the room from the rest of the emergency department?

A. Yes.

Q. Do you recall at any time that you were in the emergency room with him, with Mr. Schwartz, seeing anybody that you recognized, aside from Mr. Schwartz and Mrs. Schwartz?

A. Yes.

Q. And who was that?

A. Nursing staff of whom I was -- who would have probably known or recognized, but don't believe I could give you a name.

Q. Anybody else?

A. And Dr. Garvey.

Q. And for the record, do you know what Dr. Garvey's first name is?

A. I don't.

Q. How do you know Dr. Garvey?

A. I know him simply professionally.

Q. In his role as a physician and your role as a podiatrist?

A. (Nods head)

Q. You said you knew that the flight crew was there, the Reach flight crew. Correct?

A. Well, I didn't know they were Reach flight crew, but the flight crew was there.

Q. Fair enough. How did you identify them as flight crew?

A. Well, they have -- they have special clothing that they wear, like little blue jump suits. They come in and -- with -- with a special gurney that transports from the normal hospital gurney into the -- into the transport.

Q. Did you speak with the flight crew?

A. I don't remember.

Q. Do you recall how many there were?

A. More than two.

Q. Do you -- do you recall what they were doing when you observed them in Mr. Schwartz's suite?

A. In general, getting -- communicating with the -- with the staff, getting history, information, medical questions.

Q. Did you observe them treating Mr. Schwartz --

A. No.

Q. -- at all? In the time that you were in the suite with Mr. Schwartz, did you observe anybody treating -- providing medical treatment to Mr. Schwartz?

A. He had -- I think there was a respiratory therapist there, Dr. Garvey, nursing. I didn't see any of the Reach -- or the -- yeah, I didn't see any of the Reach people provide any care.

Q. Did you see other medical providers providing care to Dr. -- to Mr. Schwartz?

A. Nurses. The -- at one point he -- he needed to use the restroom. I am the one that helped put the urinal, helped him place that. No one else helped him do that.

Just general -- he had IV lines in. I don't remember any other specific care.

Q. Prior to you being asked to leave, did you observe any medical care that was provided to Mr. Schwartz that gave you concern?

A. No.

Q. You mentioned that you didn't speak with the Reach crew before you were asked to leave -- or the flight crew, I'll call them the flight crew, because I know you didn't know that it was Reach.

Did you ever speak with them at any point during your time at the hospital with the Schwartz family?

A. I don't remember that unless it was a simple social pleasantry.

Q. "How are you" or "hi"?

A. Correct.

Q. But nothing substantive about the care, the outcome, or anything of that nature?

A. No.

Q. And at this point Mr. Wilson had already gone home?

A. Yes.

Q. So did Mr. Wilson accompany you back to the emergency department suite after the CT scan and blessing, or did he leave straight for the -- to get the car?

A. I believe he left. But after -- I believe he left between the time he came from the CT scanner back to his E.R. suite. He wasn't -- he wasn't there very long.

Q. One of the issues -- and I realize some of these questions are sensitive. I mean, the whole situation is sensitive. I want you to know that we -- that we understand that.

Did you ever observe Mr. Schwartz consuming alcohol?

A. No.

Q. Did you ever have any reason to believe that he ever consumed alcohol?

A. No.
Q. On the day that he was in the hospital, could you smell alcohol or were there any indications that alcohol had been consumed?
A. I couldn't smell any and there were no indications of that.
Q. So you were ultimately invited to leave the room. Who invited you to leave the room?
A. You know, I don't remember.
Q. One of the staff?
A. Um-hmm.
Q. Is that a yes?
A. Yes.
Q. Sorry. That's the obnoxious follow up. Then what did you do?
A. We left.
Q. Where did you go?
A. To the waiting room in the -- in the E.R.
Q. How far is the waiting room from the suite where Mr. Schwartz was being treated?
A. Probably a hundred feet.
Q. Is there a line of sight from the waiting room --
A. No.
Q. -- to the room? And I assume there were doors

as well?
A. Yes.
Q. In the time that you were in the waiting room, can you -- or from the waiting room, can you hear what is happening in Mr. Schwartz's suite?
A. No.
Q. So you waited in the waiting room. Who was in the waiting room with you?
A. Diane, myself. There was a gentleman that works with him. I think his name is Dan. I had never met him before. And I think that's all I can remember.
Q. Mrs. Schwartz has testified that his name is Dan Benson.
A. Yeah.
Q. So I'll help you and call him Mr. Benson.
Mr. Benson, did he arrive at the hospital when you were in the waiting room after being asked to leave the emergency department?
A. I don't remember -- I don't remember that. I think -- I think he was there when I got there.
Q. Was he there when you gave Mr. Schwartz a blessing?
A. I don't remember that.
Q. Do you recall if Mr. Benson was in the emergency suite with you after the blessing but before

being asked to leave the emergency department?
A. I don't remember that.
Q. So the three of you were waiting in the waiting room. What happened next?
A. Well, she had -- Doug wanted to have a -- Doug wanted to have a kiss from Diane before she left.
And -- and then we were in the waiting room for a long time. I -- I don't know how long that was. It might have been -- I don't even remember what time it was when we were invited to leave the E.R. suite. But it seems -- it seemed like a couple of hours we were in the waiting room. It was a long -- it was a long time.
So we -- you know, we just talked and visited, trying to, you know, just, you know, help keep Diane comforted and calmed and just commenting on, you know, this is -- this is taking awhile.
I remember at -- at one point I had gone to the E.R. reception window and asked, can I -- you know, I would like to -- what my intention was, I just wanted to go in and see, kind of get an update on what was going on, why it was so long and why -- you know, just what -- what was going on.
And -- and she told me because I am -- and I wasn't trying to play that card, but I just felt like, you know, I am on staff here and I go into that place, it's not

odd for me to go into the E.R.
And I had requested, hey, can I come back and just -- just kind of see what's going on. And she said, "no, they will let you know when" -- "when they have something to tell you."
And so -- so -- I don't know, maybe it's around -- I don't know, maybe it's around midnight, somewhere around this time. So it seems like a long time has passed.
So there is just a little bit, you know, more tension growing out in the waiting room.
And then Diane had to use the restroom. And so she had gone into the restroom. And while she was in the restroom, as I recall, the nurse -- one of the nurses had popped out of the door into the waiting room and asked me to come in.
And so I did. And -- well, I will let you ask the next question.
Q. All right. Let me cover some of what you -- what you covered.
The time that you were waiting in the emergency department after being asked to leave but before Mrs. Schwartz went to the restroom, what was her state of mind that you observed?
A. Well, she was nervous, but she was -- Diane is

pretty calm. She -- she is a wonderful, wonderful lady. Great. You know, wonderful person. Calm -- or concerned. Concerned, nervous, but pleasant.

Q. Did you have a badge or some type of access card for the hospital?

A. I have a badge. Wasn't wearing a badge. I don't need -- I don't -- I don't -- I have a badge. It's not an access card, it's just a badge.

Q. Did you have it with you at the time?

A. I did not.

Q. The receptionist that you talked to -- I want to make sure the record's clear. The person that you asked if you could go back, was it the receptionist?

A. Yes.

Q. Do you recall the name of the --

A. No.

Q. -- receptionist?

A. No.

Q. Do you recall if it was a man or a woman?

A. It was a female.

Q. Do you recall if she was older or younger?

A. Younger.

Q. If you saw her or a picture of her, would you recognize her?

A. No.

Q. Anything else that you and she discussed other than you asking to go back?

A. No.

Q. Do you recall specifically what she told you?

A. No, I don't.

Q. Just, in essence, "no, we'll let you know"?

A. Yes.

Q. Do you recall anything else that she said?

A. No.

Q. So the nurse came out to get you and asked you to come back. Tell me what happened next?

A. So -- so first of all, in my -- my first thought was, okay, so, why are you asking me to come back, not Diane.

But -- so I went back and the nurse guided me over to where Dr. Garvey was, just outside of -- behind the counters and just outside of where their -- their offices are.

And I don't remember exactly what he said, but it was something in general like this. As I -- as I walked over there, I realized that -- and I remember this -- it was one of the things I really remember of this night really well. As I walked in and over to him, usually the ER is just (makes descriptive noise) there's stuff, there's stuff going on. And across the entire suite it was dead

quiet and everybody was watching me.

And so I got to Dr. Garvey and he said, "We lost him." And I -- in my mind, because of the state that he was in when we left him, that was the farthest thing from my mind. Because he was -- he was communicative, he was laughing, he was joking.

Even in all the pain and suffering that he had, that's the -- that's the position he was in. They were know, making arrangements and -- for him -- for him to go.

And so my heart just dropped. And -- and I told -- I told him, I said, "well, you know, we got to go out" -- "we got to go out and tell Diane."

Q. Let me stop you there. Did you ask Dr. Garvey what happened when he told you that we -- that he'd lost him?

A. Hm-mmm. No.

Q. Is that a no?

A. No.

Q. Sorry. When you walked back to the suite, where is the -- the place where you talked with Dr. Garvey in relation to the room where Mr. Schwartz had been treated?

A. If the location where I spoke to him was where you are sitting, his suite would have been in that far corner.

Q. Close -- I mean, you can see the suite from where you were standing?

A. I could see the suite but couldn't see inside of it.

Q. Were the curtains drawn?

A. I don't remember.

Q. Did you see -- you couldn't see anything going on, if anything was going on, in that room --

A. No.

Q. -- at that time?

A. There's a door outside of the room he was in that you open and close. Inside the room there is a curtain that goes down the middle.

Q. Do you recall if the door was shut?

A. I don't remember.

Q. When you walked back to see Dr. Garvey, did you see the Reach flight crew anywhere?

A. I don't remember.

Q. Did you see any of the other people that you had remembered seeing in the room earlier, the providers?

A. I don't remember specifically any of that.

Q. The nurse that came back to get you, do you recall who that was?

A. I don't.

Q. Did Dr. Garvey -- other than saying that "we

lost him," do you recall Dr. Garvey saying anything else to you as you were standing in the -- in the emergency department back there?

A. In general. I don't -- well, I can tell you -- if the -- I can tell you straight up, I don't remember specifics. Only a generality.

Q. Okay. Whatever you remember generally would be helpful.

A. So --

Q. And I want to focus -- I realize that later on we are going to talk about the discussion between Dr. Garvey and Mrs. Schwartz that you may have observed. But I am asking specifically at this point about the discussion just between the two of you.

A. Um-hmm. And this is a part that I am just telling you that I can't remember. Because I had a conversation with Dr. Garvey later, just before I left, around six in the morning.

And so I can't remember whether this was part of the conversation now, around midnightesque, and -- or whether it was when I visited with him for a few minutes before I left to take her home about six in the morning.

And that was that -- it was just regarding the situation of why -- why did he need to be intubated. He had aspirated when he intubated and he had tried to -- you

know, they tried over and over and over to clean out, he was just plugged.

They tried to -- to do other interventions. Nothing that they could do could -- because he had aspirated so bad. And my question is -- and my question was, why did you have to intubate him? He was doing great while we were here. I mean, he was doing great.

And his point was that -- again, I can't remember if -- I -- I just don't remember if this conversation was now or later in the morning.

But the -- but his point was that the transfer team in Utah felt he would be more stable if he was intubated. And there was some apparent conflicting opinion regarding that, which is not my opinion, whether, you know, if he is stable and he's doing well, why would he have to be intubated.

But from my memorance of him was the ultimate reason why he was intubated was -- was they felt he would be more stable in air traffic.

So that was my conversation with him, is why -- why in the world did we need to do that. Why did he need to be intubated. And so that was -- that was just the point. That was the triggering issue.

Q. Now, I realize that -- that -- well, let me ask you this, is intubation something you typically do --

A. Never.

Q. -- in your practice? Have you ever intubated anybody?

A. Yes.

Q. In what context?

A. As a resident.

Q. Approximately how many times have you intubated?

A. Okay. So that was 24, 25, 26 and 27 years ago. I am not an intubation person, I haven't done one since. I did it in my residency training under the direction of an anesthetist on my training in my rotations. I probably did 20.

Q. Are you familiar with the phrase "rapid sequence induction" in the context of intubation?

A. Um-hmm.

Q. Is that a yes?

A. Yes.

Q. Have you ever done a rapid sequence induction?

A. Not that I remember.

Q. Even in -- and including in your training?

A. I don't remember that.

Q. And you don't -- and I know you're here as a fact witness, but you're -- you're not -- you don't hold yourself out as an expert --

A. Not at all.

Q. -- in intubation?

A. Not at all. I -- and I have no -- and I don't -- and I don't have an opinion on what happened there.

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, communicative when we left him.

Q. Were you aware what Mr. Schwartz's particular injuries were?

A. In general.

Q. What do you understand them to have been?

A. Broken ribs, contusions. Of that nature.

Q. Do you know -- are you familiar with the term, "pneumothorax"?

A. Yes.

Q. What generally do you understand that to be?

A. Yeah, it's a collapsed lung.

Q. Do you have -- do you know if Mr. Schwartz had a pneumothorax?

A. I think he did.

Q. Do you have an opinion as to whether or not intubation is appropriate if there's a pneumothorax present?

A. Yeah. Well, sure I do. Just in general. Please understand, I am -- although I'm a doctor, I am not here describing my opinion on medical concepts in this situation.

My wife has a pneumothorax. She has had -- she had a stillborn, right after that, had a pneumothorax. We have dealt with that many, many times. She has never been -- she's never been intubated.

Q. Were you -- did you observe -- let me back up. Prior to you being asked to leave the E.R. with Mrs. Schwartz, you came back from radiology -- or not radiology, the CT scan, whoever did that. You visited in the room. At some point you were asked to leave. Correct?

A. Yes.

Q. In the time that you were in the room post-CT scan, prior to being asked to leave, did anybody explain what was going to happen to -- to Mr. Schwartz to Mrs. Schwartz?

A. I don't remember any conversation about an intubation while we were in the room with them.

The plan we left with was he was going to be transported over to Utah.

I -- I don't remember a conversation about, "okay, you are going to leave so we can intubate him." I don't remember that.

Q. Do you recall any discussion about a chest tube?

A. The discussion with Dr. Garvey was that they had tried to place a tube or do a tracheotomy type procedure to gain air access for him.

Q. Let me be more specific on my questions. Prior to being asked to -- to leave the room, do you recall anybody on the staff, Dr. Garvey, any of the providers, discussing a chest tube with Mrs. Schwartz?

A. No.

Q. Do you recall seeing any -- have you ever seen a chest tube installed?

A. Yeah, my wife had one.

Q. I assumed you had, I just have to lay the foundation.

Do you recall seeing any instruments or trays for a chest tube?

A. There was none of that that was -- had happened or -- I don't remember any of that, no.

Q. Did you observe or hear Mrs. Schwartz or Mr. Schwartz say, "no, I don't want to be intubated" before you left the room?

A. No.

Q. All right. So you and Dr. Garvey have this discussion. You indicate to him, we need to tell Mrs. Schwartz. Tell me what happened then?

A. Yeah. So this -- this is -- this is -- this -- this is a terrible part. It just -- it was terrible.

So we come back out into the room and -- and -- and Dr. Garvey just blankly, just straight up tells Diane, he -- "We lost him."

And she -- she just -- just completely lost her ability to control herself. I grabbed her. She went to the floor, screaming, screaming. There is -- certainly throughout this entire hospital, everyone had to have heard her. Just -- just relentless screaming. And so that went on for maybe up to a minute or two.

Ultimately, they got a wheelchair able to get her up to be able to transport her. Took her back into an E.R. suite. A different one that -- on the complete opposite end of where Doug had been.

And just trying to get her to calm down. That took forever. A lot of time went by right her just trying to get her -- she was just sobbing, just -- and I -- I -- you can only imagine. You know, you just -- you walk away from your husband and he is doing great. And all of a

sudden now you walk out and he is gone.

And that wasn't something that she had -- none of us had seen that coming. And so that was just an extreme -- just an extreme -- that was just right out of the blue.

And so that's how that went.

Q. Do you recall what, if anything else, Dr. Garvey said to Mrs. Schwartz other than "We lost him"?

A. I don't.

Q. Did he give any explanation to her as to what occurred?

A. He did not.

Q. In the time that you were in the hospital with Mrs. Schwartz, did Dr. Garvey speak with her after telling her that her husband had died, that you observed?

A. I was with her most of the time the rest of -- well, I was with her most of the time all of that night.

We were in the E.R. suite together. We were in the CT suite together. We were back in the E.R. together. We were out in the waiting room together. And now we're back in her E.R. room together.

I don't remember him ever telling her anything about what happened.

Q. Did you observe any time after Mrs. Schwartz was informed that her husband had passed away that the

flight crew spoke with her?

A. I don't remember that either.

Q. Did you -- did you observe --

A. I don't think that happened. But I -- but I don't remember that.

Q. So Mrs. Schwartz goes back to a separate room. You went with her?

A. (Nods head)

Q. Is that correct?

A. Yes.

Q. What happened next?

A. So they had given her some medication just to try to relax her a little bit.

And at this point now she is where she can get a little bit of just her shaking and her -- just pull herself under control. She tried to -- to get a cell phone out to be able to pull numbers off it. So I am using her cell phone to begin calling children, some very, very close -- or some brother -- family members, brother, sisters, children.

And so one by one, now in the middle of the night, I am calling each one of these people. It's -- it's somewhere around -- it's after midnight. So every single call that I make I am pulling someone out of bed unconscious and share with them that their father or family

member, whomever I was speaking to -- I called several.

Each time, you know, they went into a similar flurry that Diane had just gone through. And each time that we called somebody, they got her -- you know, just -- just put another log on the fire to flame her back up.

And that went on for -- I don't remember how many calls, but it was -- it was several -- several phone calls that we made during the night for people to get in their car and drive up and to come up and to be here and to accommodate her.

And that -- during that time I think Dr. Garvey was with us in and out. A little bit. Not much. But mostly just there was one or two nurses that were with us all that time.

Q. During the time that these phone calls were occurring and Mrs. Schwartz was in a separate room, did anybody come in --

A. And I was with -- we were together then.

Q. I mean separate from the room that her husband had been treated in --

A. Oh, yeah.

Q. -- and you two were together. Did anybody, any medical provider come in and explain to you or Mrs. Schwartz what had occurred with doc -- with Mr. Schwartz?

A. I'm going to say no. I don't -- I don't

remember anyone talking to us about that. I don't remember anyone talking to us about that until my parting conversation with Dr. Garvey just before we left.

Q. Well, let's talk a little bit about that. When you asked Dr. Garvey why was he intubated, what was Dr. Garvey's response?

A. Well, the same situation I mentioned earlier, was that the comfort level of the transferring -- or the receiving doctor at the facility, in Dr. Garvey's opinion, or in -- what Dr. Garvey had mentioned was that they had -- they had wanted him to be intubated just for stability for his flight.

Q. Did Dr. Garvey give you any specifics as to what specifically occurred when Mr. Schwartz was intubated?

A. That he had aspirated.

Q. Any other specifics?

A. He had aspirated and that he had -- you know, he was just plugged tight, and through their various interventions were unable to get any airway access for him.

Q. Did he give any specifics as to who tried what, what specific procedures or -- or methods were attempted?

A. No.

Q. Aside from the -- you -- I think you phrased it as a parting conversation as you were getting ready to

leave. Have you ever discussed Mr. Schwartz with Dr. Garvey since leaving the hospital that morning with Mrs. Schwartz?

A. I don't remember that.

Q. Have you ever discussed the care that Mr. Schwartz received on the night when he was in the emergency room with any of the medical providers that were there other than on the night that it occurred?

A. Just one.

Q. Who was that?

A. It was a nurse that was there that evening.

Q. What was her name?

A. Her name is -- I can't tell you what her name is right now.

Q. Because you don't remember it?

A. Correct.

Q. If you -- as we are talking about it, if you remember, if you'd let me know, that would be great.

What was the context in which you discussed this with -- with this nurse?

A. This -- this nurse is a -- was a patient of mine. She had -- I had seen her previous to this and then obviously after. And so I treated her for -- I had known her as -- in a professional relationship.

And I don't even remember how long it was

after this event that I had seen her in my office as a patient. But I had -- I had a conversation with her.

Q. What was the -- and I obviously don't want to get into any of the care you provided to her. I'm not interested in that. But I am interested in what she said to you about the care provided to Mr. Schwartz?

A. It's hard for me to remember that.

Q. Do you recall generally what she said?

A. Generally, yes.

Q. What did she say generally?

A. Generally it was just a very unfortunate situation.

Q. Was she critical of the care that was provided?

A. I don't remember her being critical of that.

Q. Was she directly involved with the care?

A. I don't know what capacity she was involved in the care, but she was in the room.

Q. Anything else you -- you can recall about that discussion with her?

A. Her -- her feeling was that they had worked tirelessly to -- after -- after the circumstance of the aspiration they had worked tirelessly to -- to try to revive him.

Q. Anything else that you can recall that she

said?

A. No.

Q. All right. So let's go back. You made phone calls to various children, close friends, family members. What happened next?

A. So I'm not sure what the time frame is. We were in that room together for, seems like, a few hours. So it has to be somewhere in the zone of three, four, somewhere late into the -- into the night or early in the morning.

And she wanted to see Doug. The whole time she wanted to see Doug. From the minute he told her, he wanted to see Doug -- she wanted to see Doug. And they just wouldn't let her see him at that time.

So at a later point she just continued to -- to request, I want to see, I want to see Doug, I want to see Doug, I want to see him.

And so ultimately it's now somewhere around late into the night, maybe around four o'clock in the morning, and -- as a generality. I don't remember what time it was, but late.

And so ultimately we were -- we were taken over to the room where Doug was. This is going to be a new room now. It's not the room he started in. It's not the CT room. It's not the room that she and I were in making

the phone calls. This is a different room that they put him -- they placed him into. It's a private room with a door. There is just one person in this room.

So -- so we were -- we were let in to -- to see him.

Q. And what -- what happened next? Actually, before you answer that, let me ask you this, was Mrs. Schwartz given any explanation as to why she wasn't allowed earlier to see her husband?

A. No, we were -- no.

Q. Okay. So then what happened next?

A. So then we come into the room and he is, you know, under a -- under a -- under a drape, under a sheet, similar to what we have on this table, exposing -- I mean covering all of him right up to his neck.

And then -- oh, my gosh -- then we just go through the same thing that happened when we were out in the E.R. waiting room when she was just notified of this situation.

Just a huge breakdown. I -- that just -- you know, I just tried to hold her and comfort her. She just -- you know, she just hugged her husband, just wept over him for -- for a long, long, long, long, long time.

And it was -- oh, my gosh, those are -- those are difficult circumstances to be in. Seeing him, one,

seeing her with him, it's -- that is a -- that is a tough thing to see.

And so that went on for quite awhile. And ultimately, we had a nurse -- and I don't remember who it was -- it was a nurse that was in with us. And she was in with us for, I don't know, maybe the first 15 or 20, 30 minutes.

And then once she was able to kind of collect herself and just bring her sobbing and crying -- well, her crying never really stopped. But just -- just uncontrollable emotional response, when she got that under a little bit of control, then -- then she left.

So she just had some time -- I asked her if she wanted me to leave, because that's a, you know, a personal time right there. And I remember she said, "no, just stay."

And so I just tried to kind of just stay off to the side, just caress her, just help her. And -- and then she just talked to him for maybe an hour. Maybe an hour.

And then -- and then one of the super frustrating things that happened was the coroner wanted to come in, and he just wanted her to wrap thing up and get her out. And -- and she wasn't ready to be done. She -- she just wasn't ready to be done.

So it was just, have to understand, look, we just need some more time here. So he left and then he came back and then he left and then he came back. And ultimately now it's somewhere in the area of about six-ish in the morning, and the coroner finally over -- just wore her down and -- and then kind of -- kind of booted us out there.

And that's the point where -- where, I think, from the very beginning, whether I had this conversation earlier on or whether I had it at the parting. If I had conversation at parting it would have been now with Dr. Garvey.

Q. And as you -- as you've been talking, have you -- can you think of anything else that you and Dr. Garvey may have discussed in this conversation that you haven't already testified about?

A. Generally, no.

Q. At this time in the emergency department, was the flight crew still there that you recall?

A. I don't recall.

Q. Anything else that you recall about the time in the emergency department from start to finish that you haven't already testified about?

A. No.

Q. So I assume at this point you drove Mrs.

Schwartz home?

A. Yes. So her car was -- you know, she had originally parked her car in the emergency parking lot. I went around and got that and brought it up right to this -- you know, the underhang where the ambulance comes in, and got her in. And it's about a 25-minute drive home.

And she had called my wife earlier and asked -- because she had her grandchildren, her -- her -- one of her children was on a vacation and they were taking care of the grandkids, and so she had -- I had communicated with my wife throughout the evening. She is asking, you know, what -- "do you have any updates?" I said, "We're just waiting, we're just waiting." And then, you know, finally when we heard about the death. So I updated her.

But Diane had asked her early on in the evening if she would just go over and be with her kids. So when we got the house, my wife was there, kids were sleeping -- my wife would have better information about this later today.

And it was just a difficult situation trying to get her situated and, you know, just try to -- she was just -- she was just out of gas. She is -- just no sleep, just emotionally drained and exhausted and -- and so I stayed with -- I stayed with them for, I don't know, maybe -- I don't know, 15 minutes or to a half an hour.

And then my wife stayed with them -- stayed with her until her children from southern Nevada came up. And so they got there. You know, my wife came home sometime later in the morning, ten or eleven, when her family began to arrive.

And so that's how the trip home went.

Q. I just only have a few more questions. At this time, were you in leadership in your ward at the time?

A. No.

Q. Regarding today's deposition, have you discussed today's deposition, the fact that you were being deposed, with anybody?

A. Yes.

Q. Who have you discussed it with?

A. My attorney.

Q. I won't ask what you and he talked about. Anybody else?

A. I had general conversations. You know, I have talked to my children. My kids are all adults. Beyond that, I would say no.

Q. Have you discussed today's deposition with Mrs. Schwartz?

A. I haven't spoken to her for -- for -- I can't even tell you when I spoke to her last. It's been within the year.

Q. But after receiving this subpoena, you didn't call her up and --

A. No.

Q. -- and let her know?

A. No. She had let us know that probably we would be called. That was sometime ago and -- and -- but I haven't had any communication with her.

Q. Have you ever -- sorry. I didn't mean to -- I didn't mean to interrupt you.

Have you ever reviewed the medical records in this case?

A. No.

Q. Have you ever discussed the fact that a lawsuit was filed or was going to be filed with Mrs. Schwartz?

A. A conversation early on was -- you know, she just -- I don't really remember if that's the conversation.

Q. Did you have any role in encouraging Mrs. Schwartz to file a lawsuit?

A. One hundred percent no.

Q. With respect to the Reach crew -- you know I represent Reach -- is it accurate to say that your testimony is, other than pleasantries, you had no discussions with the Reach crew?

A. Correct.

Q. And is it also accurate to say that you didn't observe the Reach crew providing any care to Mr. Schwartz?

A. Correct.

Q. And is it accurate to say that as of today you are not even sure if they provided care or not to Mr. Schwartz? The Reach crew specifically?

A. In -- boy, this -- this is -- this is a poor statement or a question, but it just is what it is.

I don't remember when or how I knew that the Reach crew had done the intubation or attempted intubation. Whether I got that from Dr. Garvey or whether that was just talked about in the hospital, I don't remember, but.

Q. Do you recall any other specifics about what you know that -- or what you were informed that the Reach crew had done?

A. Simply that they had been the one to intubate him.

MR. BURTON: All right. I don't -- I appreciate your testimony today. Other attorneys may have questions and I may ask some clean-up questions at the end. But if I don't, thank you very much, Dr. Patton.

MS. HUETH: I don't have any questions at this time.

MS. BESTICK: I just have a couple of quick questions.

THE VIDEOGRAPHER: Could we have you on microphone, please.

EXAMINATION

BY MS. BESTICK:

Q. Hi. My name is Alissa. I represent Dr. Garvey as I stated earlier.

(court reporter interjects)

Q. As you know, I represent Dr. Garvey in this matter, as I stated earlier.

I just have a couple of quick follow-up questions.

When you first arrived to the hospital, that is Northeast Nevada Regional Hospital, did you observe that Mr. Schwartz was on oxygen at any point?

A. I don't remember.

Q. You have stated a couple of times throughout your testimony that Mr. Schwartz was doing great and was stable when you last saw him.

Could you explain a little more what you base your contention that he was stable at the time that you saw him.

A. Stable in the -- stable in the fact that -- just simply stable in the fact that he was aware of person, place, time. He was conversational. He was -- had jocularity. He was pleasant.

It didn't undermine the discomfort and pain that he was in. I am not undermining that at all. He was in a ton of pain.

But he -- when I -- I reference -- my reference of stability would be asking me questions, making jokes about my son, asking about his welfare, thinking about others instead of himself. Having -- you know, wanting to kiss his wife before she left.

Things of that nature is what I would use -- great isn't a good word, I -- I sense that. But stable in that sense of alert of person, place and thing, conversational and pleasant.

Q. Okay. At the time that you were invited to leave the room prior to the intubation attempts, did Diane ask to stay?

A. I don't remember that.

Q. Okay. When you left the room, did you leave at the same time as Diane, or did she stay for a moment after you had left?

A. To my best memory, they kissed and we walked out together.

Q. Okay. And you testified previously that you discussed with Mrs. Schwartz in the waiting room the conversation about whether to transfer Mr. Schwartz or not.

Do you recall -- what do you recall about that

conversation?

A. Okay. That conversation wasn't in the E.R. waiting room. That was after he had been in the -- actually, it was either during or after he was in the CT scan, in the hallway.

And the question was, "Do you think he'll get transferred?" And my opinion -- or my response was, I don't know. But generally, here at this hospital, when a serious accident has occurred, they get transferred.

Q. Okay. Was there any point between the CT scan and going back to the room, in the E.R. suite, that you were not by Diane's side?

A. I don't believe so. But I don't remember -- I don't remember that.

Q. Okay. And you had testified that Dr. Garvey told you that there was some question about the opinions to intubate Mr. Schwartz.

And at one point I think you said that it was the Reach flight crew that wanted him to be intubated. But then I believe at one point you said it was the accepting facility that wanted him to be intubated.

A. No, it was the accepting facility --

Q. Okay.

A. -- that wanted him to be intubated.

MS. BESTICK: Okay. That's all I have.

MR. BURTON: Anybody on the phone have questions?
MS. RIES-BUNTAIN: Yes, I just have a few follow-up questions.
(court reporter interjects)

EXAMINATION

BY MS. RIES-BUNTAIN:

Q. This is Jennifer Ries-Butain. I represent the hospital. I am the one you can see on the computer screen.

So I'm going to try to make this fast for you but not so fast the court reporter cannot follow me, okay.

I just have a few follow-up questions.

You mentioned that you thought you saw a respiratory therapist there. Did you observe the respiratory therapist providing care?

A. I don't remember that.

Q. But you did see that the nurses were providing care. True?

A. In general, yes. Monitoring --

Q. And you don't recall the specifics of what they did, but it's fair to say that they were actively caring for Mr. Schwartz in your presence. True?

A. Yes. Things like monitoring vitals and things of that nature.

Q. And it's fair to say that you did not have any concerns about the nursing care while you were there,

right?

A. Correct.

Q. That conversation that you had with one of the nurses who was a patient of yours. If I told you that Donna Kevitt --

A. That's it.

Q. -- recalled a similar conversation, would that refresh your recollection?

A. That's her name. Thank you.

Q. When you were speaking with Nurse Kevitt, did she express or did you observe her sadness over Mr. Schwartz's situation?

A. Yes.

Q. And did you get the sense that she cares about her patients and that this situation had affected her?

(court reporter interjects)

Q. Did you get the sense that she cares about her patients and this affected her personally?

A. Generally, yes.

MS. MORALES: Objection, (inaudible) calls for speculation.

MR. BURTON: Jennifer Morales, you may want to say your objection again. I don't think we got all that.

MS. MORALES: Objection, form, and calls for speculation.

MR. BURTON: You can still go ahead and answer.

Q. Dr. Patton, when you were discussing your personal experience with your wife having a pneumothorax, I just have a -- one follow-up question about that.

Was she put on an -- on an airplane with a pneumothorax?

A. No.

Q. So it's fair to say that you do not have any personal knowledge about how that could impact a pneumothorax. True?

A. Generally.

Q. Yeah, and I am not asking about you as a physician and maybe what you learned in your training. I am just asking about your personal knowledge. That was not something that came up in conversations with your wife, was it?

A. No.

Q. Because it wasn't one of the circumstances. Is that true?

A. That's true.

Q. And just to be clear, it's not your intention, if you were called to testify at trial in this matter, to offer opinions about the care and treatment as a physician expert. Is that true?

A. Correct.

Q. Have we now discussed all of the recollections that you have about Mr. Schwartz's care and treatment?

A. Generally, yes.

Q. Have we now discussed all of the conversations that you can remember about Mr. Schwartz's care and treatment whether during this event or after this event?

A. No. I -- there are -- there are probably other conversations that I have had. I will -- I sit on the -- I am currently the chief of surgery at the hospital. I sit on --

Q. Okay. So I will stop you there. As the hospital's attorney, if you are about to discuss any internal investigation or review relative to this matter, I can tell you that that's privileged. And so I'm going to enter an objection about any testimony about that if that's where you are going. And I don't know if it.

MR. BURTON: And I would join that -- that objection as well.

A. Fine.

MS. RIES-BUNTAIN: Okay. All right. No further questions.

MS. MORALES: I have a few questions.

EXAMINATION

BY MS. MORALES:

Q. Doctor, my name is Jennifer Morales, and I

represent Ms. Schwartz -- Mrs. Schwartz.

You just -- you just told us that you are chief of surgery for the hospital. How long have you been the chief of surgery?

A. Since January.

Q. January of this year?

A. Correct.

Q. Okay. And I don't want to know any discussions about the meetings or -- I don't want to know about any specific discussions.

But have you been involved in any meetings, formal meetings at the hospital, that involve this case?

A. In addition to sitting on -- being on the -- as the chief of surgery, I attend the medical executive committee meetings and sit on the credentialing committee.

Dr. Garvey has come up for recredentialing, and this case was --

MS. RIES-BUNTAIN: Yeah. And again, I apologize to have to interrupt you, Dr. Patton. But also the credentialing process is privileged. So I ask you to not discuss the content of the credentialing process, please.

A. Well then no.

Q. (By Ms. Morales) Well, I am still entitled maybe not to know specifics about the meetings, but you have sat in meetings that had to do -- where this case has

been brought up. Is that fair?

A. Yes.

Q. Okay. And do you know when that meeting was held?

A. In the past few months.

Q. And what -- and I'm sorry, I think it was the reception, but what committee did you say that you are part of?

A. Credentialing.

Q. Okay. Doctor, you testified earlier that you never heard Dr. Garvey explain any risks or benefits or even that intubation procedure needed to take place. Is that correct?

A. No.

Q. That's not correct?

A. No. We never had that discussion.

Q. Okay. As you sat with Diane in the waiting room in the emergency room, was there anything Diane said that made you understand or think that she knew that her husband was being intubated?

A. No.

Q. What -- what was your understanding when you left and were asked to leave the emergency room suite of what they were doing, the medical providers were doing for Doug?

A. To -- just in general, the information we received was just preparing him for his flight to Salt Lake.

Q. And at any point during your stay in the waiting room while Doug was -- while Doug was in the emergency room suite, did anyone ever come out and explain to either you or Diane that Doug needed to be intubated?

A. No. We had no communication after the time we left until the nurse came out to get me.

Q. Were you in the waiting room when a friend of Danny Benson's came out and had indicated that there was some chaos going on in the E.R. and that they -- he was going to leave?

MR. BURTON: Objection. Lacks foundation.

MS. BESTICK: Join.

MS. RIES-BUNTAIN: Join the objection. Calls for speculation.

Q. (By Ms. Morales) You can go ahead and answer.

Do you have a recollection of sitting with Diane and Mr. Benson when a man from the E.R. came out indicating that there was chaos in the E.R.?

MS. RIES-BUNTAIN: Same objection.

MR. BURTON: Join.

MS. BESTICK: Join.

A. So am I answering this question? Or what are

we doing?

Q. I'm sorry. Did you answer that? I'm not sure if you cut out.

A. No, I'm here. So am I answering that question?

Q. Yeah, you are allowed to answer still. They are just preserving the record with their objections.

A. Yes, I did.

Q. Okay. What did you hear of that discussion?

A. No more than what you stated in your question.

Q. Were you in the emergency room with Doug when the cop -- when a cop came in to talk to him about what had happened as far as the accident itself?

A. I don't recall that.

Q. At any point when you were in the emergency room suite with Doug, did you notice that he was having any difficulty breathing?

A. Well, he was -- he was in a lot of pain and -- but as I mentioned multiple times now, he was very conversational.

Q. Okay. But you didn't see him gasping for breath or having any shortness of breath or any of those type of symptoms?

A. I never noticed him gasping for breath. And in general, he -- he had conversational breathing.

Q. Okay. Did you, after this -- after the death of Mr. Schwartz, did you ever hear any of the hospital staff screaming out that Diane should sue the hospital?

A. Yes.

Q. Okay. And do you know who was saying that?

A. I don't.

Q. If you had to describe Mr. Schwartz to someone who didn't know him, how would you describe him?

A. Intelligent, energetic, fun, dedicated, loyal.

Q. Did he do a lot for the community there in Elko?

A. Yes. He -- he involved himself in -- in a variety of things that I am not completely aware of in his business; for service activities in the church, like moving people in, moving people out, helping, assisting, picking up chairs, putting chairs down.

I know he was involved in the Utah and Nevada High School Rodeo Associations.

He coached -- well, I don't think he coached while he was in Spring Creek, but he was a previous youth coach.

He participated, he came and supported local high school activities. Things of that nature.

Q. Okay. Give me one moment here. I think I'm almost done. Going through my notes.

Did you, after this day, after this incident occurred, did you ever hear any -- any of the nurses or anyone talking at the hospital about what happened?

MS. RIES-BUNTAIN: Objection, calls for speculation.

MR. BURTON: Join.

A. Simply generalities.

Q. Okay. Any more generalities than we've already discussed today?

A. Can you repeat that?

Q. Yeah. Was -- is there anything specific that you recall hearing at the hospital that we haven't already discussed?

MS. RIES-BUNTAIN: Objection, calls for speculation.

MR. BURTON: Join.

A. No.

MS. MORALES: I have no further questions.

FURTHER EXAMINATION

BY MR. BURTON:

Q. Dr. Patton, I have just a -- one follow-up line of questions.

You were asked extensively about if you recall Dr. Garvey discussing intubation or — with Mrs. Schwartz. Do you recall that?

A. Yeah, I don't remember any conversation. I don't remember any plan or conversation about intubation before we left the room. And it -- if she remembers that, I don't remember any conversation about that.

Q. Would it surprise you that she testifies in her deposition that Dr. Garvey did discuss intubation with her?

A. It wouldn't surprise me.

MS. MORALES: Objection. Form. Misstates the testimony.

(court reporter interjects)

Q. (By Mr. Burton) Let me read to you from Mrs. Schwartz's deposition. This is page 65, starting at line 15.

"QUESTION: Did Dr. Garvey ever discuss intubation while you were present?

"ANSWER: Yes.

"QUESTION: What did he discuss?

"ANSWER: Right before I left to go to the E.R. room, he said, 'and we might intubate him just in case he needs to keep his airway open in flight.'" Close quote.

Does that help refresh your recollection as to whether or not intubation was discussed?

A. No. I -- I just do not remember a conversation about intubation.

Q. But you don't have reason to dispute Mrs. Schwartz' testimony that I read to you, do you?

A. No.

MR. BURTON: All right. Thank you. I have no further questions.

Any other questions?

MS. MORALES: No.

MS. RIES-BUNTAIN: No other questions. Thank you, Dr. Patton.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: We're off the record now at 10:39 a.m. This ends this deposition.

(Signature having not been waived, the deposition of DR. JOHN PATTON was concluded at 10:39 a.m.)

ACKNOWLEDGMENT OF DEPONENT

I, JOHN PATTON, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me and any corrections appear on the attached Errata sheet signed by me.

_____ Date

_____ Signature

STATE OF NEVADA)
)SS.
COUNTY OF ELKO)

I, LISA M. MANLEY, a certified court reporter and notary public, in and for the County of Elko, State of Nevada, do hereby certify:

That on Friday, the 31st day of May, 2019, at the hour of 9:13 a.m. of said day, at Elko, Nevada, duly appeared JOHN PATRICK PATTON, who was duly sworn by me, according to law, to testify the truth, the whole truth and nothing but the truth in the matter entitled herein, and thereupon gave answers to the questions propounded to him;

That said questions and answers were taken down in stenotype by me, a stenotype reporter, and thereafter transcribed into longhand typewriting as herein appears.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 17th day of June, 2019.

_____
LISA M. MANLEY - CCR No. 271

ERRATA SHEET

IN RE: SCHWARTZ v. GARVEY, et al.
WITNESS: JOHN PATTON
1. Page___Line___Correction:_____
2. Page___Line___Correction:_____
3. Page___Line___Correction:_____
4. Page___Line___Correction:_____
5. Page___Line___Correction:_____
6. Page___Line___Correction:_____
7. Page___Line___Correction:_____
8. Page___Line___Correction:_____
9. Page___Line___Correction:_____

_____
JOHN PATTON

Original Summary

Provision of Care Event (93061) - 06-24-2016

SIM
Safety Incident Management

Provision of Care

This form is often used as the catch-all for events that have no other place. This form can be thought of as the miscellaneous form.

GENERAL INFORMATION ABOUT THE PROVISION OF CARE EVENT

General Event Type	Provision of Care
Specific Event Type	Patient Death (Unexpected)
Type of Person Affected	In-Patient
Severity Level (Reported)	E. Death
Injury Incurred?	Yes
Equipment Involved/Malfunctioned?	No
Brief Factual Description	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 start of 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 obtained from 2 other rooms and store room. Privacy issues with other patients in the ER (Room 11-verbal witness to trauma).
Contributing Factors (Reported)	• Staff - Use of Float Staff • Staffing Issue • Task - Training Issue • Work Envmnt - Inadequate Equipment Availability
Immediate Actions (Reported)	

When and Where Event Occurred

WHEN AND WHERE THE EVENT OCCURRED	
Event Date	06-23-2016
Time (00:00) use military	01:33
Site	Northeastern Nevada Regional Hospital
Department	Emergency
Unit	Main Department
Specific Location	Patient Room
Patient room number/location	Bed 12

Person Affected Details

DETAILS OF THE PERSON AFFECTED BY THE EVENT	
Person Affected MRN	330967
Encounter/Account #	6139781
Person Affected First Name	DOUGLAS
Person Affected Middle Name	
Person Affected Last Name	SCHWARTZ
Suffix	
Person Affected Date of Birth	06-02-1958
Person Affected Admission Date	06-22-2016
Discharge Date	
Person Affected Gender	Male
Person Affected Race	White
Person Affected Preferred Language	
Person Affected Street 1	
Person Affected Street 2	
Person Affected City	
Person Affected State	
Country	United States
Person Affected ZIP	
Person Affected Phone #	
Person Affected Alternate #	
Attending Physician	
Attending Physician Service	

Injury Details

PLEASE PROVIDE INFORMATION ABOUT THE INJURY

Nature of Injury	- Other
Location of Injury on Body	Traumatic, unsuccessful intubation resulting in patient death.
Treatment Provided	Yes

Parties Involved / Notified / Witnesses

CLICK ADD TO ENTER PARTIES INVOLVED / NOTIFIED / WITNESSES IN THE EVENT

Party Involved / Notified / Witnesses

ITEM 1

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Physician
Physician Service	
Party Involved Name	Dr Garvey
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 2

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Registered Nurse
Party Involved Name	Sue Olson, RN
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 3

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Registered Nurse
Party Involved Name	Donna Kevitt
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 4

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Registered Nurse
Party Involved Name	Cindy Fus
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 5

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Other (please specify)
Other Classification of Party	ER Tech
Party Involved Name	Nancy Abrahams
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 6

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Respiratory Therapist
Party Involved Name	Tom Evers
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

Privacy Statement

PRIVACY STATEMENT

This is a confidential and privileged quality assurance and patient safety work product document. It is protected from disclosure by the provisions of the Patient Safety and Quality Improvement Act (42 CFR Part 3) and other state and federal laws. Unauthorized disclosure or duplication is prohibited.

End of Form